2020
UnitedHealthcare Care Provider
Administrative Guide

UnitedHealthcare®

Welcome to UnitedHealthcare

Welcome to the UnitedHealthcare Care Provider Administrative Guide for Commercial and Medicare Advantage (MA) products. This guide has important information on topics such as claims and prior authorizations. It also has protocol information for health care providers. This guide has useful contact information such as addresses, phone numbers and websites. More policies and electronic tools are available on **UHCprovider.com**.

- If you are looking for a Community and State manual, go to **UHCprovider.com/guides** > Community Plan Care Provider Manuals By State and select the state
- If you are a UnitedHealthcare or Optum participating care provider or facility with an active Department of Veterans Affairs Community Care Network (VA CCN) agreement, you can find more information about VA CCN, including the **VA CCN Provider Manual**, at **vacommunitycare.com**.

You may easily find information in this guide using these steps:

1. Hold keys CTRL+F.
2. Type in the key word.
3. Press Enter.

This 2020 UnitedHealthcare Care Provider Administrative Guide (this "guide") applies to covered services you provide to our members or the members of our affiliates* through our benefit plans insured by or receiving administrative services from us, unless otherwise noted.

This guide is effective April 1, 2020, for physicians, health care professionals, facilities and ancillary providers currently participating in our Commercial and MA networks. It is effective now for care providers who join our network on or after Jan. 1, 2020. This guide is subject to change. We frequently update content in our effort to support our health care provider networks.

Terms and definitions as used in this guide:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement.
- "Commercial" refers to all UnitedHealthcare medical products that are not MA, Medicare Supplement, Medicaid, CHIP, workers' compensation or other governmental programs. "Commercial" also applies to benefit plans for the Health Insurance Marketplace, government employees or students at public universities.
- "You," "your" or "provider" refers to any health care provider subject to this guide. This includes physicians, health care professionals, facilities and ancillary providers, except when indicated. All items are applicable to all types of health care providers subject to this guide.
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us.
- "Us," "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this guide.
- Any reference to "ID card" includes both a physical or digital card.

MA policies, protocols and information in this guide apply to covered services you provide to UnitedHealthcare MA members, including Erickson Advantage members and most UnitedHealthcare Dual Complete members, excluding UnitedHealthcare Medicare Direct members. We indicate if a particular section does not apply to such MA members.

If there is a conflict or inconsistency between a Regulatory Requirements Appendix attached to your Agreement and this guide, the provisions of the Regulatory Requirements Appendix controls for benefit plans within the scope of that appendix.

If there is an inconsistency between your Agreement and this guide, your Agreement controls (except where your Agreement provides protocols for our affiliates). If those protocols are in a supplement to this guide, those protocols control for services you give to a member subject to that supplement.

Per your Agreement, you must comply with protocols. Payment will be denied, in whole or in part, for failure to comply with a protocol.

*UnitedHealthcare affiliates offering commercial and Medicare Advantage benefit plans and other services, are outlined in Chapter 1: Introduction.

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Chapter 1: Introduction

Manuals and Benefit Plans Referenced in This Guide

Some benefit plans included under your Agreement may be subject to requirements found in other health care provider guides or manuals or to the supplements found in the second half of this guide.

This section provides information about some of the most common UnitedHealthcare products. Your Agreement may use "benefit contract types", "benefit plan types" or a similar term to refer to our products.

Visit **UHCprovider.com/plans** for more information about our Products and Individual Exchange benefit plans offered by state.

If a member presents a health care ID card with a product name you are not familiar with, use *Link's* self-service tools to quickly find information on the plan. You may also call us at 877-842-3210.

You are subject to the provisions of additional guides when providing covered services to a member of those benefit plans, as described in your Agreement and in the following table. We may make changes to care provider guides, supplements and manuals that relate to protocol and payment policy changes.

We may change the location of a website, a benefit plan name, branding or the member health care ID card. We inform you of those changes through one of our care provider communications resources.

Benefit Plans Subject to this Guide

Plan Name	Location of Most Members Subject to Additional Guides	Location of Plan Information
All Savers: All Savers Insurance Company	All Markets	*All Savers Supplement* to this guide **myallsaversconnect.com**
MDIPA: MD Individual Practice Association, Inc.	DC, DE, MD, VA, WV Some counties in: Southeastern PA	*Mid-Atlantic Regional Supplement* to this guide. **UHCprovider.com**
Medica HealthCare	FL counties: Broward and Miami-Dade	*Medica HealthCare Supplement* to this guide. **UHCprovider.com**
Capitated and/or Delegated Providers Commercial and MA	All Markets	*Capitation and/or Delegation Supplement* to this guide.
NHP: Neighborhood Health Partnership, Inc.	FL	*Neighborhood Health Partnership Supplement* to this guide. **UHCprovider.com**
OCI: Optimum Choice Inc.	DC, DE, MD, VA, WV Some counties in: PA	*Mid-Atlantic Regional Supplement* to this guide. **UHCprovider.com**
OneNet PPO	DC, DE, MD, NC, PA, VA, WV Limited network in: FL, GA, SC, TN	*OneNet PPO Supplement* to this guide. **UHCprovider.com**
Oxford: • Oxford Health Plans, LLC • Oxford Health Insurance, Inc. • Investors Guaranty Life Insurance Company, Inc. • Oxford Health Plans (NY), Inc. • Oxford Health Plans (NJ), Inc. • Oxford Health Plans (CT), Inc.	CT, NJ, NY (except upstate) Some counties in: PA.	*Oxford Commercial Supplement* to this guide. For commercial benefits: **OxfordHealth.com** or **UHCprovider.com** For Medicare benefits: **UHCprovider.com**

Plan Name	Location of Most Members Subject to Additional Guides	Location of Plan Information
Preferred Care Partners	FL counties: Broward, Miami-Dade and Palm Beach	*Preferred Care Partners Supplement* to this guide. **UHCprovider.com**
River Valley: • UnitedHealthcare Services Company of the River Valley, Inc. • UnitedHealthcare Plan of the River Valley, Inc., and • UnitedHealthcare Insurance Company of the River Valley	Parts of AR, GA, IA, IL TN, WI, VA Your UnitedHealthcare contract specifically references River Valley or John Deere Health protocols or Guides; and You are located in AR, GA, IA, TN, VA, WI or these counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Mercer, Whiteside, Lee, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford, McLean, and You are providing services to a River Valley Commercial member and not a River Valley Medicare Advantage, Medicaid or CHIP member. **Note:** River Valley also offers benefit plans in LA, NC, OH & SC, but the River Valley Additional Guide does not apply to those benefit plans.	*River Valley Entities Supplement* to this guide. **UHCprovider.com**
Sierra or Health Plan of Nevada: • Sierra Health and Life Insurance Co., Inc. • Health Plan of Nevada, Inc. • Sierra Healthcare Options, Inc.	Outside NV only: The health care ID card identifies the Sierra or Health Plan of Nevada members who access the UnitedHealthcare network outside of Nevada, and includes the following reference: UnitedHealthcare Choice Plus Network Outside Nevada.	Services rendered outside of Nevada to Sierra or Health Plan of Nevada members with the health care ID card reference described in this row are subject to your UnitedHealthcare Agreement and to this guide unless you are in Arizona or Utah and have a contract directly with Sierra or Health Plan of Nevada.
UnitedHealthcare West: (Formerly referenced in this guide as "PacifiCare") • UHC of California dba UnitedHealthcare of California (hereinafter referred to as UnitedHealthcare of California) • UnitedHealthcare Benefits Plan of California • UnitedHealthcare of Oklahoma, Inc. • UnitedHealthcare of Oregon, Inc. • UnitedHealthcare Benefits of Texas, Inc. • PacifiCare of Arizona, Inc. • PacifiCare of Colorado, Inc.+ • PacifiCare of Nevada, Inc. + Medicare Advantage benefit plans only.	AZ, CA, CO, NV, OK, OR, TX, WA	*UnitedHealthcare West Supplement* to this guide. **UHCprovider.com**
UnitedHealthOne: • Golden Rule Insurance Company Group #705214 • Oxford Health Insurance, Inc. Group #908410	All Markets New Jersey	*UnitedHealthOne Individual Plans Supplement* to this guide. **UHCprovider.com** and **myUHOne.com**

Benefit Plans Not Subject to This Guide

Empire Plan: In most states, we have a separate care provider network for the Empire Plan members. If you have a direct contract for our Empire Plan Network (The UnitedHealthcare Empire Plan Agreement), this guide does not apply. If you do not have an Empire Plan contract and are a care provider in AZ, CT, DC, FL, IL, MD, NJ, NC, PA, SC, VA, or WV, or if you are a national care provider, your Agreement allows Empire Plan members to access your services (unless it specifically excludes Empire Plan). In those cases, this guide applies.

Plan name	Location of most members subject to additional guides	Additional guide/ website
Rocky Mountain Health Plan (RMHP)	CO	rmhp.org
Sierra: • Sierra Health and Life Insurance Co., Inc. • Sierra Healthcare Options, Inc. • Health Plan of Nevada, Inc. • Health Plan of Nevada Medicaid/ Nevada Check Up	NV	Benefit plans for Sierra Health and Life Insurance Company, Inc.: myshlonline.com/provider Benefit plans for Sierra Healthcare Options, Inc: sierrahealthcareoptions.com Benefit plans for Health Plan of Nevada, Inc.: myhpnonline.com/provider myhpnmedicaid.com/Provider
UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured	Multiple States	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicaid, CHIP, or Uninsured. UHCprovider.com/communityplan and UHCprovider.com
UnitedHealthcare Dual Complete including references to older brand names such as AmeriChoice, Great Lakes Health Plan, Unison, Arizona Physicians IPA (APIPA)	Multiple States	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicare UHCprovider.com/communityplan and UHCprovider.com
UMR		umr.com

Online Resources and How to Contact Us

UHCprovider.com
UHCprovider.com is your home for care provider information with access to Electronic Data Interchange (EDI), Link self-service tools, medical policies, news bulletins, and great resources to support administrative tasks including eligibility, claims, claims status and prior authorizations and notifications.

Electronic Data Interchange (EDI)
EDI is a self-service resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837),
  - Eligibility and benefits (270/271),
  - Claims status (276/277),
  - Referrals and authorizations (278),
  - Hospital admission notifications (278N), and
  - Electronic remittance advice (ERA/835).

Visit UHCprovider.com/EDI for more information. Learn how to optimize your use of EDI at UHCprovider.com/optimizeEDI.

Getting Started
- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system.
- Contact clearinghouses to review which electronic transactions can interact with your software system.

Read our Clearinghouse Options page for more information.

Link
Link provides online resources to support your administrative tasks including eligibility, claims and prior authorization and notifications.

To sign in to Link, go to UHCprovider.com and click on the Link button in the upper right corner. For more information about all Link tools, go to UHCprovider.com/Link.

You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and Link for maximum efficiency in conducting business electronically.

You will use Link to access information for:

- UnitedHealthcare Commercial
- UnitedHealthcare Medicare Advantage
- UnitedHealthcare Community Plan (as contracted by state)
- UnitedHealthcare West
- UnitedHealthcare of the River Valley
- UnitedHealthcare Oxford Commercial

Available benefit plan information varies for each of our Link tools.

Here are the most frequently used tools:

- **eligibilityLink**—View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibilityLink**.
- **claimsLink**—Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claimsLink**.
- **Prior Authorization and Notification**—Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/paan**.
- **Specialty Pharmacy Transactions**—Submit notification and prior authorization requests for certain medical injectable specialty drugs using the Specialty Pharmacy Transaction tile on your Link dashboard.
- **My Practice Profile**—View and update* your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Vault**—Access reports and claim letters for viewing, printing, or download. For more information, go to **UHCprovider.com/documentvault**.
- **Paperless Delivery Options**—The Paperless Delivery Options tool can send daily or weekly email notifications to alert you to new letters when we add them to your Document Vault. With our delivery options, you decide when and where the emails are sent for each type of letter. This is available to Link Password Owners only.
- **UHC On Air**—Watch live broadcasts and on-demand programs on topics important to you. Find instructions for adding UHC On Air to your Link dashboard at **UHCprovider.com/uhconair**.

You need an Optum ID to access Link and use tools available to you. To register for an Optum ID, go to **UHCprovider.com/newuser**.

Watch for the most current information on our self-service resources by email, in the Network Bulletin, or online at **UHCprovider.com/EDI** or **UHCprovider.com/Link**.

* For more instructions, visit **UHCprovider.com/Training**.

Online Resources and How to Contact Us	Where to go
How to Join Our Network	For instructions on joining the UnitedHealthcare provider network, go to **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service tools and other helpful information.
UnitedHealthcare Provider Website	**UHCprovider.com**, or **UHCprovider.com/Link** Resources: • Access to care provider policies and protocols, tools, training and network bulletins. • Enroll in Electronic Payments and Statements (EPS) for direct deposit for covered services and electronic remittance advice. • Authorizations and referrals information, submissions and status. • Verify eligibility and benefits. • Verify your network and tier status for a member's benefit plan. • Claims management including filing, status information and claims reconsiderations. **Help Desks:** 866-842-3278 (option 1 for UHCprovider.com and Link assistance). M-F, 7 a.m. to 9 p.m., Central Time (CT)

Online Resources and How to Contact Us	Where to go
Advance Notification, Prior Authorization and Admission Notification (To submit and get status information)	**EDI:** See EDI transactions and code sets on UHCprovider.com/edi **Online:** UHCprovider.com/paan **Phone:** 877-842-3210 (United Voice Portal) See member's health care ID card for specific service contact information.
Air Ambulance Non-Emergency Transport	**Online:** UHCprovider.com/findprovider
Appeal – (Clinical) Urgent Submission (Commercial members) (Medicare Advantage – follow the directions in the customer decision letter) All Savers, Golden Rule Insurance Company and UnitedHealthcare Oxford Navigate Individual	An expedited appeal may be available if the time needed to complete a standard appeal could seriously jeopardize the member's life, health or ability to regain maximum function. **Urgent Medical fax:** 801-994-1083 **Urgent Pharmacy fax:** 801-994-1058 **Urgent Appeal fax:** 866-654-6323
Cardiology and Radiology Notification/Prior Authorization –Submission & Status	**Online:** UHCprovider.com/priorauth and select the specialty you need. **Phone:** 866-889-8054
Chiropractic, Physical Therapy, Occupational Therapy and Speech Therapy Providers (Contracted with OptumHealth Physical Health, a UnitedHealth Group company)	**Online:** myoptumhealthphysicalhealth.com **Phone:** 800-873-4575
Claims (Filing, payments, reconsiderations)	**EDI:** UHCprovider.com/edi. View our Claims Payer List to determine the correct Payer ID. **Link:** Use Claim Submission for filing and claimsLink for status information and to request reconsiderations. **Online:** UHCprovider.com/claims (policies, instructions and tips) **Phone:** 877-842-3210 (follow the prompts for status information)
Electronic Payments and Statements (EPS)	**Online:** UHCprovider.com/EPS Or: Optumbank.com > Partners > Providers > Electronic Payments and Statements Or: the EPS tool on Link **Help Desk:** 877-620-6194
Electronic Data Interchange (EDI) and EDI Support	**Online:** UHCprovider.com/edi **Help:** UHCprovider.com/EDI > Contacts **Phone:** 800-842-1109 (M-F, 7 a.m. – 9 p.m. CT) **UnitedHealthcare EDI Support** **Online:** EDI Transaction Support Form **Email:** supportedi@uhc.com **Phone:** 800-842-1109 **UnitedHealthcare Community Plan EDI Support** **Online:** EDI Transaction Support Form **Email:** ac_edi_ops@uhc.com **Phone:** 800-210-8315
Fraud, Waste and Abuse (Report potential fraud, waste or abuse concerns)	**Online:** uhc.com/fraud, select the "Report A Concern" icon. **Phone:** 844-359-7736 **Phone:** 877-842-3210 (United Voice Portal) For more information on fraud, waste, and abuse prevention efforts, refer to: *Chapter 16: Fraud, Waste and Abuse*.
Genetic and Molecular Testing	**Online:** UHCprovider.com/priorauth and select the specialty you need. **Phone:** 800-377-8809
Member/Customer Care	**Online:** myuhc.com **Phone:** 877-842-3210

Online Resources and How to Contact Us	Where to go
Mental Health and Substance Use Services	See member's health care ID card for carrier information and contact numbers.
Outpatient Injectable Chemotherapy and Related Cancer Therapies	**Online:** UHCprovider.com/priorauth and select the specialty you need. **Phone:** 888-397-8129
Pharmacy Services	**Online:** professionals.optumrx.com **Phone:** 800-711-4555
Provider Advocates For participating hospitals, health care, and ancillary providers; Locate your physician or hospital advocate	**Online:** UHCprovider.com > Contact Us > Find a Network Contact
Provider Directory	UHCprovider.com/findprovider
Referral Submission and Status You can determine if a member's benefit plan requires a referral when you view their eligibility profile.	**EDI:** 278 transaction **Link:** UHCprovider.com/referralLink **Online:** UHCprovider.com/referrals Note: Submitted referrals are effective immediately but may not be viewable for 48 hours.
Skilled Nursing Facilities (Free-standing)	**Online:** UHCprovider.com/skillednursing **Phone:** 877-842-3210 (for Provider Service)
Therapeutic Radiation Prior Authorization	**Online:** UHCprovider.com/oncology > Commercial Intensity Modulated Radiation Therapy Prior Authorization Program UHCprovider.com/oncology > Medicare Advantage Therapeutic Radiation Prior Authorization Page **Phone:** 866-889-8054 (MA only)
Transplant Services	See member's health care ID card for carrier information and contact numbers.
Vision Services	See member's health care ID card for carrier information and contact numbers.

Chapter 2: Provider Responsibilities and Standards

Verifying Eligibility, Benefits and Your Network Participation Status

Check the member's eligibility and benefits prior to providing care. Doing this:

- Helps ensure that you submit the claim to the correct payer;
- Allows you to collect copayments;
- Determines if a referral and prior authorization or notification is required; and
- Reduces denials for non-coverage.

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information.

There are three easy ways to verify eligibility and benefits as shown in the *Online Resources and How to Contact Us* section in Chapter 1: Introduction.

EDI: Eligibility and Benefit Inquiry (270) and Response (271)

The EDI 270/271 transaction allows you to obtain members' eligibility and benefit information in "real-time". The HIPAA ANSI X12 270/271 format is the only acceptable format for this EDI transaction. Enhancements to these transactions are made periodically and are located in the Helpful Resources section of the **270/271 page**.

Eligibility Grace Period for Individual Exchange Members

When individuals enroll in a health benefit plan through the Individual Health Insurance Marketplace (also known as Individual Exchange), the plans are required to provide a three-month grace period before terminating coverage. The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least one full month's premium within the benefit year.

You can verify if the member is within the grace period when you verify eligibility.

If the date of service occurs after the 'through date', the member is in the grace period. They are at risk of retroactive termination if the premium is not paid in full at the end of the three-month period.

Understanding Your Network Participation Status

Your network status is not returned on 270/271 transactions. Know your status prior to submitting 270 transactions. As our product portfolio evolves and new products are introduced, it is important for you to confirm your network status and tier status (for tiered benefit plans) while checking **eligibilityLink** or by calling us at **877-842-3210**. If you are not participating in the member's benefit plan or are outside the network service area for the benefit plan (i.e., Compass), the member may have higher costs or no coverage. For more information about Tiered Benefit Plans, visit **UHCprovider.com/plans** > Select your state > Commercial > UnitedHealthcare Tiered Benefit Plans.

Health Care Identification (ID) Cards

Our members receive health care ID cards that include information necessary for you to submit claims, such as the payer ID for electronic claims submission. Information on the cards may vary by health benefit plan.

You can view current ID cards for most members when you verify eligibility using UHCprovider.com/**eligibilityLink**.

Please check the member's health care ID card at each visit. You may keep a copy of both sides of the health care ID card for your records. Possession of a health care ID card is not proof of eligibility.

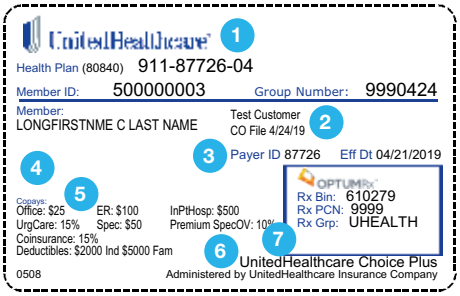
Bar-coded Health Care ID Cards

We use bar codes on most health care ID cards for easy access to member information.

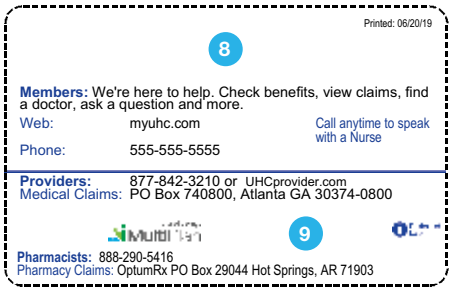
A 2D bar code scanner is required to scan these cards. The scanner can be used together with **UHCprovider.com** to access the Member's Personal Health Record, verify eligibility, submit a claim and perform other administrative transactions. We use the national Workgroup for Electronic Data Interchange (WEDI) card standards for our ID cards.

Commercial Health Care ID Card Legend

Front



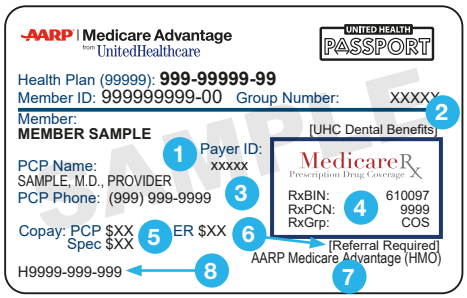
Back



1. **UnitedHealthcare brand:** This includes UnitedHealthcare, AllSavers, Golden Rule, UnitedHealthcare Oxford, UnitedHealthOne.
2. **Member Plan Identifier:** This is a customized field to describe the member's benefit plan (i.e., Individual Exchange, Tiered Benefits, ACO, etc.).
3. **Payer ID:** Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.
4. **Primary Care Provider (PCP) name and phone number:** Included for benefit plans that have PCP selection requirements. For Individual Exchange Members 'PCP required' is listed in place of the PCP name and number. This section may also include Laboratory (LAB), PLN (Preferred Lab Network Designation) and Radiology (RAD) participant codes.
5. **Copay information:** If this area is blank, the member is not required to make a copay at the time of service.
6. **The Benefit Plan Name:** Identifies the applicable benefit plan name.
7. **Referral requirements identifier:** Identifies plans with referral requirements. Requires PCP to send electronic referrals.
8. **For Members section:** Lists benefit plan contact information and if applicable, referrals and notifications information.
9. **For Providers section:** Includes the prescription plan name.

Medicare Advantage (MA) Health Care ID Card

Front



Back

MA ID card legend:

1. **Payer ID:** Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.
2. **Dental Benefits:** Included if routine dental benefits are part of the benefit plan and/or if the member purchased an optional supplemental dental benefit rider.
3. **PCP name and phone number:** Included for benefit plans that require a PCP selection.
4. **Prescription information:** If the benefit plan includes Part D prescription drug coverage, the Rx Bin, PCN and Group code are visible. If Part D coverage is not included, this area lists information for Medicare Part B Drugs.
5. **Copay information including PCP, specialist, and ER copays.** Some special needs plans do not list copay information. One PPO plan in New York has two copayments for PCPs and for specialists. Select Erickson plans have two copayments for PCPs.
6. **Referral requirements identifier:** Identifies benefit plans with referral requirements. Refer to the *Medicare Advantage (MA) Referral Required Plans* of this guide for more detailed information. If the benefit plan does not require referrals "No Referral Required" appears on the back of member's health care ID card.
7. **The Benefit Plan Name:** Identifies the applicable Medicare Advantage benefit plan name.
8. **Plan ID Number:** Identifies the plan ID number that corresponds to CMS filings.
9. **For Members:** Lists benefit plan contact information for the member.
10. **For Providers:** Lists benefit plan contact information for the care provider.

Access Standards

Covering Physician

As a primary care provider (PCP), you must arrange for 24 hours a day, seven days per week coverage of our members. If you are arranging a substitute care provider, use those who are in-network with the member's benefit plan.

You must alert us if the covering care provider is not in your medical group practice to prevent claim payment issues. Use modifiers for substitute physician (Q5), covering physician (CP) and locum tenens (Q6) when billing services as a covering physician. Collect the copay at the time of service.

To find the most current directory of our network physicians and health care professionals, go to **UHCprovider.com/findprovider**.

Appointment Standards

We have appointment standards for access and after-hours care to help ensure timely access to care for members. We use these to measure performance annually. Our standards are shown in the following table.

Type of service	Standard
Preventive Care	Within 30 calendar days
Regular/Routine Care Appointment	Within 14 calendar days
Urgent Care Appointment	Same day
Emergency Care	Immediate
After-Hours Care	24 hours/seven days a week for PCPs

These are general UnitedHealthcare guidelines. State or federal regulations may require standards that are more stringent. Contact your Network Management representative for help determining your state or federal-specific regulations.

After-Hours Phone Message Instructions

If a member calls your office after hours, we ask that you provide emergency instructions, whether a person or a recording answers. Tell callers with an emergency to:

- Hang up and dial 911, or its local equivalent, or
- Go to the nearest emergency room.

When it is not an emergency, but the caller cannot wait until the next business day, advise them to:

- Go to a network urgent care center,
- Stay on the line to connect to the physician on call,
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames, or
- Call an alternative phone or pager number to contact you or the physician on call.

Timely Access to Non-Emergency Health Care Services (Applies to Commercial in California)

- The timeliness standards require licensed health care providers to offer members appointments that meet the California time frames. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, is:
  - Acting within the scope of their practice and consistent with professionally recognized standards of practice, and
  - Has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the member's health.
- Triage or screening services by phone must be provided by licensed staff 24 hours a day, seven days a week. Unlicensed staff shall not use the answers to those questions in an attempt to assess, evaluate, advise or make any decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.
- UnitedHealthcare of California managed care members and covered persons under UnitedHealthcare Insurance Company benefit plans have access to free triage and screening services 24 hours a day, seven days a week through Optum's NurseLine at 866-747-4325. If a member or covered person is unable to obtain a timely referral to an appropriate provider, refer to the *Non-Participating Care Provider Referrals*, *Referrals & Referral Contracting,* or *Out-of-Network Provider Referrals (Commercial HMO and Medicare Advantage)* sections for further details. If still unable to obtain a timely referral to a care provider after following these steps, contact:
- For members with Department of Managed Healthcare regulated plans: 888-466-2219
- For members with California Department of Insurance regulated plans: 800-927-4357

Provider Privileges

You must have privileges at participating facilities or an arrangement with another participating care provider to admit and offer facility services. This helps our members have access to appropriate care and lower their out-of-pocket costs.

Cultural Competency

Provide services in a culturally competent manner. This includes handling members with limited English proficiency or reading skills, diverse backgrounds and physical or mental disabilities.

Network Participating Care Provider Responsibilities

Primary Care Physicians (PCP)

As a PCP, you are responsible to provide medically necessary primary care services. You are the coordinator of our members' total health care needs. You are responsible for seeing all members on your panel who need assistance, even if the member has never been in for an office visit. Some benefit plans require PCPs to submit electronic referrals for the member to see another network physician. Go to *Chapter 5: Referrals* for detailed information on referral requirements.

Civil Rights

Non-Discrimination

You must not discriminate against any patient with regard to quality of service or accessibility of services because they are our member. You must not discriminate against any patient on the basis of:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of payment

You must maintain policies and procedures to demonstrate you do not discriminate in the delivery of service and accept for treatment any members in need of your service.

Americans with Disabilities Act (ADA) Guidelines

Participating care providers must have practice policies showing they accept any patient in need of the health care they provide. The organization and its care providers must make public declarations (i.e., through posters or mission statements) of their commitment to non-discriminatory behavior in conducting business with all members. These documents should explain that this expectation applies to all personnel, clinical and non-clinical, in their dealings with each member.

In this regard, you must undertake new construction and renovations, as well as barrier reductions required to achieve program accessibility, following the established accessibility standards of the ADA guidelines. For complete details go to ADA.gov > Featured Topics > A Guide to Disability Rights Laws.

We may request any of the following ADA-related descriptions of:

- Accessibility to your office or facility
- The methods you or your staff use to communicate with members who have visual or hearing impairments
- The training your staff receive to learn and implement these guidelines

Care for Members Who Are Hearing-Impaired

Refusing to provide care or interpreter services for a person with a qualifying disability is an ADA violation. Members who are hearing-impaired have the right to use sign-language interpreters to help them at their care provider visits.

Cooperation with Quality Improvement and Patient Safety Activities

You must follow our quality improvement and patient safety activities and programs. These include:

- Quick access to medical records when requested.
- Timely responses to queries and/or completion of improvement action plans during quality of care investigations.
- Participation in quality audits, including site visits and medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Allowing use of practitioner and care provider performance data.
- Notifying us when you become aware of a patient safety issue or concern.

Demographic Changes

If you have received the upgraded My Practice Profile and have editing rights, you can access Link's My Practice Profile tool to make many of the updates required in this section. Facilities can use the UnitedHealthcare Facility Demographic Updates tool. For more information, go to **UHCprovider.com/mypracticeprofile**.

Physician/Health Care Professional Verification Outreach

We are committed to providing our members with the most accurate and up-to-date information about our network. We are currently undertaking an initiative to improve our data quality. This initiative is called Professional Verification Outreach (PVO).

Your office may receive a call from us asking to verify your data currently on file in our provider database. This information is confidential and updated immediately in our database.

Provide Official Notice

Notify us, at the address in your Agreement, within 10 calendar days if any of these situations occur:

- Material changes to, cancellation or termination of liability insurance.
- Bankruptcy or insolvency.
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession.
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice. For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility.
- Relocation or closure of your practice, and, if applicable, transfer of member records to another physician/facility.
- External sanctions or corrective actions levied against you by a government entity.

Provide Timely Notice of Demographic Changes

Primary Care Physicians

As a PCP, you are responsible for monitoring your office capacity based on member assignments and for notifying us if you have reached your maximum capacity. A self-reporting tool is available for you to generate a PCP panel roster report using **UHCprovider.com/reports**.

We have developed specific definitions for open, closed or existing-only practices to promote consistency throughout the participating care provider network related to acceptance of new or transferring members. For purposes of this section, a new member may be a member who has switched health plans and/or coverage plans, such as a member who switches from a Fee-For-Service (FFS) plan to a Commercial HMO/MCO plan.

Follow these definitions:

- Open status – the PCP's practice is open to additional new members and transferring members.
- Closed status – the PCP's practice is closed to all new members and transferring members.
- Existing-only status – the PCP's practice is only open to new or transferring members who have an established chart with the care provider's office.

Notification of Changes Must be Proactive

Every quarter, you, or an entity delegated to handle credentialing activities on behalf of us (a "delegate"), are expected to review, update and attest to the care provider information available to our members. If you or the delegate cannot attest to the information, correct it online or through the Provider Service Center. You or the delegate must tell us of changes to the information at least 30 calendar days before the change is effective. This includes adding new information and removing outdated information, as well as updating the information listed in the following paragraph. Delegates are responsible for notifying us of these changes for all of the participating care providers credentialed by the delegate. If you or a delegate fails to (1) update records, or (2) give 30 days prior notice of changes, or (3) attest to the information, you, or the participating care providers credentialed by the delegate, may be subject to penalties. Penalties may include a delay of processing claims or the denial of claims payment, until the records are reviewed and attested to or updated.

You and the delegates are required to update all care provider information, such as:

- Patient acceptance status
- Address(es) of practice location(s)
- Office phone number(s)
- Email address(es)
- Care provider groups affiliation
- Facility affiliation
- Specialty
- License(s)
- Tax identification number
- NPI(s)
- Languages spoken/written by staff
- Ages/genders served
- Office hours

If a health care provider leaves your practice, notify us immediately. This gives us time to notify impacted members.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the care provider. On-call and substitute care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

California Commercial: The penalties do not apply to benefit plans issued or administered by UnitedHealthcare Benefit Plans of California.

To Change Panel Status (Open/Closed/ Existing-Only)

If you wish to change your panel status (i.e., open to new patients, open to existing patients only, or closed), the request must be made in writing 30 days in advance. Changes to panel status applies to all patients for all lines of business (LOB) and products for which a care provider is participating. If you feel that exceptional circumstances

exist, you may request to have a different panel status for an LOB or product. The exception must be included in the written request and approval is at our discretion. We may notify you in writing of changes in our panel status including closures based on state and/or federal requirements, current market dynamics and patient quality indicators. Access the MyPracticeProfile tool on Link from UHCprovider.com to update your information.

To Change an Existing TIN or to Add a Physician or Health Care Provider

To submit the change, please complete and email the *Provider Demographic Change Form* to the appropriate email address listed on the form.

The *Provider Demographic Change Form* is available on UHCprovider.com/findprovider.

You can also submit detailed information about the change and the effective date of the change on your office letterhead. Send it to us using the fax number on the bottom of the demographic change request form.

To Update Your Practice or Facility Information

You can make updates to your practice information by :

1. **Link** and using the My Practice Profile tool for providers; UnitedHealthcare Facility Demographic Updates form for facilities.
2. Emailing the completed *Provider Demographic Change Form* to the appropriate email address listed on the bottom of the form; or
3. Calling our Enterprise Voice Portal at **877-842-3210**.

For Medica HealthCare and Preferred Care Partners, you must contact their Network Management Department by email, pcp-NetworkManagementServices@uhcsouthflorida.com, or call 877-407-9069. Changes should not be made in Link.

Notification of Practice or Demographic Changes (Applies to Commercial Benefit Plans in California)

California Senate Bill 137 requires us to perform ongoing updates to our care provider directories, both online and hard copy. As a participating medical group, IPA or independent physician, you are required to update UnitedHealthcare within five business days if there are any changes to your ability to accept new patients.

As a participating medical group, IPA or independent physician, if a member or potential enrollee seeking to become a patient contacts you, and you are no longer accepting new patients, you must direct them to report any inaccuracy in our care provider directory to both:

- UnitedHealthcare for additional assistance in finding a care provider, and, as applicable,
- Either the California Department of Managed Health Care or the California Department of Insurance.

You shall cooperate with and provide the necessary information to us so we may meet the requirements of Senate Bill 137. We are required to contact all participating care providers, including but not limited to, contracted medical groups or IPAs on an annual basis and independent physicians every six months. This outreach includes a summary of the information that we have on record and requires you to respond by either confirming your information is accurate, or providing us with applicable changes.

If we do not receive a response from you within 30 business days, either confirming that the information on file is correct, or providing us with the necessary updates, we have an additional 15 business days to make attempts for you to verify the information. If these attempts are unsuccessful, we will notify you that, if you continue to be nonresponsive, we will remove you from our care provider directory after 10 business days.

If the final 10-business day period lapses with no response from you, we may remove you from the directory. If we receive notification that the provider directory information is inaccurate, the care provider group, IPA, or physician may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we are required to make outreach if we receive a report of inaccuracy for any care provider data in the directories. We are required to confirm your information is correct. If we attempt to contact you and do not receive a response, we will provide you a 10 business-day notice that we will suppress your information from our care provider directory.

Medical groups, IPAs, or independent physicians can submit applicable changes to:

For Delegated providers: email changes to Pacific_DelProv@uhc.com or delprov@uhc.com.

For Non-Delegated providers: Visit UHCprovider.com for the *Provider Demographic Change Submission Form* and further instructions.

Administrative Terminations for Inactivity

Up-to-date directories are a critical element of providing our members with the information they need to take care of their health. To offer more exact and up-to-date directories, we:

- Administratively terminate Agreements for care providers who have not submitted claims for one year, and
- Inactivate any tax identification number (TIN) under which there have been no claims submitted for one year.

When care providers tell us of practitioners leaving a practice, we make multiple attempts to get documentation of that change.

We administratively terminate a care provider if:

- We get oral notice that a practitioner is no longer with a practice, and
- We make three attempts to obtain documentation confirming the practitioner's departure, but do not receive the requested documentation, and
- The practitioner has not submitted claims under that practice's TIN(s) for six months prior to our receipt of oral notice the practitioner left the practice, or the effective date of departure provided to us, whichever is sooner. This does not apply to Medica HealthCare and Preferred Care Partners.

Continuity of Care Following Termination of Your Participation

If your Agreement ends for any reason, you may be required to help our members find another participating care provider. You may need to provide services at our contracted rate during the continuation period, per your Agreement and any applicable laws. We are ready to help you and our members with the transition. We tell affected members at least 30 calendar days prior to the effective date of your participation termination, or as required under applicable laws.

Member Dismissals Initiated by a PCP (Medicare Advantage)

We recognize there are certain instances a PCP may choose to terminate a patient relationship. While we will not interfere with the PCP's decision, we will:

- Remind the PCP of their obligation to terminate the relationship in accordance with applicable requirements,
- Help ensure that the PCP provides us a reason for making the decision, and
- Require documentation that they have communicated this decision to the member.

Each dismissal should be carefully considered based on the facts and circumstances specific to the member.

In addition, PCPs who wish to terminate their relationship with a Medicare Advantage (MA) member (dismiss) and have a member reassigned must:

- Comply with all applicable legal and regulatory requirements;
- Send a certified letter to the member (evidence that the letter was mailed is acceptable even if a letter comes back as "undeliverable as addressed");
- Provide continuity of care as required by applicable laws and regulations for no less than 30 days from the member's receipt of the dismissal letter; and
- Provide us written notice.

Required Information from the PCP

For member reassignment, we require information from the PCP:

- PCP's reason for reassignment or termination
- Member's name, date of birth, address, and member ID
- PCP's name, NPI, and TINs
- Copy of certified letter the PCP sent to the member notifying them of the termination

We use good faith efforts to reassign the member to another PCP within 90 days of receipt of request. Changes will not be applied retroactively.

Medicare Opt-Out

We follow, and require our care providers to follow, Medicare requirements for physicians and other practitioners who opt out of Medicare. If you opt out of Medicare, you may not accept federal reimbursement. Care providers who opt-out of Medicare (and those not participating in Medicare) are not allowed to bill Medicare or its MA benefit plans during their opt-out period for two years from the date of official opt-out. For our MA membership, we and our delegated entities do not contract with, or pay claims to, care providers who have opted-out of Medicare. Exception: In an emergency or urgent care situation, if you have opted out of Medicare, you may treat an MA beneficiary and bill for the treatment. In this situation, you may not charge the member more than what a non-participating care provider is allowed to charge. You must submit a claim to us on the member's behalf. We pay Medicare covered items or services furnished in emergency or urgent situations.

Additional MA Requirements

As an MA organization, UnitedHealthcare and its network care providers agree to meet all laws and regulations applicable to recipients of federal funds.

If you participate in the network for our MA products, you must comply with the following additional requirements for services you provide to our MA members.

- You may not discriminate against members in any way based on health status.
- You must allow members direct access to screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services. For additional information, refer to the *Medicare Advantage Coverage Summary for Preventive Health Services and Procedures* available

on UHCprovider.com/policies > Medicare Advantage Policies > **Coverage Summaries for Medicare Advantage Plans**.

- You must provide female members with direct access to a women's health specialist for routine and preventive health care services.
- You must make sure members have adequate access to covered health services.
- You must make sure your hours of operation are convenient to members.
- You must make sure medically necessary services are available to members 24 hours a day, seven days a week.
- Primary care providers must have backups for absences.
- You must adhere to CMS marketing regulations and guidelines. This includes, but is not limited to, the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge, or attempt to persuade Medicare beneficiaries to enroll or disenroll in a specific plan based on the care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner taking into account limited English proficiency or reading skills, hearing or vision impairment, and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to tell members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member's medical record whether they have executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.
- You must make sure any payment and incentive arrangements with subcontractors are specified in a written Agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the **False Claims Act**, and the **Anti-Kickback Statute**; and (b) **HIPAA administrative simplification rules** at 45 CFR Parts 160, 162 and 164.
- The payments you receive from us or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must comply with our processes for notifying members of your Agreement terminations.
- You must submit all *Risk Adjustment Data* (see definition in glossary), and other MA program-related information we may request, within the time frames specified and in a form that meets MA program requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information and belief.
- You must comply with our MA medical policies, Policy Guidelines, Coverage Summaries, quality improvement programs, and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within two hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.
- You must comply with the Medicare Advantage Regulatory Requirements Appendix (MARRA) in your Provider Agreement.

Member Communication (CMS Approval Required)

Member communications require CMS approval. This includes:

- Anything with the MA and/or the AARP name or logo, including MA Dual Special Needs Plans
- Correspondence that describes benefits
- Marketing activities

Approval is not necessary for communications between care providers and patients that discuss:

- Their medical condition
- Treatment plan and/or options
- Information about managing their medical care

Once CMS approves, we send the letter to the member.

In addition to making sure the letter is approved by the governing regulatory body, we direct the letter to

the correct audience. For example, we may need to distinguish a mailing to MA plan individual members versus Medicare group retiree members, as their benefits are distinctly different.

Part C Reporting Requirements

MA organizations are subject to additional reporting requirements. We may request data from our contracted care providers. This data is due by 11:59 p.m. Pacific Time on our established reporting deadline.

Some measures are reported annually, while others are reported quarterly or semi-annually. This includes, but is not limited to:

- Grievances
- Organization determinations/reconsiderations including source data for all determinations and reopenings
- Special needs plans care management
- Rewards and incentive programs
- Payments to care providers
- Telehealth benefits

Filing of a Lawsuit by a Member

Lawsuits Against a Care Provider

We do not automatically move the member to another medical group/IPA because of a lawsuit.

We consider a transfer if:

- The complaint is about problems with quality of care or inappropriate behavior AND the care provider requests removal from their care.
- The transfer would not affect the member's current treatment.
  - › The treating care provider must confirm this.
  - › The treating care provider must cooperate in the transfer of medical records and information to the new care provider.
- The member wants another care provider who is part of the same medical group/IPA but located in a different office.

Lawsuits Against a Medical Group/IPA

We do not deny the member access to care providers within a medical group/IPA because of a lawsuit. We consider a transfer if the member's complaint is about problems with the general practices and procedures of the medical group/IPA.

Note: If you receive notification of a member's plan to sue, please notify your care provider advocate.

New York (NY) Domestic and Sexual Violence Hotline (only applicable to NY care providers who see Commercial and Oxford Health Plan members)

New York state law requires that all NY care providers post the Domestic and Sexual Violence Hotline information in their office. You can download the information at UHC.com > Legal > New York > **Members with a New York UnitedHealthcare insurance policy who may be in danger from another family member** (pdf).

Chapter 3: Commercial Products

We create new commercial products and networks to meet member needs for affordable and quality care. We offer a variety of fully insured and self-funded commercial products for small and large groups. We also have individual benefit plans. These products vary by network size and make-up, gated or non-gated requirements, and benefit structure.

Health Insurance Marketplaces (Exchanges)

We offer commercial products on the Individual or Small Business Health Options Program (SHOP) Exchange in some states. Commercial products on the Individual and SHOP Exchange follow the same policies and protocols within this guide, unless otherwise stated in your Agreement.

Understanding Your Network Participation Status

You are contracted to see all commercial members (including Exchange), unless your Agreement excludes you. This includes new benefit plans brought into your market after the effective date of your Agreement. UnitedHealthcare Compass requires you to be located in a limited geographic market called the Compass network service area. Verify the current Compass network service area at **UHCprovider.com/Plans**.

Commercial Networks

Each commercial product has a network of care providers we work with to provide more affordable, quality health care. Our commercial benefit plans include a subset of our commercial network care providers: Navigate, Charter, Core, Compass and NexusACO. A list of participating care providers by benefit plan is on **UHCprovider.com/findprovider**. Your Agreement requires you to coordinate care with other participating (network) care providers.

Commercial Product Overview Table

Product Name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Choice and Choice Plus	Members can choose any network physician or health care professional without a referral and without designating a PCP. UnitedHealthcare Choice Plus provides out-of-network benefits. UnitedHealthcare Choice does not cover out-of-network services (except for emergency services).	No, members have open access to a national network of care providers.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Doctors Plan and Doctors Plan Plus	Members choose, or are assigned, a network PCP for each family member. Members are encouraged to see their PCP to coordinate their care, but are not required to see that PCP, or to obtain a referral from a PCP when accessing a network specialist or facility for care. UnitedHealthcare Doctors Plan Plus provides out-of-network benefits. UnitedHealthcare Doctors Plan does not cover out of-network services (except for emergency services).	No, members have open access to a national network of care providers.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Select and Select Plus	Members choose, or are assigned, a network PCP for each family member. Members are encouraged to see their PCP to coordinate their care, but are not required to see that PCP, or to obtain a referral from a PCP when accessing a specialist or facility for care. UnitedHealthcare Select Plus provides out-of-network benefits. UnitedHealthcare Select does not cover out-of-network services (except for emergency services).	No, members have open access to a national network of care providers.	Yes, on selected procedures, as described in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Options PPO	Members can choose any network physician or health care professional without a referral and without designating a PCP. Options PPO provides out-of-network benefits.[3]	No, members have open access to a national network of care providers.	Members are responsible for notifying us using the phone number on their health care ID card, as described under the member's benefit plan.

Product Name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Indemnity	Members can choose any physician or health care professional.	No, members have open access to any care provider.	No, members are responsible for notifying us using the phone number on their health care ID card.
UnitedHealthcare Core and Core Essential	Members can choose any network physician or health care professional without a referral and without designating a PCP. Core provides out-of-network benefits. Core Essential does not (except for emergency services).	No, members have open access to a limited network of care providers available nationally.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Navigate®, Navigate Balanced®, Navigate Plus®	Members must see their PCP and have electronic referrals submitted to UnitedHealthcare by their PCP before seeing another network physician. Navigate Balanced and Plus benefit plans provide additional network coverage at a higher member cost-share for services from a network physician other than the member's PCP without a referral. Navigate Plus provides out-of-network benefits[3]. Navigate and Navigate Balanced do not (except for emergency services).	Yes, an electronic referral from the member's PCP is required prior to receiving services from a provider participating in a limited network. See *Chapter 5: Referrals* of this guide.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Charter®, Charter® Balanced, Charter® Plus	Members must see their PCP and have electronic referrals submitted by their PCP before seeing another network physician to receive the highest level of coverage. Charter Balanced and Charter Plus benefit plans provide additional network coverage at a higher member cost-share for services from a network physician other than the member's PCP without a referral. Charter Plus provides out-of-network benefits [3]. Charter and Charter Balanced do not (except for emergency services).	Yes, an electronic referral from the member's PCP is required prior to receiving services from a provider participating in a limited network. See *Chapter 5: Referrals* of this guide.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Compass, Compass Balanced, Compass Plus	Members must see their PCP and have electronic referrals submitted by their PCP before seeing another network physician within the network service area to receive the highest level of coverage [4]. Compass Balanced and Plus benefit plans provide network coverage at a higher member cost-share for services from a network physician other than the member's PCP without a referral. Compass Plus provides out-of-network benefits. [3] Compass and Compass Balanced do not (except for emergency services).	Yes, an electronic referral from the member's PCP is required prior to receiving services from a physician other than the member's PCP. See *Chapter 5: Referrals* of this guide.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare NexusACO OA® **NexusACO OAP®**	NexusACO OA is a tiered benefit plan where members choose, or are assigned, a network PCP for each family member. The member is encouraged to see their PCP to coordinate their care, but is not required to see that PCP or obtain a referral when accessing other network care providers. NexusACO OAP is a tiered benefit plan and provides out-of-network benefits. [3] NexusACO OA does not cover out-of-network services (except for emergency services).	No, members have open access to a national network of care providers.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.

Product Name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare NexusACO R® **UnitedHealthcare NexusACO RB®** **NexusACO RP®**	NexusACO® is a tiered benefit plan where members must see their assigned network PCP and have electronic referrals submitted by their PCP before seeing another network specialist to receive the highest level of coverage. NexusACO R provides out-of-network benefits.[3] NexusACO RB and RP do not (except for emergency services). All NexusACO benefit plans are tiered.	Yes, an electronic referral from the member's PCP is required prior to the member receiving specialist services see *Chapter 5: Referrals* of this guide.	Yes, on selected procedures as described in *Chapter 6: Medical Management* of this guide.

1 The UnitedHealthcare Network may be different among commercial products in your local market. Please refer to your contract to determine whether you are part of that local network.

2 Physicians and health care professionals must be licensed for the health services provided and the health care services provided must be covered under the member's benefit contract.

3 The benefit level for non-emergency services from out-of-network physicians and other care providers is generally less than that for services from network physicians and other care providers.

4 For more information about the Compass service area, please go to **UHCprovider.com/plans**.

Benefit Plan Types

Open access benefit plans: No referral or PCP approval is required for members to see other network care providers. Prior authorization and notifications are required for certain services, described in *Chapter 6: Medical Management*, with the exceptions noted in the previous table. Benefit plans vary in the type of coverage offered based on network and tier status (for tiered benefit plans only).

Gated benefit plans: Members must select and see their assigned PCP. The PCP must submit electronic referrals before a member sees another network physician; this helps ensure the highest level of coverage. Benefit plans vary in type of coverage offered based on PCP and referral requirements, network status, and tier status (for tiered benefit plans only).

Tiered Benefit Plans: Plans define tier 1 care providers differently. Check your tier status when verifying eligibility using **eligibilityLink**. Some of our commercial products feature tiered benefits. NexusACO is always offered as a tiered benefit plan. Members may have lower out-of-pocket costs for services provided by a tier 1 care provider or facility. Members with a tiered benefit plan have an identifier on the front of their health care ID card.

W500 Additional Network Benefits
Some benefit plans include Additional Network Benefits referred to as W500 Emergent Wrap. We contract with non-participating care providers to provide network coverage for urgent, emergent and gap exception services. This extends the network of care providers available to members outside their primary network for these services. Members with additional network benefits display W500 on the back of their ID card.

PCP Selection

Members in a gated plan choose a network PCP at the time of their enrollment. If not, we assign one. A PCP is a physician in family practice, internal medicine, pediatrics, or general practice. Other specialties may be included if required by state law.

The PCPs designated by the member and enrolled dependent(s) do not need to be the same person, or affiliated with the same group. The member and enrolled dependent(s) must select a PCP within the geographic area where the subscriber lives.

You can verify a member's assigned PCP when you verify their eligibility, as shown in the *Verifying Eligibility, Benefits, and Your Network Participation Status* section in Chapter 2.

Consumer-Driven Health Benefit Plans

Consumer-driven health care describes health benefit plans made to help members:

- Become more informed and careful about their health care choices.
- Take control over their health and health care purchases.

These benefit plans are listed on the health care ID card and on **eligibilityLink**.

These plans include:

1. A member responsibility, which is the amount members pay from their own pockets for their deductibles, copayments and coinsurance, up to the out-of-pocket maximum.

2. An account that helps members pay their out-of-pocket costs on a pre-tax basis. The account can either be a health savings account (HSA) or a health reimbursement account (HRA).
3. Health coverage that pays benefits after members meet the deductible and that pays 100% of network preventive care services.
4. Resources that give information about network care providers, cost of services and options for getting health care.

HRAs and HSAs are similar in many ways:

- They are both a type of medical savings account.
- The medical benefit includes a deductible. Members typically use their HSA or HRA to pay out-of-pocket expenses until they meet the deductible. The benefit plans include an out-of-pocket maximum and, once met, they pay 100 percent of covered services, including pharmacy.
- They cover routine, preventive care under the basic medical benefit. These services are not subject to the deductible.

HRAs and HSAs differ in that:

- Employers most often fund HRAs.
- Employees most often fund HSAs.
- With HSAs, if members do not have sufficient funds in their account, or choose to save those funds for a later date, they pay any remaining cost-share out-of-pocket. The HSA belongs to the account holder even if they change employers. The Internal Revenue Service allows annual deposits that can equal the benefit plan's deductible.

Chapter 4: Medicare Products

Visit: **UHCprovider.com**, **AARPMedicarePlans.com**, **UHCMedicareSolutions.com**, or **UHCprovider.com/communityplan** for more information about our Medicare products in your area.

UnitedHealthcare Medicare products offer Medicare Advantage (MA) benefit plans for Medicare eligible individuals and employer group retirees. If a member presents a health care ID card with a product name with which you are not familiar, verify the member's eligibility using eligibilityLink. Product lists provided for your convenience are subject to change at any time.

This guide does not apply to UnitedHealthcare Medicare Direct, our MA Private Fee-for-Service product, which does not use a contracted Medicare provider network. For information about UnitedHealthcare MedicareDirect, go to: **UHCprovider.com/plans** > Select your state > Medicare > UnitedHealthcare® MedicareDirect (PFFS).

Medicare Product Overview Tables

MA – Products for Individuals

Product Name	Medicare Member's Eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give notification when providing certain services?
HMO and HMO-POS plans (Each plan name below is preceded by either the AARP or UnitedHealthcare brand name): **HMO** • Medicare Advantage • Medicare Advantage Access • Medicare Advantage Essential • Medicare Advantage Focus • Medicare Advantage Mosaic • Medicare Advantage Value • Medicare Advantage Walgreens • The VillagesMedicare Advantage **HMO-POS** • Medicare Advantage • Medicare Advantage Essential • Medicare Advantage Focus • Medicare Advantage Plus • Medicare Advantage Premier • Medicare Advantage Profile • Medicare Advantage Value • The VillagesMedicare Advantage	Members who are Medicare eligible for Part A and B, reside in the plan's service area and do not have ESRD.	Members choose a PCP from the Medicare network of physicians who can help coordinate their care. HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis. HMO-POS benefit plans provide out-of-network coverage for some covered benefits.*	A referral may or may not be required to see a specialist, depending on the benefit plan.* * For further information, go online to see *Medicare Advantage (MA) Referral Required Plans*, or call 877-842-3210. Please have the health care ID and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	Yes, see guidelines in *Chapter 6: Medical Management.*

Product Name	Medicare Member's Eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give notification when providing certain services?
Local PPO and Regional PPO (RPPO) plans (Each plan name below is preceded by either the AARP or UnitedHealthcare brand name): • Medicare Advantage Assure • Medicare Advantage Choice • Medicare Advantage Choice Essential • Medicare Advantage Essential • Medicare Advantage Focus • Medicare Advantage Headwaters • Medicare Advantage Lakeshore • Medicare Advantage Mosaic Choice • Medicare Advantage Open • Medicare Advantage Open Essential • Medicare Advantage Open Premier • Medicare Advantage Riverbank • Medicare Advantage Walgreens • Sync **Local PPO plan in Virginia:** • Piedmont Select Medicare	Members who are Medicare eligible for Part A and B, reside in the plan's service area and do not have ESRD.	Members should choose a PCP from the Medicare network of physicians who can help coordinate their care. PPO benefit plans provide out-of-network coverage for all covered network benefits.*	No, a referral is not needed.	Yes, see guidelines in *Chapter 6: Medical Management.*
Institutional Special Needs Plans (HMO, HMO-POS, PPO) • UnitedHealthcare Nursing Home Plan • UnitedHealthcare Assisted Living Plan	Members reside in a contracted skilled nursing facility or assisted living facility and require an institutional level of care.	Members choose a PCP from the Medicare network of physicians to coordinate their care. PPO and HMO-POS benefit plans provide out-of-network coverage.* HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	No, a referral is not needed.	Yes, see guidelines in *Chapter 6: Medical Management.*

* The benefit level for non-emergency services from non-network physicians and other care providers is generally less than that for services from Medicare network physicians and other care providers.

** Most services provided to members of gatekeeper benefit plans require referrals and/or authorizations from the PCP or Physician Hospital Organization, dependent upon contractual arrangement. See *Medicare Advantage (MA) Referral Required Plans* in Chapter 5 for more information.

Product Name	Medicare Member's Eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give notification when providing certain services?
Dual Special Needs Plans (HMO, HMO-POS, PPO and Regional PPO) HMO, HMO-POS, PPO, RPPO UnitedHealthcare Dual Complete HMO: UnitedHealthcare Dual Complete Focus UnitedHealthcare Senior Care Options (Massachusetts) PPO, RPPO: UnitedHealthcare Dual Complete Choice	Members who are both Medicare and Medicaid eligible.	Members choose a PCP from the Medicare network of physicians, to coordinate their care. HMO-POS and PPO benefit plans provide out-of-network coverage.* HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	A referral may or may not be required to see a specialist, depending on the benefit plan.** For further information, call 877-842-3210. Please have the health care ID card and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	Yes, see guidelines in *Chapter 6: Medical Management.*
Chronic Special Needs Plans (HMO, PPO and Regional PPO) HMO: UnitedHealthcare Chronic Complete UnitedHealthcare Medicare Advantage Assist UnitedHealthcare Medicare Advantage Walgreens PPO: UnitedHealthcare Medicare Advantage Assist RPPO: UnitedHealthcare Medicare Gold UnitedHealthcare Medicare Silver	Members who have one or more of the following qualifying chronic conditions: diabetes, chronic heart failure, and/or cardiovascular disorders.	Members choose a PCP from the Medicare network of physicians who can help coordinate their care. PPO benefit plans provide out-of-network coverage for all covered network benefits.* HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	A referral may or may not be required to see a specialist, depending on the benefit plan.** For further information, call 877-842-3210. Please have the health care ID card and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	Yes, see guidelines in *Chapter 6: Medical Management.*
Erickson Advantage Plans (HMO and HMO-POS) HMO: Erickson Advantage Liberty HMO-POS: Erickson Advantage Signature Erickson Advantage Freedom HMO-POS (Special Needs Plans): Erickson Advantage Champion (Chronic) Erickson Advantage Guardian (Institutional)	Members who reside in an Erickson Retirement Community.	Members are assigned a PCP from the Erickson Health Medical Group network of physicians. The primary physician coordinates their care. HMO-POS benefit plans provide out-of-network coverage for some covered benefits.* HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	No, a referral is not needed.	Yes, see guidelines in *Chapter 6: Medical Management.*

Medicare Products for Groups

Product Name	Member's Eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and or facility required to give notice when providing certain services?
UnitedHealthcare Group Medicare Advantage (HMO)	Members must meet all Medicare eligibility requirements as well as the employer's requirements.	Members choose a PCP from the Medicare network of physicians. The primary physician coordinates their care. HMO benefit plans provide out-of-network coverage for some covered benefits.* HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	A referral may or may not be required to see a specialist based on the benefit plan.** For further information, go online to see *Medicare Advantage (MA) Referral Required Plans*, or call the number on the back of the health care ID card. Please have the health care ID and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	Yes, see guidelines in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Group Medicare Advantage Plans (Regional PPO)	Members must meet all Medicare eligibility requirements as well as the employer's requirements.	Members may choose a primary care physician from the Medicare network of physicians. If a primary physician is chosen, the primary physician coordinates their care. Regional PPO plans provide out-of-network coverage.*	No, a referral is not needed.	Yes, see guidelines in *Chapter 6: Medical Management* of this guide.
UnitedHealthcare Group Medicare Advantage Plans (PPO)	Members must meet all Medicare eligibility requirements as well as the employer's requirements.	Members are encouraged but not required to see a primary care physician from the Medicare network of physicians to help coordinate their care.	No, a referral is not needed.	Yes, see guidelines in *Chapter 6: Medical Management* of this guide.

* The benefit level for non-emergency services from non-network physicians and other care providers is generally less than that for services from Medicare network physicians and other care providers.

** Most services rendered to members in referral-required benefit plans require referrals and/or authorizations from the PCP or Physician Hospital Organization, dependent upon contractual arrangement.

MA Products

Individual HMO, HMO-POS and PPO Plans

These plans provide all of the benefits covered under Original Medicare and more. Our plans do not have limits for pre-existing conditions and they do not require physical exams. Members with end-stage renal disease (ESRD) may not be eligible to enroll in a plan. The member may have multiple choices of health plans depending on where they live.

While exact benefits may vary, these plans may give:

- Access to medical care through a trusted network of care providers
- Coverage for many preventive services with no copays
- Help with financial protection with annual out-of-pocket limits
- Worldwide emergency care coverage
- Medicare Part D prescription drug coverage
- Coverage for additional benefits like routine vision and hearing exams

Some plans do not require an additional monthly premium for this coverage. The member simply continues to pay the Medicare Part B premium unless the member has coverage through Medicaid or another third party.

Dual Special Needs Plans

This Special Needs Plan (SNP) meets the needs of individuals enrolled in Medicare who also qualify for Medicaid (called dual eligible). This plan combines the benefits of Medicare and Medicaid.

Chronic Special Needs Plans

This SNP is for members who have one or more severe or disabling chronic conditions. We help members manage their condition as well as their overall health and well-being.

Institutional Special Needs Plans

These SNPs are for members who reside in a contracted skilled nursing facility or assisted living facility and require an institutional level of care.

UnitedHealthcare Group MA

We offer these plans to employer groups for their retired Medicare-eligible employees. They have benefits similar to the individual plans. The member's health care ID card has the employer group name and number on it.

PCP Selection

For most plans, members are required to select a Medicare network PCP (some plan exclusions may apply). If not, we assign one automatically.

Changing PCP

Members may change their network PCP at any time. Changes are generally effective on the first day of the following month. The change does not affect referrals previously submitted by their PCP as long as the member remains in the same network.

Coverage Summaries and Policy Guidelines for MA Members

Hierarchy of References/Resources

We develop our MA Coverage Summaries and Policy Guidelines with the help of:

1. National Coverage Determination (NCD) or other Medicare guidance, e.g., Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual, Medicare Learning Network (MLN) Matters Articles
2. Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC)
3. UnitedHealthcare Commercial Medical Policies/ Coverage Determination Guidelines

Coverage Summaries and Policy Guidelines

Our MA plan Evidence of Coverage (EOC) and Summary of Benefits (SB) list the member's covered benefits, limitations and exclusions. We use our MA Coverage Summaries and Policy Guidelines to interpret benefits for our members. The policies are subject to change based on Medicare's coverage requirements, clinical evidence, technology and evolving practice patterns. You are responsible for reviewing the CMS Medicare coverage guidance documents. If there is a conflict between our policies and the guidance documents, the CMS information controls. Our MA Coverage Summaries and Policy Guidelines are available on: UHCprovider.com/policies > **Medicare Advantage Policies**.

Coverage Summary and Policy Guideline Updates

We publish monthly editions of the Medicare Advantage Coverage Summary and Policy Guideline Update Bulletins. These online resources provide notice to our network care providers of changes to MA Coverage Summaries and Policy Guidelines. The bulletins are posted on the first calendar day of every month on:

- UHCprovider.com/policies > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans > **Medicare Advantage Coverage Summary Update Bulletins**
- UHCprovider.com/policies > Medicare Advantage Policies > Policy Guidelines for Medicare Advantage Plans > **Medicare Advantage Policy Guideline Update Bulletins**

A supplemental reminder to the policy updates announced in the Medicare Advantage Coverage Summary and Policy Guideline Update Bulletins is also included in the monthly Network Bulletin available on **UHCprovider.com/news**.

Dual Special Needs Plans Managed by Optum

UnitedHealthcare Dual Special Needs Plans (DSNPs) are one type of Medicare Advantage Special Needs Plan. This protocol is applicable to:

- PCPs in UnitedHealthcare's network for DSNPs
- Members of UnitedHealthcare DSNPs managed by our affiliate Optum

It does not apply to members who are assigned to an Accountable Care Organization based upon the member's PCP or whose PCP participates in a global capitation or risk-sharing arrangement with UnitedHealthcare.

This protocol establishes the guidelines and process for clinical integration, cooperation, and collaboration of and with respect to the care of members of UnitedHealthcare DSNPs managed by Optum. UnitedHealthcare or Optum will advise PCPs and members in those plans.

UnitedHealthcare DSNPs managed by Optum include the Optum At Home Program, which is an integrated care delivery program that coordinates the delivery and provision of clinical care of members in their place of residence. When members participate in this program, their care providers must follow a communications structure that helps ensure better coordination of their medical care.

To promote the best possible outcomes, the program supports:

- Sharing information between care team members, including performance reviews
- Tracking clinical outcomes
- Communicating evidence-based guidelines

The Optum At Home Program's Interdisciplinary Care Team includes an Optum trained Advanced Practice Clinician (ARNP/PA), the member's PCP and other care providers as appropriate, in addition to the member and the member's family. Together, they provide care customized to the member's needs and goals of care.

Optum clinicians:

- Conduct annual evaluations
- Provide longitudinal care management for high-risk members to address medical, behavioral and socioeconomic concerns
- Help ensure care coordination for members experiencing a care transition

We do member evaluations, care management and care coordination along with the member's PCP as well as other members of the Interdisciplinary Care Team.

The Optum At Home Program supplements care provided by our members' PCPs. It is not intended to replace the care provided by our members' PCPs.

Protocols for UnitedHealthcare DSNPs Managed by Optum

If these protocols differ from or conflict with other protocols in connection with any matter pertaining to members of UnitedHealthcare DSNP plans managed by Optum, these protocols govern unless statutes and regulations dictate otherwise.

As the PCP of UnitedHealthcare DSNP Plan members managed by Optum, you must:

1. Collaborate and cooperate with the Optum At Home Program, including Optum Advanced Practice Clinicians and other staff assigned to UnitedHealthcare DSNP Plan members managed by Optum.
2. Attend PCP meetings when requested by Optum.
3. Take part in the review of information provided by Optum, including care provider performance reviews, tracking of clinical outcomes and the communication of evidence-based guidelines to team members.
4. Work with other members of the Interdisciplinary Care Team designated by UnitedHealthcare and other treating professionals to provide and arrange for the provision of covered services to our UnitedHealthcare DSNP Plan members managed by Optum.

Medicare Supplement Benefit Plans

AARP Medicare Select Benefit Plans

This Medicare Supplement product is available only to AARP members who reside within the service area of a participating hospital in our Medicare Select network.

What is Medicare Select?

Medicare was not designed to cover all health care expenses incurred by older adults.

- Medicare Supplement plans cover many of the out-of-pocket costs that Original Medicare (Part A and B) does not cover, which can provide consumers with a greater sense of security.
- Medicare Select plans offer consumers the benefits of a standard Medicare Supplement plan at a lower price. Unlike a standard Medicare Supplement plan, Medicare Select requires members to use a Medicare Select network hospital to receive their full benefits.

Members must use a Medicare Select network hospital for inpatient services. They can seek services from the Medicare Select network physician of their choice and retain full Medicare benefits.

Network hospitals agree to waive the Part A Inpatient Hospital Deductible ($1,364 in 2019). While a network hospital waives the Part A Deductible, the hospital still receives the remaining reimbursement from Medicare. UnitedHealthcare reimburses all other Medicare-eligible expenses not paid by Medicare other than the Part A deductible amounts waived under the terms of the hospital Agreement. Hospitals can arrange for automatic deposits or reimbursements.

UnitedHealthcare uses these savings to offer a Medicare Supplement plan with a lower premium. If an insured member receives inpatient services outside of the Medicare Select network, the member is responsible for the Part A deductible, unless:

- The services were emergency related
- The service was not available from a participating hospital
- The member was more than 100 miles from home

**No prior authorization for medical services is required.

Medicare Select Plans C, F, G and N

These Medicare plans reduce member expenses by covering some or all of the following:

- Part A inpatient hospital deductible
- Part A inpatient hospital coinsurance for days 61-90 in a Medicare benefit period
- Part A inpatient hospital coinsurance for days where lifetime reserve days are used
- Part A eligible expenses for a lifetime maximum of 365 days after all Medicare Part A benefits are exhausted
- Part B coinsurance
- Part B deductible (Select Plans C and F only)
- Daily coinsurance for days 21-100 for Skilled Nursing Facility stays
- Part A and B blood deductible for the first three pints of un-replaced blood
- Foreign travel emergencies
- Hospice and respite care copayments and coinsurance

- Part B excess charges for Medicare approved services (Select Plans F and G only)

Claims Submission Information

To submit a claim electronically, please contact your Clearinghouse and provide our Electronic Payer ID (36273). This number is specific to AARP Supplemental and Personal Health Plans.

To submit a Part A or Part B claim via mail, send a standard billing form along with a Part A or B Remittance Advice to:

UnitedHealthcare Insurance Company
P.O. Box 740819
Atlanta, GA 30374-0819

To promote timely processing on all claim submissions, follow standardized Medicare billing practices. Be sure to include the member's 11-digit AARP membership number.

Free Medicare Education for Your Staff and Patients

Medicare Made Clear (MMC) is our public service campaign that gives consumers the information they need to select a Medicare benefit plan that is right for them. Consumers can easily access important information on topics such as the parts of Medicare, enrollment timing, what's covered (and what's not) and what they need to know to make good choices on our reference website **MedicareMadeClear.com**.

Chapter 5: Referrals

Referrals vs. Prior Authorization and Notification

The referral process, advance notification process, and prior authorization process are separate processes. All care providers must follow the notification and/or prior authorization requirements when providing a service that requires a notification and/or prior authorization.

A referral does not replace the advance notification or prior authorization process.

Referral Submission Requirements*

Referrals must be submitted by the member's PCP or by a PCP within the same tax ID number. Specialists can't request referrals in our system. They must ask the PCP to make a referral. Referrals are accepted to network physicians only.

The member's assigned PCP must:

- Submit referrals electronically using
  - › EDI Transaction 278R
  - › UHCprovider.com/referrallink
  - › Delegated entity's website listed on the back of the member's health care ID card
- Enter a start date within five calendar days of submission date
  - › Referrals are effective immediately, but may take up to two business days to be viewable on the portal system. They may be backdated up to five calendar days before the date of entry.
- Follow all requirements
  - › If you provide services and a referral is not on file, we deny the claim and the charge is non-billable to the member.

Referrals are effective immediately. They are viewable online within 48 hours.

If you need to refer a member to an out-of-network care provider because there are no available network care providers in the area, request prior authorization by calling Provider Services at 877-842-3210. You can also sign into Link by going to UHCprovider.com and clicking on the Link button in the top right corner. Then, select the Prior Authorization and Notification tool tile on your Link dashboard.

Maximum Referral Visits

The PCP determines the number of visits needed for each referral in a six-month period. They may submit another referral after the member uses the visits or they expire. Services done under a new referral are established patient visits.

Commercial Products Referrals

These referral requirements apply to covered services given to commercial members enrolled in these plans:

- Navigate, Navigate Balanced, Navigate Plus
- Charter, Charter Balanced, Charter Plus
- Compass, Compass Balanced, Compass Plus
- NexusACO R, NexusACO RB, NexusACO RP

Not obtaining a referral for a required service means that:

- Navigate, Charter, Compass and Nexus ACO® — The service is not covered.
- Navigate, Charter, Compass and Nexus ACO® (Balanced and Plus versions) — There is a higher cost for the member.

Commercial members of gated benefit plans have "In-Network Referral Required" printed on the back of their health care ID card.

Specialist Referrals

The member's assigned PCP manages their care. The member's PCP needs to submit electronic referrals to us before the member sees another network care provider (a network care provider that is not within the same tax ID as the member's PCP). Referrals are valid for any care provider within the same TIN as the specialist listed. It is best practice to communicate clinical findings to the referring PCP.

Online Referral Submission & Status Verification

There are multiple ways to submit referrals electronically:

1. **EDI:** Transaction 278R
2. **Link:** Go to UHCprovider.com/referrallink to determine referral requirements by plan

Managing Referrals

Specialists and facilities must check the status of a referral for the admitting physician's TIN before each visit. For planned admissions and outpatient services rendered by a physician, facilities must check that the servicing physician has a referral to see the member. If not, the facility claim may not be covered, or the member may have a higher cost-share. Referrals are for the specialist rendering the service or for the facility. Care providers should review a list of referrals related to the member on Link when verifying the member's eligibility.

- Referrals are only valid for the authorized number of visits or through the indicated referral end date. Any unused visits are not valid after the end date.
- If a referral is no longer valid, but the member requires additional care, the member or specialist must contact

* Delegated may follow different referral submission requirements.

the member's PCP to request a new referral. The PCP then decides whether to issue an additional referral.

- If a network specialist sees a need for a member to go to another specialist, the specialist must ask the member's PCP to issue an additional referral.

Online Submissions of Referrals
Referral submissions are separate from both notification and prior authorization requests. Use the **Link referral tool** to submit referrals.

Commercial Benefit Plan Services Not Requiring a Referral

Members in these plans do not need a referral for:

- Services from network physicians in the same TIN as the member's PCP or their covering network physicians
- Services from network OB/GYN specialists, nurse practitioners, nurse midwives, and physicians assistants
- Routine refractive eye exam from a network care provider
- Network optometrists
- Mental health/substance use services with network behavioral health clinicians
- Services rendered in any emergency room, network urgent care center, network convenience care clinic or designated network online "virtual clinic visits"
- Services billed as observation
- Admitting physician services for emergency/unscheduled admissions
- Services from facility-based inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons, or network team surgeons
- Services from a network pathologist, network radiologist or network anesthesia physician
- Outpatient network lab, network x-ray, or network diagnostic services
  - › Services billed by a network specialist require referral.
- Network rehabilitative services with exception of manipulative treatment and vision therapy (physician services)
  - › Services billed by a network specialist require referral.
- Other services for which applicable law does not allow us to impose a referral requirement

Referral Submission Requirements

- Referrals must be submitted to UnitedHealthcare electronically.
- Referrals are effective immediately.
- They are viewable online within 48 hours.
- We do not accept referrals by phone, fax or paper, unless state law requires us to.
- We can backdate them up to five calendar days from the date of submission.
- Web users must have access to the Referral Submission role on their user profile to submit and verify referrals.
- Only the member's PCP, or other PCP practicing under the same TIN, can submit referrals for the member to see a network specialist. A specialist cannot enter a referral.

Maximum Referral Visits

The PCP may submit up to six visits on a referral. Unused visits expire after six months. For members with the following chronic conditions, the PCP may submit up to 99 visits for up to six months per referral.

- AIDS/HIV
- Anemia
- Cancer
- Cystic Fibrosis
- Schizophrenia spectrum and other psychotic disorders
- Parkinson's Disease
- Amyotrophic Lateral Sclerosis
- Multiple Sclerosis
- Epileptic Seizure
- Myasthenia Gravis
- Glaucoma
- Retinal detachment
- Thrombotic Microangiopathy
- Allergic Rhinitis
- Renal Failure (acute)
- Seizure
- Fracture Care

Non-Participating Care Providers (All Commercial Plans)

In non-emergent circumstances, you are required to refer our members to an in-network care provider. You can confirm if a care provider is in our network at **UHCprovider.com**, or call 877-842-3210.

For an exception to this requirement, you must either:

1. Follow the prior approval process outlined in the next paragraph, or
2. Get the member's written consent to involve an out-of-network care provider.

To get prior approval to involve an out-of-network care provider, submit a request by calling the number on the back of the member's health care ID card. We review the request and network care providers available. If approved, we will apply the network benefits to the services done by

the out-of-network care provider. We will mail our decision to the requesting care provider and the member.

To get a member's written consent to involve an out-of-network care provider, you must use the **Member Consent for Referring Out-of-Network form**. The member must acknowledge that you:

1. Summarized the reason you are referring them to an out-of-network care provider,
2. Disclosed whether you have a financial interest in, or relationship with, the care provider to whom you are referring the member, and
3. Explained that the member may have additional costs as a result of your referral.

For referrals to an out-of-network laboratory, use the **eligibilityLink** tool to provide us with the completed Member Consent for Referring Out-of-Network form.

If you violate this protocol, and do not confirm the member's consent for the referral, you will be in violation of our Agreement. As a result, we may:

1. Disqualify you from any rewards or incentive program.
2. Decrease your fee schedule.
3. Hold you financially responsible for any costs collected from a member by a non-participating care provider.
4. Terminate your agreement.

Before Submitting a Request for Network Benefits for Services From a Non-Participating Care Provider:

1. See if there is a network care provider available by searching on the **Physician Directory**.
2. If a network care provider is not available, see if the W500 icon appears on the back of the member's health care ID card.
   a. If W500 is indicated, search for a network care provider in the W500 Emergent Wrap directory.
      I. If you find a W500 Emergent Wrap care provider, submit a request for coverage for the member to see that care provider.
   b. If W500 is not on the member's health care ID card or you cannot find a network care provider in the W500 Emergent Wrap Directory, continue submitting your request.

To find a list of care providers participating in the W500 network, go to UHCprovider.com/findprovider > **Search for Care Providers in the General UnitedHealthcare Plan Directory** > Medical Directory > All UnitedHealthcare Plans > Shopping Around > W500 Emergent Wrap.

Medicare Advantage Referral Required Plans

Some Medicare Advantage (MA) benefit plans require referrals to specialists and rehabilitation centers. These plans focus on coordination of care through the PCP. These plans are network-only benefit plans. Members must have a referral to receive network benefits for services from specialists. If members see a specialist without a referral, we will not pay for it. The care provider is responsible for confirming that there is a referral. If there is no referral, the care provider is liable for the charges; you cannot bill the member. These plans require notification and prior authorization for some services as well. A referral does not replace a notification or prior authorization.

Check the front of the member's health care ID card for referral language. MA members of gated plans have 'Referral Required' printed on the front of their health care ID card. The **eligibilityLink** and **referralLink** tools also show if referrals are required.

For more detailed information on health care ID cards and to see a sample health care ID card, please refer to the *Health Care Identification (ID) Cards* section of Chapter 2: Provider Responsibilities and Standards.

MA Services Not Requiring a Referral*

These services do not require a referral. However, they may require prior notification or authorization. For information on authorization requirements, refer to **UHCprovider.com/priorauth**.

- Any service provided by a network PCP
- Any service provided by a network physician practicing under the same tax ID as the member's PCP
- Any service from a network OB/GYN, chiropractor, optometrist, ophthalmologist, optician, podiatrist, audiologist, oncologist, nutritionist, or disease management and infectious disease specialist
- Services performed while in an observation setting
- Allergy immunotherapy
- Mental health/substance abuse services with behavioral health clinicians
- Any service from a pathologist or inpatient consulting physician including hospitalists
- Any service from an anesthesiologist
- Services rendered in an emergency room, emergency ambulance, or a network urgent care center or convenience clinic
- Virtual visits**
- Medicare-covered preventive services, kidney disease education or diabetes self-management training
- Routine annual physical exams, vision or hearing exams

*Delegated benefit plans may follow a separate referral exclusion list.
** Applies to select MA benefit plans.

- Any lab services and radiological testing service, excluding radiation therapy
- Durable medical equipment, home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies and Medicare Part B drugs
- Additional benefits that may be covered by some MA benefit plans but are not covered by Medicare, such as hearing aids, routine eyewear, fitness memberships, or outpatient prescription drugs
- Services obtained under the UnitedHealth Passport® Program, which allows for services while traveling

Chapter 6: Medical Management

The purpose of the UnitedHealthcare Medical Management Program is to determine if medical services are:

- Covered under the member's benefit plan;
- Clinically necessary and appropriate; and
- Performed at the most appropriate setting for the member.

Benefit Plans Not Subject to this Protocol

Please refer to the Additional Guide, Manual or Supplement in the *Benefit Plans Subject to this Guide* section for additional details. Some benefit plans may have separate advance notification and prior authorization requirements.

Excluded Plans (Benefit Plans Not Subject to this Protocol)

- UnitedHealthcare Options PPO: Care providers are not required to follow this protocol for Options PPO benefit plans because members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization.
- UnitedHealthcare Indemnity
- UnitedHealthOne - Golden Rule Insurance Company ("GRIC" group number 705214) only
- M.D.IPA, Optimum Choice or OneNet
- Neighborhood Health Partnership (NHP)
- *Oxford Commercial*, except for UnitedHealthcare Oxford Navigate Individual benefit plans (group number 908410)
- Benefit plans subject to the *River Valley Entities Supplement*
- Benefit plans subject to the *UnitedHealthcare West Supplement*
- Medicare Advantage plans that have delegated arrangements with medical groups/IPAs - in these arrangements, the delegate's protocols must be followed.
- Plans subject to an additional guide or supplement (see *Chapter 1*) (As explained in the in the *Benefit Plans Subject to this Guide* section, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an additional guide, manual or supplement and, therefore, are subject to this guide and this notification protocol.)
- Other benefit plans such as Medicaid, CHIP and Uninsured that are neither commercial nor MA.

The advance notification requirements outlined in this Protocol do not apply to services subject to the following Protocols, each are addressed in separate sections later in this guide:

- *Outpatient Cardiology Notification/Prior Authorization Protocol.*
- *Outpatient Radiology Notification/Prior Authorization Protocol.*
- *Laboratory Services Protocol*.

Advance Notification vs. Prior Authorization

Advance notification is the first step in determining coverage. We also use it for case and condition management program referrals. The information we receive about planned medical services helps support the pre-service clinical coverage review and care coordination. Advance notification helps assist members from pre-service planning to discharge planning.

Advance notification is required for services listed on the Advance Notification/Prior Authorization List located at **UHCprovider.com** under the Advance Notification and Plan Requirement Resources section.

We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Just because we require notification for a service, does not mean it is covered. We determine coverage by the member's benefit plan.

If there is a conflict or inconsistency between applicable regulations and the notification requirements in this guide, the applicable regulations govern.

Advance Notification/Prior Authorization Requirements

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including for non-emergent air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

Facilities are responsible for:

- Obtaining prior authorization for inpatient admission to Skilled Nursing Facility, Acute Inpatient Rehabilitation and/or Long Term Acute Care.
- Confirming coverage approval is on file prior to the date of service.
- Providing admission notification for inpatient services even if coverage approval is on file.

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If that specified date of service or date range has passed, you must submit a new request.

- Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about care providers on either a sanctions and excluded list, and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:
  - The member's benefit plan,
  - If you are eligible for payment,
  - Claim processing requirements, and
  - Your Agreement.

See *Coverage Determinations and Utilization Management Decisions* section for additional details.

Information Required for Advance Notification/ Prior Authorization Requests

Your request must have the following information:

- Member name and member health care ID number
- Ordering care provider name and TIN or National Provider Identification (NPI)
- Rendering care provider name and TIN or NPI
- ICD-10-CM diagnosis code
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and, if relevant, the volume of service
- Place of service
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease (ESRD) only)

If the member's benefit plan requires a clinical coverage review, we may request additional information, as described in more detail in the *Clinical Coverage Review*.

Advance Notification/ Prior Authorization List

To view the most current and complete Advance Notification Requirements, including procedure codes and associated services, go to: UHCprovider.com/priorauth > **Advance Notification and Plan Requirement Resources**.

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require prior authorization require a clinical coverage review based on medical necessity.

Advance Notification/Prior Authorization Lists are available online. They are subject to change. We notify you of changes through the Network Bulletin.

If you need a paper copy of the requirements, please contact your UnitedHealthcare Network Management representative or Physician Advocate.

When to Submit Advance Notification or Prior Authorization Requests

We recommend that you submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service (unless the Advance Notification Requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.

After submitting your request, you get a service reference number. This is not an authorization. When we make a coverage determination, we issue it under this reference number.

It may take up to 15 calendar days (14 calendar days for standard MA requests and 72 hours for expedited requests) for us to make a decision. We may extend this time if we need additional information. Submitting requests through the Prior Authorization and Notification tool on Link assists in timely decisions.

We prioritize case reviews based on:

- Case specifics
- Completeness of the information received
- CMS requirements
- State or federal requirements

If you require an expedited review, please call the number listed on the back of the member's health care ID card. You must explain the clinical urgency. You will need to provide required clinical information the same day as your request.

*PECOS is the CMS online enrollment system where care providers and health care entities are required to register so they can manage their Medicare Provider file & establish their Medicare specialty as eligible to order & refer services/items.

We expedite reviews upon request when the member's condition:

- Could, in a short period of time, put their life or health at risk
- Could impact their ability to regain maximum function
- Causes severe, disabling pain (as confirmed by a physician)

Durable Medical Equipment
Durable Medical Equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose.
- Not useful to a person in the absence of illness, disability, or injury.
- Ordered or prescribed by a care provider.
- Reusable.
- Repeatedly used.
- Appropriate for home use.
- Determined to be medically necessary.

Refer to our Commercial Coverage Determination Guideline for Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements at **UHCprovider.com/policies** > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans** or our Medicare Advantage Coverage Summary for Durable Medical Equipment, Prosthetics, Corrective Appliances/ Orthotics and Medical Supplies on **UHCprovider.com/policies** > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans.

Facilities: Standard Notification Requirements*

Confirming Coverage Approvals

Before providing a service on the Advance Notification/ Prior Authorization List, the facility must confirm coverage approval is on file. This promotes an informed pre-service discussion between the facility and member. If the service is not covered, the member can decide whether to receive and pay for the service.

If the facility does not confirm a coverage approval is on file and performs the service and we decide the service is not a covered benefit, we may deny the facility claim.

The facility may not bill the member or accept payment from the member due to the facility's non-compliance with our notification protocols.

Admission Notification Requirements

Benefit Plans Not Subject to this Protocol*

- UnitedHealthcare Option PPO care providers are not required to follow this protocol for Options PPO benefit plans because members enrolled in these benefit plans are responsible for providing notification or requesting prior authorization.
- UnitedHealthcare Indemnity
- M.D.IPA, Optimum Choice, or *OneNet PPO*
- *Neighborhood Health Partnership (NHP)*
- *Oxford Commercial*, except for UnitedHealthcare Oxford Navigate Individual Benefit Plans (group number 908410)
- Benefit plans subject to the *River Valley Entities Supplement*
- Benefit plans subject to the *UnitedHealthcare West Supplement*
- Medicare Advantage plans that have delegated arrangements with medical groups/IPAs - in these arrangements, the delegate's protocols must be followed.
- Erickson Advantage
- Benefit plans subject to an additional guide or supplement (please refer to the *Benefit Plans Subject to this Guide* table.)
- Other benefit plans, such as Medicaid, CHIP and Uninsured that are neither commercial nor MA.

*These benefit plans may have separate notification or prior authorization requirements. Refer to the applicable additional guide in the Benefit Plans Table in Chapter 1: Introduction, for additional details. Please see the supplements of this guide for the plans listed.

Facilities are responsible for Admission Notification for the following inpatient admissions. We need admission notification, even if advance notification was provided by the physician, and pre-service coverage approval is on file:

- Planned/elective admissions for acute care
- Acute inpatient rehabilitation
- Long-term acute care
- Unplanned admissions for acute care
- Skilled Nursing Facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation
- Newborns admitted to Neonatal Intensive Care Unit (NICU)
- Newborns who remain hospitalized after the mother is discharged. Notice is required within 24 hours of the mother's discharge.

Weekday admissions, you must notify us within 24 hours, unless otherwise indicated.

Weekend and holiday admissions, you must notify us by 5 p.m. local time on the next business day.

* For state specific variations, refer to UHCprovider.com/priorauth > **Advance Notification and Plan Requirement Resources**.

Emergency admissions (when a member is unstable and not capable of providing coverage information), you must:

- Notify us by phone or fax with 24 hours, or the next business day if on a weekend/holiday, from the time coverage information is known
- When notifying us, you must communicate the extenuating circumstances

Payment is not reduced due to notification delay in an emergency.

Receipt of an admission notification does not ensure payment. Payment for covered services depends on the member's benefits, facility's contract, claim processing requirements, and eligibility for payment.

You must include these details in your admission notification:

- Member name, health care ID number, and date of birth
- Facility name and TIN or NPI
- Admitting/attending physician name and TIN or NPI
- Description for admitting diagnosis or ICD-10-CM diagnosis code
- Actual admission date
- Extenuating circumstances, if an emergency admission

All Skilled Nursing Facility admissions for UnitedHealthcare Nursing Home and Assisted Living Plan members must be authorized by an Optum nurse practitioner or physician's assistant. Claims may be denied if authorizations are not coordinated through Optum.

Emergency Services

Our Medical Director (or designee) decides if services were emergent. This determination is subject to appeal. You can find a definition of "emergency" in the *Glossary*.

Reimbursement Reductions for Lack of Timely Admission Notification

Facilities must provide timely admission notification (even if advance notification was provided by the physician and pre-service coverage approval is on file) as follows or claims payments are denied in full or in part:

Notification Time frame	Reimbursement Reduction
Admission notification received after it was due, but not more than 72 hours after admission.	100% of the average daily contract rate[1] for the days preceding notification.[2]
Admission notification received after it was due, and more than 72 hours after admission.	100% of the contract rate (entire stay).
No admission notification received.	100% of the contract rate (entire stay).

1 The average daily contract rate is calculated by dividing the contract rate for the entire stay by the number of days for the entire length of stay.

2 Reimbursement reductions are not applied to "case rate facilities" if admission notification is received after it was due, but not more than 72 hours after admission As used here, "case rate facilities" means those facilities in which reimbursement is determined entirely by a MS-DRG or other case rate reimbursement methodology for every inpatient service for all benefit plans subject to these Admission Notification requirements.

Note: We do not apply reductions for maternity admissions. We apply reductions for post-acute inpatient admissions on our Commercial plans. We do not apply them for our MA plans.

Maryland State-Specific Notification Requirements for Facilities

If advance notification or prior authorization is required for an elective inpatient procedure, the physician must get the approval. The facility must notify us within 24 hours (or the following business day if the admission occurs on a weekend or holiday) of the elective admission. If the physician gets the approval, but the facility does not get theirs within a timely manner, we reduce payment to only room and board charges.

If the physician received coverage approval, we pay the initial day of the inpatient admission unless any of the following are true:

1. The information submitted to us regarding the service was false or intentionally misrepresentative;
2. Critical information requested by us was missing and our determination would have been different had we known the information;
3. A planned course of treatment approved by us was not followed; or
4. On the date the pre-authorized or approved service was delivered: (i) the individual was not covered by UnitedHealthcare, (ii) a member eligibility verification system was available to the care provider by phone or internet, and (iii) the member eligibility verification system using eligibilityLink shows no coverage.

Inpatient Concurrent Review: Clinical Information

We require you to comply with our requests:

- For information, documents or discussions related to concurrent review and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).

- From our interdisciplinary care coordination team and/or Medical Director. This includes our requests that you help us engage our members directly face-to-face or by phone.
  - › If you receive the request before 1 p.m. local time:
    - Please supply all requested information within four hours
  - › If you receive our request after 1 p.m. local time:
    - Please provide the information within the same business day, but no later than 12 p.m. local time the next business day

Facility Denial Process

We issue a denial letter if the level of care or any inpatient bed days are not medically necessary. We decide this through concurrent or retrospective review. We use nationally recognized criteria and guidelines to determine if the service/care was medically necessary under the member's benefit plan. We can provide the criteria to you upon request.

A facility denial letter is available to the member upon request.

How to Submit Advance or Admission Notifications/Prior Authorizations*

You can submit advance or admission notifications and prior authorizations many ways. After receiving confirmation, please do not resubmit your request. Prior authorization for Skilled Nursing Facility, Acute Inpatient Rehabilitation and Long Term Care Acute can only be submitted through Link/UHCprovider.com (preferred) or phone.

	EDI 278 Transactions	Link/ UHCprovider.com	Live Call	VoiCert
Method	**Electronic** Advance Notification and Prior Authorization (278A) and Admission Notification (278N).	**Electronic** UHCprovider.com/paan	**Non-Electronic** Advance notification and prior authorization and admission notification; notification status for previously submitted notifications.	**Non-Electronic** Inpatient admission notification.
Description	12 different EDI submissions available directly to UnitedHealthcare or through a clearinghouse.	Submit or check the status of an advance notification or prior authorization	Phone submission directly to UnitedHealthcare through 877-842-3210 (option 3) OR dial the number provided on member's health care ID card. For Erickson Advantage, call Erickson Campus customer service number on the member's health care ID card.	Phone submission through assigned 800 number specific to facility.
Business Hours **(all times Eastern)**	Monday – Friday: 7 a.m. - 2 a.m. Saturday: 7 a.m. - 6 p.m. Sunday: 7 a.m. - 6 p.m. Holidays: Same as above	UHCprovider.com: Generally available 24 hours per day, seven days a week. Maintenance is scheduled outside of the following hours: Monday – Friday: 6:30 a.m. - 12 a.m. Saturday: 7 a.m. - 6 p.m. Sunday: 7 a.m. - 5 p.m. Holidays: Same as above	Monday – Friday: 7 a.m. - 8 p.m. Saturday: 9 a.m. - 6 p.m. Sunday: 9 a.m. - 6 p.m. Holidays: 9 a.m. - 6 p.m.	VoiCert can be used 24/7, but submissions are processed the following business day: Monday – Friday: 7 a.m. - 8 p.m. Saturday: 9 a.m. - 6 p.m. Sunday: 9 a.m. - 6 p.m. Holidays: 9 a.m. - 6 p.m.

*Starting Jan. 1, 2020, we will retire certain fax numbers for medical prior authorization requests. We ask you to use the Prior Authorization and Notification tool on Link. Some plans have a state requirement for fax capability and will continue to use their existing fax number for their members. However, you can still use the Prior Authorization and Notification tool on Link to submit requests for those plans. A listing of active fax numbers as well as information regarding retired and retiring fax numbers can be found at UHCprovider.com/priorauth.

Updating Advance Notification or Prior Authorization Requests

Before services are rendered and before we make a coverage decision, you may make updates to your notification/prior authorization request. If a coverage decision has been made, updates can be made only to the date of service as long as the original requested date of service has not passed. If the original requested date of service has passed, and the date of service or any other changes need to be made to your notification/prior authorization request, you must submit a new notification/prior authorization request.

Submit updated requests through **UHCprovider.com/priorauth** or by phone at 877-842-3210 (option 3) or the number provided on member's health care ID card.

After services are rendered, you cannot make updates to an existing advance notification or prior authorization request.

If we do not approve the notification/prior authorization request, you cannot make updates to it. You may submit an appeal by following the instructions listed in the adverse determination letter we send you.

Coverage and Utilization Management Decisions

We base coverage decisions, including medical necessity decisions, on:

- Member's benefits
- State and federal requirements
- The contract between us and the plan sponsor
- Medicare guidelines including National Coverage Determination (NCD) and Local Coverage Determination (LCD) guidelines
- Medicare Benefit Policy Manual (MA members)
- Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, Coverage Summaries, and Utilization Review Guidelines

Our employees, contractors, and delegates do not receive financial incentives for issuing non-coverage decisions or denials. We and our delegates do not offer incentives for underutilization of care/services or for barriers to care/service. We do not hire, promote or terminate employees or contractors based on whether they deny benefits.

We use tools such as UnitedHealthcare medical policies, and third party resources (such as MCG Care Guidelines and other guidelines), to assist us in administering health benefits and determining coverage. We also use tools and third party resources to assist clinicians in making informed decisions.

These tools and resources are not equivalent to the practice of medicine or medical advice and you should use them in addition to independent, qualified medical judgment.

Clinical Coverage Summaries and Policy Guidelines for Medicare Advantage

We follow CMS guidance (including NCD and LCD guidelines) if the tools and resources we use contradict CMS guidance. If we do not perform a pre-service clinical coverage review, we may use Medicare guidelines, including NCD and LCD guideline to perform a clinical review when we receive the claim.

Copies of the Medicare Advantage Policy Guidelines and Coverage Summaries are on UHCprovider.com/policies > **Medicare Advantage Policies**.

Coverage Decisions

Some plans require prior authorization through a pre-service clinical coverage review. Once you notify us of any planned service, item or drug on our Advance Notification/Prior Authorization List, we will inform you of any required information necessary to complete the clinical coverage review as part of our prior authorization process. We will notify you of the coverage decision within the time frame required by law.

You and our member must be aware of coverage decisions before you render services. If you provide the service before a coverage decision is made, and we determine the service is not covered, we may deny the claim. The member cannot be billed. If you provide services prior to our decision, the member cannot make an informed decision about whether to pay for and receive the non-covered service.

Clinical Coverage Review

You can review a list of required information by service on **UHCprovider.com/protocols** > Medical Records Requirement for Pre-Service. If you submit required information with the advance notification/prior authorization, your review will go faster. You must:

- Return calls from our care management team and/or Medical Director.
- Submit the most correct and specific code available for the services.
- Comply with our request for additional information or documents and discussions, including requests for medical records and imaging studies/reports:
- If you receive our request before 1 p.m. local time:
  - › Supply the information within four hours
- If you receive our request after 1 p.m. local time:
  - › Provide the information no later than 12 p.m. local time the next business day

Medical & Drug Policies and Coverage Determination Guidelines for Commercial Members

A complete library of our clinical policies and guidelines is available on UHCprovider.com/policies > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines**.

We develop Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines to support the administration of medical benefits. You may request a copy of our clinical policies and guidelines by calling our care management team at 877-842-3210. They are only for informational purposes; they are not medical advice. You are responsible for deciding what care to give our members. Members should talk to their care providers before making medical decisions. Drug policies for commercial members covered under Pharmacy benefit are on **UHCprovider.com/pharmacy**.

Benefit coverage is determined by:

- Laws that may require coverage
- The member's benefit plan document
  - Summary Plan Description
  - Schedule of Benefits
  - Certificate of Coverage

The member's benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. If there is a conflict, the member's benefit plan document supersedes our policies and guidelines.

We develop our policies and guidelines as needed. We regularly review and update them. They are subject to change. We believe the information in these policies and guidelines is accurate and current as of the publication date. We also use tools developed by third parties, such as the MCG Care Guidelines, to help us manage health benefits.

Medical Policy Updates
For more information on Medical Policy updates, refer to the *Medical Policy Update Bulletin* section of Chapter 17: Provider Communications.

Pre-Service Appeals

A pre-service appeal is a request to change a denial of coverage for a planned health care service. The member's rights in the member's benefit plan govern this process. You can submit normal pre-service appeal requests through the standard fax line or mailed to the address in the pre-service denial letter. A peer-to-peer review is highly recommended before you file a pre-service appeal.

Expedited or Urgent Appeals

If you have already provided the service, an expedited or urgent appeal is not available. Submit a claim based on the service provided. See the appeal section for more information.

You may request an urgent pre-service appeal on behalf of the member by using the urgent appeals fax number listed in the pre-service denial letter. We consider requests urgent when:

- The standard review time frame risks the life or health of the member
- The member's ability to regain maximum function is jeopardized
- The member's severe pain is not able to be managed without the care or treatment requested

Refer to the UnitedHealthcare Commercial Clinical Pre-Service Expedited or Urgent Appeals Process Frequently Asked Questions document using the 'Search' box on **UHCprovider.com** for additional information and a list of fax numbers by benefit plan.

Clinical Trials, Experimental or Investigational Services

Experimental items and medications have limited coverage. We do not delegate utilization management for experimental or investigational services or clinical trials.

Commercial

Members with cancer may have coverage for routine costs related to the cancer clinical trial. It depends on the state. You should consider recommending the clinical trial if there is a potential for the member to benefit.

Medicare Advantage (MA)

Experimental and investigational procedures, items and medications are not a covered MA benefit. Call us at 877-842-3210 for a clinical coverage review.

Certain clinical trials are a benefit of MA plans. You should bill Medicare directly. Members can get additional information on clinical trials by calling 800-MEDICARE.

Approval or Denial of Clinical Trials

After a clinical review, we send a determination notice to the member and care provider. An experimental/investigational denial requires a disclosure of additional rights. It also requires information regarding the independent external review process. This includes:

- An Independent Medical Review (IMR) packet
- Physician certification form
- One-page application form and addressed envelope that the member returns to the Department of Managed Health Care to request the IMR (CA only)

Evaluations Prior to Entry into a Clinical Trial

Evaluations, tests, and consultations are benefits of both the commercial and MA plans. Coverage for these does not change if the member does not qualify for a clinical trial. For capitated providers, the member's care provider is responsible for these tests, unless stated differently in your contract.

You can find more information on clinical trials and experimental procedures in:

- **Commercial:** The Coverage Determination Guideline for Clinical Trials available on UHCprovider.com/policies > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines**.
- **MA:** The Coverage Summary for Experimental Procedures and Items, Investigational Devices, and Clinical Trials is available on UHCprovider.com/policies > Medicare Advantage Policies > **Coverage Summaries for Medicare Advantage Plans**.

Medical Management Denials/ Adverse Determinations

We may issue denials/adverse determinations. We issue these when:

- The service, item, or drug is not medically necessary
- The service, item, or drug is not covered
- We receive no supporting (or incomplete) information

If you disagree with our determination, you may appeal on behalf of the member. Appeal information is on the determination letter we send you. Our medical reviewers are able to discuss the denial with the treating or attending care provider.

We make our authorization determination and communicate it in a manner based on the nature of the member's medical condition and following state and federal law.

We base our decisions on sound clinical evidence. This includes:

- Medical records review
- Consultation with the treating care providers
- Review of nationally recognized criteria; for example, Medicare Coverage Criteria.

Denials, Delays or Modifications

Requests that do not meet the criteria for immediate authorization are reviewed by the Medical Director or the Utilization Management Committee (UMC), designated care provider, or presented to the collective UMC or subcommittee.

Only a care provider (MD or DO, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may delay, modify or deny services to a member for reasons of medical necessity. We use board-certified licensed care providers from appropriate specialty areas to help determine medical necessity.

- Care providers will not review their own referral requests,
- Our qualified staff members review referral requests being considered for denial, and
- Any referral request where the medical necessity or the proposed treatment plan is not clear can be clarified by discussion with the care provider thereafter. Complex cases go to the UMC/Medical Director for further discussion and decision.
- Individual(s) who meet the qualifications of holding financial ownership interest in the organization may not influence the clinical decision making regarding payment or denial of a service.
- Prior authorization determinations may include the following decision:
  - Approved as requested — No changes;
  - Approved as modified — Referral approved, but the requested care provider or treatment plan is modified. Denial letter must be sent if requested care provider is changed or specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy);
  - Extension — Delay of decision regarding a specific service. (e.g., need additional documentation, information, or require consultation by an expert reviewer).
  - CMS allows delays of decision (extensions) for Medicare Advantage members when the extension is justified and in the member's interest:
    - Due to the need for medical evidence from a non-contracted care provider that may change the decision to deny an item or service; or
    - Due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest.
  - Delay in Delivery — Access to an approved service postponed for a specified period or until a specified date will occur. This is not the same as a modification. A written notification in the denial letter format is required;
  - Denied — Non-authorization of a request for health care services; reasons for denials of requests for services include, but are not limited to, the following:
  - Not a covered benefit — the requested service(s) is a direct exclusion of benefits under the member's benefit plan — specific benefit exclusion must be noted;
  - Not medically necessary or benefit coverage limitation — specify criteria or guidelines used in making

the determination as it relates to the member's health condition;

- Member not eligible at the time of service;
- Benefit exhausted — include specific information as to what benefit was exhausted and when;
- Not a network care provider — a network care provider/service is available;
- Experimental, investigational or unproven procedure/treatment;
- Self-referred/no prior authorization (for non-emergent post-service);
- Services can be provided by the PCP.

We have aligned reimbursement policy on Wrong Surgical or Other Invasive Procedure Events Professional Reimbursement Policy to be consistent with CMS.

We do not reimburse for a surgical or other invasive procedure when the care provider erroneously performs:

- A different procedure altogether;
- The correct procedure, but on the wrong body part; or
- The correct procedure, but on the wrong member

We do not reimburse facilities or professional services related to these wrong surgical or other invasive procedures.

MA Part C Reopenings

CMS requires us to adhere to the appropriate handling of reopenings of our determination. A reopening is a remedial action taken to change a final determination or decision, even though the determination or decision was correct based on the evidence of record.

Reopening Reason Categories:

- New and Material Evidence — documentation that was not previously available or known during the decision making process that could possibly result in a different decision.
- Clerical Error — includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding and computer errors, inaccurate data entry, and denial of claims as duplicates.
- Fraud or Similar Fault — post-service decision when reliable evidence shows the decision was procured by fraud or similar fault when the claim is auto-adjudicated in the system.

Reopening requests made by a member, member's authorized representative, or a non-contracted care provider, must be:

- Clearly stated;
- Include the specific reason for the reopening;
- In writing, and
- Filed within the prescribed periods.

The request does not have to use the actual term "reopening." We must process a clerical error as a reopening, instead of an appeal.

A request for a reopening may occur under the following conditions:

- A binding determination or decision has been issued, and
- The 60-calendar day time frame for filing a reconsideration has expired, and
- There is no active appeal pending at any level.

Types of determinations or requests that cannot be reopened are as follows:

- A pre-service determination cannot be reopened for any reason other than for a clerical error, unless the 60-calendar day period to file a reconsideration has expired.
- Upon receipt of previously requested documentation for a pre-service determination denied due to lack of information, the delegate must consider and submit to us as a reconsideration, unless there is a clerical error.
- A pre-service determination made as part of the appeals process.
- Upon request for a peer-to-peer review following an adverse pre-service determination, if the member, member's representative, or non-contracted care provider provides new and material evidence not previously known or available, which changes the decision or the rationale for the prior decision, we will not review as a reopening and will provide instructions on how to file a reconsideration;
- A request to review a post-service determination cannot be reopened for any reason (i.e., New and Material Evidence, Error on the Face of Evidence, Fraud or Similar Fault, Other) other than for a clerical error, unless the 60-calendar day time frame to file a reconsideration has expired:
  - If a verbal request for review of a post-service determination, we or our delegate may review the request and reopen, if applicable and not already being reviewed as reconsideration.

Impact on Peer-to-Peer Requests

We offer a peer-to-peer discussion with the Medical Director that made the pre-service determination. Once a pre-service adverse determination has been made, Medicare does not allow the decision to be changed as a result of the peer-to-peer discussion. Any additional information received as a result of that post-decision discussion must be submitted as part of a Medicare Reconsideration (Appeal).

To allow for a change in decision as a result of a peer-to-peer discussion, we have a pre-decision peer-to-peer window for standard clinical denials (excludes expedited and administrative denials). This is for outpatient and inpatient pre-service requests. We reach out to offer a 24-hour window, prior to finalizing a potential adverse determination, to allow for the discussion between the physician and the Medical Director. If additional information is received during this pre-decision peer-to-peer window, the final decision could then potentially result in a changed determination. If the discussion does not happen before the end of the 24-hour window, the decision is finalized and any peer-to-peer discussion that follows is informational only.

Outpatient Cardiology Notification/ Prior Authorization Protocol

This protocol applies to commercial members and Medicare Advantage (MA) members. It does not apply to the following commercial or MA benefit plans, or other benefit plan types including Medicaid, CHIP, or uninsured benefit plans. The following benefit plans may have separate cardiology notification or prior authorization requirements. Refer to Chapter 1: Introduction for additional supplements or health care provider guides that may be applicable.

Commercial Benefit Plans not Subject to These Requirements

UnitedHealthcare Options PPO: Care providers are not required to follow this protocol for Options PPO benefit plans because members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization.

UnitedHealthOne – Golden Rule Insurance Company ("GRIC") group number 705214 only

M.D.IPA, Optimum Choice, (See the Mid-Atlantic Regional Supplement), or **OneNet**

Oxford (USA, New Jersey Small Group, certain NJ public Sector groups, CT public Sector, Brooks Brothers (BB1627) and Weil, Gotshal and Manages (WG00101), any member at VAMC facility.)

UnitedHealthcare Indemnity / Managed Indemnity

Benefit plans sponsored or issued by certain self-funded employer groups

Medicare Advantage Benefit Plans not Subject to These Requirements

The following plans are aligned with delegated medical groups/IPAs and must follow the delegate's protocols.

Connecticut: The following groups are delegated to OptumCare: UnitedHealthcare Medicare Advantage Plan 1 (HMO) – Group 27062, 27151; UnitedHealthcare Medicare Advantage Plan 2 (HMO) – Group 27064, 27153; UnitedHealthcare Medicare Advantage Essential (HMO) – Groups 27155, 27156; UnitedHealthcare Medicare Advantage Plan 3 (HMO) – Groups 27100, 27150, AARP Medicare Advantage Walgreens (PPO) – Group 90125.

Florida: The following groups are delegated to WellMed: AARP Medicare Advantage (HMO) – Groups 82969; AARP Medicare Advantage (HMO-POS) – Groups 82980, 82958, 82960, 82977, 82978; AARP Medicare Advantage Focus (HMO-POS) – Groups 70341, 82970; AARP Medicare Advantage Plan 1 (HMO) – Group 27151; AARP Medicare Advantage Plan 2 (HMO) – Group 82962; UnitedHealthcare The Villages Medicare Advantage 1 (HMO) – Group 82940; UnitedHealthcare The Villages Medicare Advantage 2 (HMO-POS) – Group 82971; AARP Medicare Advantage Choice Plan 2 (Regional PPO) – Group 72811; AARP Medicare Advantage Choice Essential (Regional PPO) Group 72790; AARP Medicare Advantage Choice (PPO) – Groups 70342, 70343, 70344, 70345, 70346, 70347, 70348, 80192, 80193, 80194; UnitedHealthcare Medicare Advantage Walgreens (HMO C-SNP) – Groups 95115, 95116, 95117, 95118

Hawaii: The following groups are delegated to MDX: AARP Medicare Advantage Choice (PPO) – Groups 77026, 77027; AARP Medicare Advantage Choice Plan 1 (PPO) – Groups 77000, 77007; AARP Medicare Advantage Choice Plan 2 (PPO) – Groups 77024, 77025; AARP Medicare Advantage Choice Essential (PPO) – Groups 77003, 77008

Indiana: The following groups are delegated to WellMed/ American Health Network Indiana: AARP Medicare Advantage Choice (PPO) – Groups 67034, 90101, 90102, 90103, 90105, 90106; AARP Medicare Advantage; AARP Medicare Advantage Choice Plan 1 (PPO) – Groups 67030, 67026; AARP Medicare Advantage Choice Plan 2 (PPO) – Groups 90126, 90127, 90128; AARP Medicare Advantage Focus (PPO) – Group 74000; AARP Medicare Advantage Plan 1 (HMO-POS) – Groups 00744, 00745, 00748, 00749, 00750, 00751, 00755, 00756, 00758, 00759, 00761, 00762; AARP Medicare Advantage Plan 2 (HMO-POS) – Group 00754; AARP Medicare Advantage Profile (HMO-POS) – Groups 00746, 00747

Texas: The following groups are delegated to WellMed: UnitedHealthcare Dual Complete (HMO D-SNP) – Group 00012; UnitedHealthcare Dual Complete Focus (HMO D-SNP) – Groups 00303, 00305, 00307, 00310; AARP Medicare Advantage Focus (HMO) – Groups 00300, 00304, 00306, 00309, 00315; AARP Medicare Advantage Focus Essential (HMO-POS) – Groups 00308, 96000; AARP Medicare Advantage Choice (PPO) – Groups 79717, 79730, 90114, 90115; AARP Medicare Advantage (HMO-POS) – Groups 90107, 90124; AARP Medicare Advantage Plan 1 (HMO-POS) – Groups 90122, 90123; AARP Medicare Advantage Plan 2 (HMO) – Groups 90116, 90117; AARP Medicare Advantage Walgreens (PPO) – Groups 90110, 90111, 90112, 90113; UnitedHealthcare Chronic Complete (HMO C-SNP) – Groups – 90118, 90119, 90120, 90121

Utah: The following groups are delegated to OptumCare: AARP Medicare Advantage Plan 1 (HMO) – Groups 42000, 42024; AARP Medicare Advantage Plan 2 (HMO) – Groups 42022, 42026; AARP Medicare Advantage Essential (HMO) – Groups 42004, 42009; UnitedHealthcare Group Medicare Advantage – Group 42020; UnitedHealthcare Medicare Advantage Assure (PPO) – Group 42027; UnitedHealthcare Medicare Advantage Assist (HMO C-SNP) – Groups 90055, 90056; AARP Medicare Advantage Walgreens (HMO) – Group 42030

For the **Medica and Preferred Care Partners of Florida** groups, please refer to the Medica HealthCare and Preferred Care Partners Prior Authorization Requirements located at UHCprovider.com > Prior Authorization and Notification > **Advance Notification and Plan Requirement Resources** > Plan Requirements and Procedure Codes.

Erickson Advantage Plans

UnitedHealthcare Medicare Direct (PFFS)

This protocol applies to all participating care providers who order or render any of the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Echocardiograms
- Stress echocardiograms

Notification/prior authorization is required for certain cardiology procedures listed above.

A cardiology procedure for which notification/prior authorization is required is referred to as a 'Cardiac Procedure'.

Notification/prior authorization is required under this protocol only for these specified cardiology procedures:

- Diagnostic catheterizations, echocardiograms and stress echocardiograms: notification/prior authorization is required only for outpatient and office-based services.
- Electrophysiology implants: notification/prior authorization is required for outpatient, office-based and inpatient services.

Cardiology procedures done in and appropriately billed with any of the following places of service do not require notification/prior authorization:

- Emergency room visits,
- Observation unit,
- Urgent care or
- Inpatient stays (except for electrophysiology implants).

If you do not complete the entire notification/prior authorization process before you do the procedure, we will reduce or deny the claim. You cannot bill the member if claims are denied in this instance.

For the most current listing of CPT codes for which notification/prior authorization is required pursuant to this protocol, refer to: **UHCprovider.com/cardiology** > Specific Cardiology Programs. Please note for Medicare Advantage benefit plans, prior authorization is not required for echocardiograms.

Prior Authorization and Notification Process for Cardiac Procedures

Ordering Care Provider

The care provider ordering the cardiac procedure must contact us prior to scheduling the procedure. Once we receive procedure notification and if the member's benefit plan requires medical necessity to cover services, we conduct a clinical coverage review, based on our prior authorization process, to determine if the service is medically necessary. You do not need to determine if a clinical coverage review is required because once we receive notification, we will let you know if a clinical coverage review is required.

You must notify us, or request prior authorization, by contacting us:

- **Online:** UnitedHealthcare, UnitedHealthcare West, UnitedHealthcare Oxford Navigate Individual, All Savers, Neighborhood Health Partnership, UnitedHealthcare of the River Valley Commercial and Medicare Advantage benefit plans subject to this Protocol: **UHCprovider.com/cardiology**; select the Go to Prior Authorization and Notification tool.
- **Phone:** 866-889-8054

Non-participating care providers provide notification, and complete the prior authorization process if applicable, either through **UHCprovider.com** (once registered), or by calling 866-889-8054.

We may request the following information at the time you notify us:

- Member's name, address, phone number and date of birth
- Member's health care ID number and group number
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The working diagnosis with the appropriate ICD code(s)
- Ordering care provider's name, TIN/NPI, address, phone and fax number, and email address
- Rendering care provider's name, address, phone number and TIN/NPI (if different)
- The member's clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering care provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

Medicare Advantage benefit plans and certain commercial benefit plans require covered services be medically necessary.

If the member's plan requires covered services to be medically necessary, and if the service is determined to be medically necessary, we issue an authorization number to the ordering care provider. To help ensure proper payment, the ordering care provider must communicate the authorization number to the rendering care provider.

If it is determined the service is not medically necessary, we issue a clinical denial. If we issue a clinical denial for lack of medical necessity, the member and care provider receive a denial notice outlining the appeal process.

Certain commercial benefit plans do not require covered health services to be medically necessary.

If the member's benefit plan does not require covered health services to be medically necessary and:

- If the service is consistent with evidence-based clinical guidelines, we issue a notification number to the ordering care provider.
- If the service is not consistent with evidence-based clinical guidelines, or if we need additional information to assess the request, we will let the ordering care provider know what we need from them, including whether a physician-to-physician discussion is required.
- If a physician-to-physician discussion is required, you must complete that process to help ensure eligibility to receive payment. Upon completion of the discussion, the care provider confirms the procedure ordered and we issue a notification number. The purpose of the physician-to-physician discussion is to support the delivery of evidence-based health care by discussing evidence-based clinical guidelines. This discussion is not a prior authorization, pre-certification or medical necessity determination unless applicable state law dictates otherwise.

Receipt of a notification number or authorization number does not guarantee or authorize payment unless state regulations (including regulations pertaining to a care provider's inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System [PECOS]* list, or Medicare Preclusion List), and Medicare Advantage guidelines require it. Payment for covered services depends upon:

- Coverage with an individual member's benefit plan,
- The care provider being eligible for payment,
- Claims processing requirements, and
- The care provider's participation with UnitedHealthcare.

The notification/prior authorization number is valid for 45 calendar days. It is specific to the cardiac procedure requested, to be performed one time, for one date of service within the 45-day period. When we enter a notification/authorization number for a procedure, we use the date we issued the number as the starting date for the 45-day period in which the procedure must be performed. If you do not do the procedure within 45 calendar days, you must request a new notification/authorization number.

Urgent Requests During Regular Business Hours
The ordering care provider may make an urgent request for a notification/prior authorization number if they determine the service is medically urgent. Make urgent requests by calling 866-889-8054. The ordering care provider must state that the case is clinically urgent and explain the clinical urgency. We respond to urgent requests within three hours of our receipt of all required information.

Retrospective Review Process for Urgent Requests Outside of Regular Business Hours
If the ordering care provider determines that a cardiac procedure is medically required on an urgent basis, and the ordering care provider cannot request a notification/prior authorization number because it is outside of our normal business hours, they must make a retrospective notification/authorization request using the following guidelines:

- Within two business days of the date of service for:
  - Echocardiograms and
  - Stress echocardiograms.
- Within 15 calendar days of the date of service for:
  - Diagnostic catheterizations and
  - Electrophysiology implants.

Request the retrospective review by calling 866-889-8054, in accordance with the process described below:

- Documentation must explain why the procedure must be done on an urgent basis and why a notification/authorization number could not have been requested during our normal business hours.
- Once we receive retrospective notification of a cardiac procedure, and if the member's benefit plan requires services to be medically necessary to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. If we determine the service was not medically necessary, we will issue a denial and we will not issue an authorization number. The member and care provider will receive a denial notice outlining the appeal process.
- Once we receive retrospective notification of a cardiac procedure and if the member's benefit plan does not require services to be medically necessary to be covered:
  - We issue a notification number to the ordering care provider if the service is consistent with evidence-based clinical guidelines.
  - If the service is not consistent with evidence-based clinical guidelines, or if we need additional information to assess the request, we will let the ordering care provider know if they must have a physician-to-physician discussion to explain the request, to give us more clinical information, and to discuss alternative approaches. After the discussion is completed, the ordering care provider will confirm the procedure ordered and we will issue a notification number.

Rendering Care Provider
Prior to performing a cardiac procedure, the rendering care provider must confirm a notification/authorization number is on file. If the member's benefit plan requires covered health services be medically necessary, the rendering care provider must validate the prior authorization process has

been completed and a coverage determination has been issued.

If the rendering care provider finds a coverage determination has not been issued, and the ordering care provider does not participate in our network, and is unwilling to complete the notification/prior authorization process, the rendering care provider is required to complete the notification/prior authorization process. The rendering care provider must verify we have issued a coverage decision based on this protocol, prior to performing the service. Contact us at the phone number or online address listed in the Ordering Care Provider section above if you need to notify us, request prior authorization, confirm that a notification number has been issued or confirm whether a coverage determination has been issued.

If the member's benefit plan does not require that services be medically necessary to be covered and:

- If you render a cardiac procedure and submit a claim without a notification number, we will deny or reduce payment. You cannot bill the member for the service in this instance.
- If you determine there is no notification number on file, and the ordering care provider participates in our network, we use reasonable efforts to work with you to urge the ordering care provider to complete the notification process and obtain a notification number prior to the rendering of services.
- If you determine there is no notification number on file, and the ordering care provider does not participate in our network, and is not willing to obtain a notification number, you are required to obtain a notification number.
- If you do not obtain a notification number for the procedure ordered by a non-participating care provider, we will deny or reduce payment for failure to provide notification. You cannot bill the member for the service in this instance.

If the member's benefit plan does require services to be medically necessary to be covered and:

- If you determine we have not issued a coverage determination, and the ordering care provider participates in our network, we use reasonable efforts to work with you to urge the ordering care provider to complete the prior authorization process and obtain a coverage decision prior to the rendering of services.
- If you determine we have not issued a coverage determination, and the ordering care provider does not participate in our network, and is not willing to complete the prior authorization process, you are required to complete the prior authorization process and verify that we have issued a coverage decision prior to rendering the service.
- If you provide the service before a coverage decision is issued, we deny or reduce your claim payment. You cannot bill the member for the service in this instance.
- Services not medically necessary are not covered under the member's benefit plan. When we deny services for lack of medical necessity, we issue the member and ordering care provider a denial notice with the appeal process outlined. We do not issue an authorization number if we determine the service is not medically necessary. We issue an authorization number to the ordering care provider if the service is medically necessary.

Crosswalk Table

You are not required to modify the existing notification/prior authorization request, or request a new notification/prior authorization record for the CPT code combinations in the Cardiology Notification/Prior Authorization CPT Code List and Crosswalk table available online on **UHCprovider.com/cardiology** > Specific Cardiology Programs.

For code combinations not listed on the Cardiology Notification/Prior Authorization CPT Code List and Crosswalk table, you must follow the Cardiology Notification/Prior Authorization Protocol process.

Outpatient Radiology Notification/ Prior Authorization Protocol

This protocol applies to commercial members and Medicare Advantage (MA) members. It does not apply to the following Commercial or Medicare Advantage benefit plans or other benefit plan types including Medicaid, CHIP, or uninsured benefit plans. The following benefit plans may have separate radiology notification or prior authorization requirements. Refer to Chapter 1: Introduction for additional supplements or health care provider guides that may be applicable.

Commercial Benefit Plans not Subject to These Requirements

UnitedHealthcare Options PPO: Care providers are not required to follow this protocol for Options PPO benefit plans because members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization.
UnitedHealthOne – Golden Rule Insurance Company ("GRIC") group number 705214 only
M.D.IPA, Optimum Choice, (See the Mid-Atlantic Regional Supplement), or **OneNet**
Oxford Healthplans
UnitedHealthcare Indemnity / Managed Indemnity
Benefit plans sponsored or issued by certain self-funded employer groups

MA Benefit Plans not Subject to These Requirements
The following plans are aligned with delegated medical groups/IPAs and must follow the delegate's protocols:

Connecticut: The following groups are delegated to OptumCare: UnitedHealthcare Medicare Advantage Plan 1 (HMO) – Group 27062, 27151; UnitedHealthcare Medicare Advantage Plan 2 (HMO) – Group 27064, 27153; UnitedHealthcare Medicare Advantage Essential (HMO) – Groups 27155, 27156; UnitedHealthcare Medicare Advantage Plan 3 (HMO) – Groups 27100, 27150, AARP Medicare Advantage Walgreens (PPO) – Group 90125

Florida: The following groups are delegated to WellMed: AARP Medicare Advantage (HMO) – Groups 82969; AARP Medicare Advantage (HMO-POS) – Groups 82980, 82958, 82960, 82977, 82978; AARP Medicare Advantage Focus (HMO-POS) – Groups 70341, 82970; AARP Medicare Advantage Plan 1 (HMO) – Group 27151; AARP Medicare Advantage Plan 2 (HMO) – Group 82962; UnitedHealthcare The Villages Medicare Advantage 1 (HMO) – Group 82940; UnitedHealthcare The Villages Medicare Advantage 2 (HMO-POS) – Group 82971; AARP Medicare Advantage Choice Plan 2 (Regional PPO) – Group 72811; AARP Medicare Advantage Choice Essential (Regional PPO) Group 72790; AARP Medicare Advantage Choice (PPO) – Groups 70342, 70343, 70344, 70345, 70346, 70347, 70348, 80192, 80193, 80194; UnitedHealthcare Medicare Advantage Walgreens (HMO C-SNP) – Groups 95115, 95116, 95117, 95118

Hawaii: The following groups are delegated to MDX: AARP Medicare Advantage Choice (PPO) – Groups 77026, 77027; AARP Medicare Advantage Choice Plan 1 (PPO) – Groups 77000, 77007; AARP Medicare Advantage Choice Plan 2 (PPO) – Groups 77024, 77025; AARP Medicare Advantage Choice Essential (PPO) – Groups 77003, 77008

Indiana: The following groups are delegated to WellMed/American Health Network Indiana: AARP Medicare Advantage Choice (PPO) – Groups 67034, 90101, 90102, 90103, 90105, 90106; AARP Medicare Advantage; AARP Medicare Advantage Choice Plan 1 (PPO) – Groups 67030, 67026; AARP Medicare Advantage Choice Plan 2 (PPO) – Groups 90126, 90127, 90128; AARP Medicare Advantage Focus (PPO) – Group 74000; AARP Medicare Advantage Plan 1 (HMO-POS) – Groups 00744, 00745, 00748, 00749, 00750, 00751, 00755, 00756, 00758, 00759, 00761, 00762; AARP Medicare Advantage Plan 2 (HMO-POS) – Group 00754; AARP Medicare Advantage Profile (HMO-POS) – Groups 00746, 00747

Texas: The following groups are delegated to WellMed: UnitedHealthcare Dual Complete (HMO D-SNP) – Group 00012; UnitedHealthcare Dual Complete Focus (HMO D-SNP) – Groups 00303, 00305, 00307, 00310; AARP Medicare Advantage Focus (HMO) – Groups 00300, 00304, 00306, 00309, 00315; AARP Medicare Advantage Focus Essential (HMO-POS) – Groups 00308, 96000; AARP Medicare Advantage Choice (PPO) – Groups 79717, 79730, 90114, 90115; AARP Medicare Advantage (HMO-POS) – Groups 90107, 90124; AARP Medicare Advantage Plan 1 (HMO-POS) – Groups 90122, 90123; AARP Medicare Advantage Plan 2 (HMO) – Groups 90116, 90117; AARP Medicare Advantage Walgreens (PPO) – Groups 90110, 90111, 90112, 90113; UnitedHealthcare Chronic Complete (HMO C-SNP) – Groups – 90118, 90119, 90120, 90121

Utah: The following groups are delegated to OptumCare: AARP Medicare Advantage Plan 1 (HMO) – Groups 42000, 42024; AARP Medicare Advantage Plan 2 (HMO) – Groups 42022, 42026; AARP Medicare Advantage Essential (HMO) – Groups 42004, 42009; UnitedHealthcare Group Medicare Advantage – Group 42020; UnitedHealthcare Medicare Advantage Assure (PPO) – Group 42027; UnitedHealthcare Medicare Advantage Assist (HMO C-SNP) – Groups 90055, 90056; AARP Medicare Advantage Walgreens (HMO) – Group 42030

For the **Medica and Preferred Care Partners of Florida** groups, please refer to the Medica HealthCare and Preferred Care Partners Prior Authorization Requirements located at UHCprovider.com > Prior Authorization and Notification > **Advance Notification and Plan Requirement Resources** > Plan Requirements and Procedure Codes.

Erickson Advantage Plans

UnitedHealthcare Medicare Direct (PFFS)

This applies to all participating care providers that order or render any of the following advanced imaging procedures:

- Computerized Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron-Emission Tomography (PET)
- Nuclear Medicine
- Nuclear Cardiology

Notification/prior authorization is required for certain advanced imaging procedures listed above.

An advanced imaging procedure for which notification/prior authorization is required is called an 'Advanced Outpatient Imaging Procedure'.

Notification/prior authorization is required for outpatient and office-based services only.

Advanced imaging procedures done in and appropriately billed with any of the following places of service do not require notification/prior authorization:

- Emergency room visits,
- Observation unit,
- Urgent care, or
- Inpatient stay.

If you do not complete the entire notification/prior authorization process before you do the procedure, we will reduce or deny the claim. Do not bill the member for denied claims in this instance.

For the most current listing of CPT codes for which notification/prior authorization is required pursuant to this protocol, refer to: **UHCprovider.com/radiology** > Specific Radiology Programs. Please note that for MA benefit plans, prior authorization is not required for CT, MRI, or MRA.

Prior Authorization and Notification Process for Advanced Outpatient Imaging Procedures

Ordering Care Provider

The care provider ordering the advanced outpatient imaging procedure must contact us before scheduling the procedure. Once we receive procedure notification and if the member's benefit plan requires covered health services to be medically necessary, we conduct a clinical coverage review, based on our prior authorization process, to determine if the service is medically necessary. You do not need to determine if a clinical coverage review is required. Once we receive notification, we will let you know if we require a clinical coverage review.

You must notify us, or request prior authorization, by contacting us:

- **Online:** UnitedHealthcare, UnitedHealthcare West, UnitedHealthcare Oxford Navigate Individual, All Savers , Neighborhood Health Partnership, UnitedHealthcare of the River Valley Commercial and Medicare Advantage benefit plans subject to this Protocol: **UHCprovider.com/radiology**; select the Go to Prior Authorization and Notification tool.
- **Phone:** 866-889-8054

Non-participating care providers can provide notification, and complete the prior authorization process if applicable, either through **UHCprovider.com/link** (once registered) or by calling 866-889-8054.

We may request the following information at the time you notify us:

- Member's name, address, phone number and date of birth
- Member's health care ID number and group number
- The examination(s) or type of service(s) requested, with the CPT code(s)
- The working diagnosis with the appropriate ICD code(s)
- Ordering care provider's name, TIN/NPI, address, phone and fax number, and email address
- Rendering care provider's name, address, phone number and TIN/NPI (if different)
- The member's clinical condition, including any symptoms, treatments, dosage and duration of drugs, and dates for other therapies
- Dates of prior imaging studies performed
- Any other information the ordering care provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

MA benefit plans and certain commercial benefit plans require covered health services to be medically necessary. If the member's plan requires covered services to be medically necessary, and if the service is medically necessary, we issue an authorization number to the ordering care provider. To help ensure proper payment, the ordering care provider must communicate the authorization number to the rendering care provider.

If it is determined the service is not medically necessary, we issue a clinical denial. If we issue a clinical denial for lack of medical necessity, the member and care provider receive a denial notice outlining the appeal process.

Certain commercial benefit plans do not require covered health services to be medically necessary.

If the member's benefit plan does not require health services to be medically necessary to be covered and:

- If the service is consistent with evidence-based clinical guidelines, we issue a notification number to the ordering care provider.
- If the service is not consistent with evidence-based clinical guidelines, or if we need additional information to assess the request, we let the ordering care provider know what we need from them, including whether a physician-to-physician discussion is required.
- If a physician-to-physician discussion is required, you must complete that process to help ensure eligibility to receive payment. Upon completion of the discussion, the care provider confirms the procedure ordered and we issue a notification number. The purpose of the physician-to-physician discussion is to support the delivery of evidence-based health care by discussing evidence-based clinical guidelines. This discussion is not a prior authorization, pre-certification or medical necessity determination unless applicable state law dictates otherwise.

Notification or authorization number receipt does not guarantee or authorize payment unless state regulations (including regulations pertaining to a care provider's inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System [PECOS]* list) and MA guidelines require it. Payment for covered services depends upon:

- Coverage with an individual member's benefit plan,
- The care provider being eligible for payment,
- Claims processing requirements, and
- The care provider's participation with UnitedHealthcare.

The notification/authorization number is valid for 45 calendar days. It is specific to the advanced outpatient imaging procedure requested, to be performed one time, for one date of service within the 45-day period. When we enter a notification/authorization number for a procedure, we use the date we issued the number as the starting date for the 45-day period you must perform the procedure. If

you do not do the procedure within 45 calendar days, you must request a new notification/authorization number.

Urgent Requests During Regular Business Hours
The ordering care provider may make an urgent request for a notification/prior authorization number if they determine the service is medically urgent. Make urgent requests by calling 866-889-8054. The ordering care provider must state the case is clinically urgent and explain the clinical urgency. We respond to urgent requests within three hours of our receipt of all required information.

Retrospective Review Process for Urgent Requests Outside of Regular Business Hours
If the ordering care provider determines an advanced outpatient imaging procedure is medically required on an urgent basis and they cannot request a notification/prior authorization number because it is outside of our normal business hours, the ordering care provider must make a retrospective notification/prior authorization request within two business days after the date of service. Request the retrospective review by calling 866-889-8054, based on the following process:

- Documentation must explain why:
  - The procedure must be done on an urgent basis
  - You could not request a notification/authorization number during our normal business hours.
- Once we receive retrospective notification of an advanced outpatient imaging procedure, and if the member's benefit plan requires services to be medically necessary to be covered, we conduct a clinical coverage review to determine medical necessity. If we determine the service was not medically necessary, we issue a denial and do not issue an authorization number. The member and care provider receive a denial notice outlining the appeal process.
- Once we receive retrospective notification of an advanced outpatient imaging procedure and if the member's benefit plan does not require services to be medically necessary to be covered:
  - We issue a notification number to the ordering care provider if the service is consistent with evidence-based clinical guidelines.
  - If the service is not consistent with evidence-based clinical guidelines, or if we need additional information to assess the request, we let the ordering care provider know if they must have a physician-to-physician discussion to explain the request, to give us more clinical information, and to discuss alternative approaches. After the discussion is completed, the ordering care provider confirms the procedure ordered and we issue a notification number.

Rendering Care Provider
Before performing an advanced outpatient imaging procedure, the rendering care provider must confirm that a notification/authorization number is on file. If the member's benefit plan requires that health services be medically necessary to be covered, the rendering care provider must validate that the prior authorization process has been completed and a coverage determination has been issued. If the rendering care provider finds a coverage determination has not been issued, and the ordering care provider does not participate in our network, and is unwilling to complete the notification/prior authorization process, the rendering care provider is required to complete the notification/prior authorization process. The rendering care provider must verify that we have issued a coverage decision in accordance with this protocol, before performing the service. Contact us at the phone number or online address listed in the Ordering Care Provider section above if you need to notify us, request prior authorization, confirm that a notification number has been issued or confirm whether a coverage determination has been issued.

If the member's benefit plan does not require covered services be medically necessary and if you:

- Render an advanced outpatient imaging procedure and you submit a claim without a notification number, we will deny or reduce payment. You cannot bill the member for the service in this instance.
- Determine there is no notification number on file, and the ordering care provider participates in our network, we use reasonable efforts to urge the ordering care provider to complete the notification process and obtain a notification number before rendering services.
- Determine there is no notification number on file, and the ordering care provider does not participate in our network, and is not willing to obtain a notification number, you are required to obtain a notification number.
- Do not obtain a notification number for the procedures ordered by a non-participating care provider, we will deny or reduce payment for failure to provide notification. You cannot bill the member for the service in this instance.

If the member's benefit plan does require covered services be medically necessary and:

- If you determine we did not issue a coverage determination and the ordering care provider participates in our network, we use reasonable efforts to work with you to urge the ordering care provider to complete the prior authorization process and obtain a coverage decision before rendering services.
- If you determine we did not issue a coverage determination and the ordering care provider does not participate in our network, and is not willing to complete the prior authorization process, you are required to complete the prior authorization process and verify that we issued a coverage decision before rendering service.

- If you provide the service before we issue a coverage decision, we deny or reduce your claim payment. You cannot bill the member for the service in this instance.
- Services not medically necessary are not covered under the member's benefit plan. When we deny services for lack of medical necessity, we issue the member and ordering care provider a denial notice with the appeal process outlined. We do not issue an authorization number if we determine the service is not medically necessary. We issue an authorization number to the ordering care provider if the service is medically necessary.

Provision of an Additional or Modified Advanced Outpatient Imaging Procedure
If, during the delivery of an advanced outpatient imaging procedure, the rendering care provider determines an additional advanced outpatient imaging procedure should be delivered above and beyond the approved service(s) assigned a notification/prior authorization number, then the ordering care provider must request a new notification/prior authorization number before rendering the additional service, based on this protocol.

If, during the delivery of an advanced outpatient imaging procedure for which the care provider completed the notification/prior authorization processes, the physician modifies the advanced outpatient imaging procedure, and if the CPT code combination is not on the CPT Code Crosswalk Table, then follow this process:

- Contiguous body part – if the procedure is for a contiguous body part, the ordering or rendering care provider must modify the original notification/authorization number request online or by calling within two business days after rendering the procedure.
- Non-contiguous body part – if the procedure is not for a contiguous body part, the ordering care provider must submit a new notification/authorization number request and must have a coverage determination before rendering the procedure.

Crosswalk Table
You are not required to modify the existing notification/prior authorization request, or request a new notification/prior authorization record for the CPT code combinations in the UnitedHealthcare Radiology Notification/Prior Authorization Crosswalk Table available online at **UHCprovider.com/radiology** > Specific Radiology Programs.

For code combinations not listed on the UnitedHealthcare Radiology Notification/Prior Authorization Crosswalk Table, you must follow the Radiology Notification/Prior Authorization Protocol process.

Medication-Assisted Treatment (MAT)

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat Opioid Use Disorders (OUD). The Food and Drug Administration (FDA) approved medications for OUD including Buprenorphine, Methadone, and Naltrexone.

To prescribe Buprenorphine, you must complete the waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and obtain a unique identification number from the United States Drug Enforcement Administration (DEA).

As s medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on liveandworkwell.com.

To find a medical MAT provider in a state:

1. Go to UHCprovider.com
2. Select "Find a Care Provider" from the menu on the home page
3. Select "Search for Care Providers in the General UnitedHealthcare Plan Directory"
4. Click on "Medical Directory"
5. Choose a type of plan
6. Select applicable plan
7. Refine the search by typing "Medication Assisted Treatment" in the search bar

For more SAMHSA waiver information:
Physicians- samha.gov

Nurse Practitioners (NPS) and Physician Assistants (PAs)

If you have questions about MAT, please call Provider Services at 877-842-3210, enter your Tax Identification Number (TIN), then say 'Representative', then 'Representative' a second time, then 'Something Else' to speak to a representative.

Trauma Services

Trauma services are medically necessary, covered services that are given at a state-licensed, designated trauma facility or a facility designated to receive trauma cases. Trauma services must meet identified county or state trauma criteria.

We may retrospectively review trauma service claims and medical records to verify that they met the trauma criteria.

We may also confirm the trauma facility has an active trauma license.

We consider these criteria when authorizing trauma services:

- Trauma team activated.
- Trauma surgeon is the primary treating care provider.
- Member's clinical status meets the county's current EMS protocols for designating a trauma member.
- Trauma services, once rendered, apply to the first 48 hours post-facility admission, unless there is documented evidence of medical necessity indicating that trauma level services are continuing delivery.
- Trauma service status should no longer apply when, based on medical necessity, the member is stable and/or medically appropriate for transfer out of the critical care area.
- Clinical management of a member(s) by the trauma team is not the sole criterion used to determine and authorize continued trauma services care.

Chapter 7: Specialty Pharmacy and Medicare Advantage Pharmacy

Commercial Pharmacy

For information related to commercial pharmacy benefits:

Online: UHCprovider.com/pharmacy

- View and search the Prescription Drug List (PDL) and a current list of participating specialty pharmacy provider(s) that apply to the use of certain pharmaceuticals.
- Learn about pharmaceutical management procedures for prior authorization requirements, supply limits and step therapy protocols.
- View medications requiring notification and prior authorization.

For pharmacy notification, prior authorization or questions on utilization management procedures, call:

Phone: 800-711-4555

Specialty Pharmacy Requirements for Certain Specialty Medications (Commercial Plans – not applicable to UnitedHealthcare West)

New Prior Authorization Process Change for Certain Outpatient Medical Benefit Specialty Medications for Commercial Plan Members

Optum manages prior authorization requests for certain medical benefit injectable medications for UnitedHealthcare commercial plan members. This includes the affiliate plans UnitedHealthcare of Mid-Atlantic, Inc., Neighborhood Health Partnership and UnitedHealthcare of the River Valley. You will be notified when other commercial plans and lines of business migrate to this new process.

How the New Process Works

Click on the Specialty Pharmacy Transactions tile on your Link Dashboard. The system will document clinical requirements during the intake process and prompt you to provide responses to the clinical criteria questions. Please attach medical records, if requested.

Coverage of Self-Infused/Injectable Medications under the Pharmacy Benefit

This protocol applies to the provision and billing of self-infused/injectable medications, such as Hemophilia Factor products, under the pharmacy benefit.

Under most UnitedHealthcare products, self-infused/injectable medications are generally excluded from coverage under the medical benefit. A pharmacy rider can provide coverage for a self-infused/injectable medication. This exclusion from the medical benefit does not apply to self-infused/injectable medications due to their characteristics, as determined by UnitedHealthcare, that are typically administered or directly supervised by a qualified physician or licensed/certified health care professional in an outpatient setting.

If medications are subject to this exclusion, participating physicians, health care professionals, home infusion providers, hemophilia treatment centers or pharmacies fulfilling, distributing, and billing for the provision of self-infused/injectable medications to members are required to submit claims for reimbursement under the member's pharmacy benefit.

Prohibition of Provision of Non-Contracted Services

- This protocol applies to the provision and billing of specific specialty pharmacy medications covered under a member's medical benefit.
- Specialty pharmacy or home infusion providers are prohibited from providing non-contracted services for a therapeutic category, even if the specialty pharmacy or home infusion provider is contracted for other medical benefit medications and services, and billing us as a non-participating or non-contracted specialty pharmacy or home infusion provider.
- This protocol does not apply when a physician or other health care professional, who procures and bills us directly for specific specialty mediations, administers special medications in an office setting.

Requirement of Specialty Pharmacy and Home Infusion Provider(s) to be a Network Care Provider

We have contracted with a network of specialty pharmacy and home infusion care providers by therapeutic category to distribute specialty medications covered under a member's medical benefit. We selected the contracted specialty pharmacy and home infusion providers by therapeutic category for network inclusion based upon their distribution, contracting, clinical capabilities, and member services. This national network provides fulfillment and distribution of the specialty medications on a timely basis to meet the needs of our members and our network. Full program participation requirements are identified in the contracted specialty pharmacy or home infusion provider's Agreement.

Specialty Pharmacy Program Requirements

This protocol applies to the specialty medications listed on UHCprovider.com/pharmacy > Specialty Pharmacy Program > Drug sourcing requirements through Specialty Pharmacy. This program may be limited to specific places of service.

The medications addressed in our Specialty Pharmacy Program are subject to change. This protocol does not apply when Medicare or another health benefit plan is the primary payer and we are the secondary payer.

Requirement to Use a Participating Specialty Pharmacy Provider for Certain Medications

We have contracted providers for the distribution of these specialty medications. Our participating specialty pharmacy providers give fulfillment and distribution services to meet the needs of our members and our care providers. Our participating specialty pharmacy providers provide reviews consistent with our drug policies for these drugs. They work directly with the clinical coverage review unit to determine whether treatment is covered. Our National Pharmacy & Therapeutics Committee periodically reviews and updates our drug policies for these drug preparations. The committee helps ensure the policies are consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy providers report clinical data and related information and are audited on an ongoing basis to support our clinical and quality improvement activities. You must acquire these specialty medications from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by us. Submit requests for prescriptions of these specialty medications with the applicable enrollment request forms available on UHCprovider.com/pharmacy > Specialty Pharmacy Program > Enrollment Forms. The specialty pharmacy will dispense these drugs in compliance with the UnitedHealthcare Drug Policy and the member's benefit plan and eligibility, and bill UnitedHealthcare for the medication.

You only need to bill for administration of the medication. Do not bill us for the medication itself. The specialty pharmacy will advise the member of any medication cost-share responsibility and arrange for collection of any amount due before dispensing the medication to the physician office.

For a list of the medications and participating specialty pharmacy provider(s), refer to the enrollment forms online.

Administrative Actions for Non-Network Acquisition for Certain Specialty Medications

We anticipate that all care providers will be able to procure certain medications from a participating specialty pharmacy provider.

We may deny, in whole or in part, any claim from the use of non-participating specialty pharmacy providers, wholesalers, or direct purchase from the manufacturers by you or any other health care professional without prior approval from us. You may also be subject to other administrative actions as provided in your Agreement.

Please contact your local UnitedHealthcare Network Manager if you have any questions.

MA Pharmacy

Pharmacy Network

A member may fill prescriptions from any network pharmacy in the pharmacy directory or online at optumrx.com.

Reimbursement for prescriptions from a non-network pharmacy is available to some members in limited circumstances.

MA Prescription Drug Formulary

We use the United States Pharmacopoeia's drug classification system for development of the Formulary for MA.

The Pharmacy & Therapeutics Committee conducts formulary development and oversight. The committee is also responsible for identifying safe, cost-effective and medically appropriate drug therapies that reflect community and national standards of practice.

MA Formulary Tier Structure

The MA Prescription Drug Formulary is a list of drugs that are covered as a pharmacy plan benefit for MA members.

For non-group plans, we categorize medications into five tiers:

- Tier 1: Preferred generic drugs
- Tier 2: Non-preferred generic drugs
- Tier 3: Preferred brand-name drugs
- Tier 4: Non-preferred drugs
- Tier 5: Specialty drugs

Please Note: Tiers 2-4 may include higher cost generic drugs as well.

For group plans, several formularies are available. Medications are often categorized into four tiers:

- Tier 1: Preferred generic drugs
- Tier 2: Preferred brand-name drugs
- Tier 3: Non-preferred drugs
- Tier 4: Specialty drugs

Please Note: Tiers 2 and 3 may include higher cost generic drugs as well.

For MA Prescription Drug Formulary information, see AARPMedicarePlans.com, UHCMedicareSolutions.com, UHCprovider.com/communityplan, or UHCprovider.com.

If a drug is not on our formulary, you might be able to switch the member to a different drug that we do cover, or you can request a formulary exception. While we are evaluating the exception, we may provide members with a temporary supply.

MA Prescription Drug Benefit

UnitedHealthcare offers several prescription drug coverage plans based on the member's county of residence and the member's prescription drug needs. The benefit structure follows the CMS model:

- Prescription Drug Deductible — some benefit plans have a deductible the member must meet before getting access to the prescription drug benefit. In some plans, this deductible will only apply to specific drug tiers, (e.g., Tier 3, Tier 4 and Tier 5 only).
- Initial coverage limit — During this period the member is responsible for a specific copayment or coinsurance for prescription drugs.
- Coverage gap — While in the coverage gap, the member will pay 25% of the total cost of brand name and generic drugs in 2020. Coverage plans vary and the member may pay a different amount.
- Catastrophic coverage level — Members who reach this level may have a significantly lower copayment/coinsurance for prescription drugs, until the end of the year. Coverage plans vary and the member may pay a different amount

Prescriptions for a non-formulary or non-covered drug are not covered unless the member or the member's care provider requests and receives an approved formulary exception through the prior authorization process.

The member pays 100% of our contracted rate with the pharmacy if this amount is less than the member's applicable copayment/coinsurance for the prescription. This process does not apply to excluded medications.

Refer to the exceptions process described below for the criteria for coverage of a non-formulary or non-covered drug.

MA Part D Members

Prior Authorization Requests

OptumRx follows the coverage determination timelines as established by CMS. We must complete standard coverage determinations within 72 hours of receipt of request or prescriber's supporting statement for exceptions. OptumRx must complete expedited coverage determinations within 24 hours of receipt of request or prescriber's supporting statement for exceptions.

OptumRx asks for more information from the prescriber, or their designee, and the member if needed, and sends notification of the resulting case decision.

Different types of requests include:

- Prior Authorization (PA)
- Medicare Part B vs Medicare Part D
- Non-Formulary Exception (NF)
- Step Therapy (ST)
- Quantity Limit (QL)
- Opioid Safety Edits
- Tier Cost-sharing Exception (TCSE)*

Tier Cost-sharing Exception rules vary by specific benefit plan and available alternatives. Criteria for copayment reduction TCSE are:

- The requested drug is FDA-approved for the condition being treated; or
- One of the following:
  - Diagnosis is supported as a use in American Hospital Formulary Service (AHFS), under the Therapeutic Uses section; or
  - Diagnosis is supported in the Therapeutic Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better; or
  - Diagnosis is listed in the Therapeutic Uses section in DRUGDEX Evaluation and carries a Strength of Recommendation of III or Class Indeterminate; and Efficacy is rated as "Effective" or "Evidence Favors Efficacy"; and
  - History of failure, contraindication, or intolerance to all formulary alternatives in the lower qualifying tiers.

Coverage Limitations

For some drugs we may require authorization before the drug can be prescribed (prior authorization), we may limit the quantity that can be prescribed per prescription (quantity limits), or we may require that you prescribe drugs in a sequence (step therapy), trying one drug before another drug.

We provide an exception process to allow for the chance the formulary may not accommodate the unique medical needs of a member. To make an exception to these restrictions or limits, or to initiate a prior authorization, submit a coverage determination request:

Online: professionals.optumrx.com > Prior authorizations

Phone: 800-711-4555

More information about requirements is available at professionals.optumrx.com > Resources > **Formulary Lists** or by calling the OptumRx Prior Authorization department at the number above.

Part B Covered Drugs

Drugs covered under Part B are typically administered and obtained at the care provider's office. For example, certain cancer drugs, administered by a physician in their office. Some drugs covered under Part B are dispensed by outpatient pharmacies. For example, certain oral cancer drugs, insulin when administered by a pump,

immunosuppressants for Medicare-covered transplants, and diabetic test supplies.

Diabetes Monitoring Supplies

Some plans have a Preferred Diabetic Supply program for members who have diabetes (insulin and non-insulin users). Covered services include supplies to monitor blood glucose (blood glucose monitor, blood glucose test strips, lancet devices and lancets) and glucose control solutions for checking the accuracy of test strips and monitors.

UnitedHealthcare only covers the following brands of blood glucose monitors and test strips:

Blood glucose monitors: OneTouch Verio® Flex , Accu-Chek® Guide Me , Accu-Chek® Guide, and Accu-Chek® Aviva Plus. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, Accu-Chek® SmartView, and Accu-Chek® Compact Plus.

Other brands are not covered.

The Preferred Diabetic Supply program is a Part B covered benefit. It is also available through OptumRx as well as through some of our DME providers.

Drugs Covered Under Part B or Part D

Some drugs can fall under either Part B or Part D. We base our determination of coverage as to whether the drug is Part B or Part D on several factors such as diagnosis, route of administration and method of administration. For a list of medications in each category, refer to the CMS website at cms.gov > Medicare > **Prescription Drug Coverage - General Information** > Downloads, and select the appropriate document. You may also call 800-711-4555.

Long Term Care Facility (Includes Mental Health Facilities) Pharmacies

We provide convenient access to network long-term care (LTC) pharmacies for all members residing in LTC and mental health facilities. For a list of network pharmacies covering long-term care facilities, refer to the provider directory on **UHCprovider.com/findprovider**.

Home Infusion

Our plan will cover drugs for home infusion therapy for home infusion services provided by a home infusion therapy network pharmacy. However, Medicare Part D does not cover the supplies and equipment needed for administration. For information on home infusion therapy, contact our Pharmacy department at 877-306-4036.

Vaccines

Part D covers most vaccines and the associated administration fees. Our plan provides coverage of a number of vaccines. Some vaccines are medical benefits (Part B medications) and others are Part D drugs.

Part D covers most preventive vaccines; Part B covers flu, pneumococcal, hepatitis B, and some other vaccines (e.g., rabies) for intermediate or high-risk individuals when directly related to the treatment of an injury or direct exposure to a disease or condition.

The rules for coverage of vaccinations are complex and dependent on a number of factors. If you are unsure of the member's benefit coverage for vaccines, call 877-842-3210.

For a current list of vaccines and how they are covered, visit professionals.optumrx.com > Resources > **Formulary**.

Injectable Medications

We may require prior authorization for injectable medications administered in a care provider's office or self-administered medications from a specialty pharmacy supplier. Refer to the Drug Utilization Review Program section for more information.

Request these authorizations one to two weeks in advance of the service date to allow for eligibility and coverage review and for shipping.

Call 800-711-4555 for details on the rules governing injectable medications or to submit a prior authorization request for injectable medications obtained by the pharmacy. For medications provided and administered in the office (i.e., buy and bill), please call 877-842-3210.

Drug Utilization Review Program

We conduct drug utilization reviews to help ensure members are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor prescribing their medications.

We review member drug utilization each time members fill a prescription and also by regularly reviewing our records.

We look for medication problems such as:

- Possible medication errors;
- Duplicate drugs that are unnecessary because the member is taking another drug to treat the same medical condition;
- Drugs that are inappropriate because of age or gender;
- Possible harmful interactions between drugs;
- Drug allergies; or
- Drug dosage errors.

If we identify any problems, we share our findings with you and discuss other alternatives. You may receive calls or faxes from our pharmacy department following up on findings. If you have questions, please contact the pharmacy department.

Exceptions Process

We delegate prior authorization services to OptumRx®. OptumRx staff adhere to benefit plan-approved criteria, National Pharmacy and Therapeutics Committee (NPTC) practice guidelines, and other professionally recognized standards.

We offer a formulary exception process to allow for cases where the formulary or its restrictions may not accommodate the unique medical needs of members. To request an exception, submit a prior authorization request as described below. If you request an exception, you must also submit a supporting statement explaining why the exception is being requested.

Generally, we will only approve your request for an exception if alternative drugs included on our formulary list, a lower-tiered drug, or additional utilization restrictions would not be as effective in treating the member's condition or would cause the member to have adverse medical effects.

New members taking drugs that are not on our formulary list, or for which there are restrictions, should talk with you to decide if they should switch to another appropriate drug that we do cover, or if you should request an exception.

You can request an authorization or exception by:

- **Online:** professionals.optumrx.com > Prior Authorizations.

  This online service enables physicians and health care professionals to submit a real-time prior authorization request 24 hours a day, seven days a week. After logging on at OptumRx.com with their unique National Provider Identifier (NPI) number and password, a physician or health care professional can submit patient details securely online, enter a diagnosis and medical justification for the requested medication, and, in many cases, receive authorization instantly.

- **Phone:** 800-711-4555

Generic Substitution

Our network pharmacies may recommend or give members the generic version of a drug unless you tell us otherwise. Brand name drugs may require our approval if the generic equivalent is covered.

Therapeutic Interchange

The pharmacy may contact you by phone, letter, or fax to request that a member be switched to a preferred alternative drug.

Medication Therapy Management

The Medication Therapy Management (MTM) Program is a free service we offer to members. We conduct reviews on members who:

- Have multiple chronic conditions;
- Are taking multiple Part D drugs; and
- Incur an annual cost of at least $4,255 for all covered Part D drugs.

We use the MTM program to help ensure our members are using appropriate drugs to treat their medical conditions and to identify possible medication errors. We attempt to educate members as to drugs currently on the market, making recommendations for lower-cost or generic drugs where applicable.

We may relay this information to the care provider as well with the option for doctors to change drug therapies, as appropriate. You may receive calls or faxes from our pharmacy department following up on any interventions discussed with your patient.

Transition Policy

Our transition policy allows for a one-month coverage for members who have an immediate need for a drug not on our formulary, subject to restriction, or no longer covered. You should switch the member to a different drug or request a formulary exception. We may provide the member with a temporary transition supply while you pursue an exception. The drug must be a Part D drug purchased at a network pharmacy.

Note:

- New members must get their one-month supply, as described in their Evidence of Coverage (EOC), during the first 90 days with the plan.
- Continuing members must get their one-month supply within the first 90 days of the calendar year if the drug has encountered a negative formulary change.
- After the first 90 days as a new member, or if a member has a change in level of care, they may be eligible for a one-time, temporary one-month supply if they qualify for an emergency fill while residing in a long-term care (LTC) facility.

The following table summarizes the rules for receiving a transition supply of a drug. Members should read their plan's EOC for details.

Transition Eligible Situations	Temporary Transition Supply Amount
New Members: During the first 90 days of membership in the plan. **Continuing Members:** During the first 90 days of the calendar year if the drug encountered a negative formulary change	At least a one-month supply, as described in member's EOC.
For members who have been in the plan for more than 90 days **and** reside in a long-term care (LTC) facility **and** need a supply right away	At least a 31-day supply, as described in the member's EOC.
Members who have a level of care change **at any time during the plan year** (i.e., going into a LTC facility from a hospital, going home from a hospital stay, or going home from an LTC facility stay).	At least a one-month supply, as described in member's EOC.

To request a formulary exception, you may use the online tool at professionals.optumrx.com or call our Pharmacy Department at 800-711-4555.

Chapter 8: Specific Protocols

Non-Emergent Ambulance Ground Transportation

Non-emergent ambulance transportation is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the member's health and ambulance transportation is medically required.

There is no referral required for in-network care providers.

Laboratory Services Protocol

Clinical Information Submission

To comply with state and federal data collection and reporting requirements, we require clinical data from you. It helps us measure quality of care for our members. It helps us collaborate with you to address gaps in care. You must submit all clinical data including laboratory test results. Give us this data within 30 calendar days from the date of service or within the time specified by law.

When giving us clinical data, you must follow state and federal laws, and obtain prior consent to give us the clinical data when state or federal law requires it. We need to provide the source of the data to satisfy National Committee for Quality Assurance (NCQA) audits or other compliance requirements. You must confirm that the information given to us is accurate and complete.

We verify that security measures, protocols, and practices are compliant with:

- HIPAA regulations
- UnitedHealthcare data usage, governance, and security policies

We use the clinical data to:

- Perform treatment
- Payment
- Follow state and federal law
- Health care operations, as defined in HIPAA

Health care operations may include:

1. Compliance with state and federal data collection and reporting requirements, including:
   - Healthcare Effectiveness Data and Information Set (HEDIS)
   - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
   - Health Outcomes Survey (HOS)
   - NCQA accreditation
   - CMS or Star Ratings
   - CMS Hierarchical Condition Category Risk Adjustment System
2. Care coordination and other care management and quality improvement programs such as:
   - Physician performance
   - Pharmaceutical safety
   - Member health risks using predictive modeling and the subsequent development of disease management programs used by UnitedHealthcare
   - Other member and care provider health awareness programs
3. Quality assessment and benchmarking data sets

We will work collaboratively with you to help ensure all clinical data values are being transmitted effectively. This allows for lawful identification and use of the clinical data.

We define the HIPAA minimum necessary data requirements defined in specific documents related to the method of clinical data acquisition. The companion guides that contain these requirements are on **UHCprovider.com/edi**.

Self-Referral and Anti-Kickback

This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals.

We do not allow our care providers to earn money from referring members to a lab. This includes profits from:

- Investments in an entity where the referring care provider generates business
- Profits from collection, processing, and/or transporting of specimens
- Cost reductions below but not limited to:
  - Free Wi-Fi
  - Free urine cups

If you do not follow this rule, we may:

- Decrease your fee schedule
- Terminate your network participation
- Prosecute

Structured Exchange of Clinical Data

Our protocols require electronic submission of lab results within 30 days of a lab test. This supports HEDIS closure rates and significantly reduces the burden of manual chart requests for our care providers.

Care providers are required to submit an expanded set of clinical data following a physician visit, as well

as a discharge summary within seven days of an inpatient discharge. Failure to comply with this clinical data exchange may result in penalties to your practice.

When you share this data with us electronically, we can:

- Promote timely engagement between you and our members.
- Reduce the administrative burden of manual information sharing.
- Drive quality outcomes for you and our members by closing gaps and improving coordination of care.

To begin sharing the required information, please visit **UHCprovider.com/ediconnect** to find the best solution for your practice. Care providers have different data transfer capabilities, and we will work with you to find the best method of data transmission.

Nursing Home and Assisted Living Plans

UnitedHealthcare Nursing Home Plans and Assisted Living Plans are Medicare Advantage Institutional Special Needs Plans. This protocol is only applicable to PCPs, nurse practitioners (NP), and physician assistants (PA) who participate in the network for the Nursing Home Plan and/or the Assisted Living Plan Care Team, which includes both an onsite Advance Practice Clinician (ARNP/PA) and a registered nurse who cooperate with and are bound by these additional protocols.

If these protocols conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan or Assisted Living Plan members, these protocols apply, unless statutes and regulations dictate otherwise.

Nursing Home Plan Primary Care Provider (PCP) Protocols

As the PCP, you cooperate with and are bound by these additional protocols:

1. Attend PCP orientation session and annual PCP meetings.
2. Conduct face-to-face initial and ongoing assessments of the medical needs of our members, including those mandated by regulatory requirements.
3. Deliver health care to our members at their residence with the primary care team.
4. Participate in family care conferences with responsible parties, family and/or legal guardian to discuss the member's condition, care needs, overall plan of care and goals of care, including advance care planning.
5. Collaborate with other members of the primary care team designated by us and other treating professionals to provide and arrange for the provision of covered services to our Nursing Home Plan members. This includes making joint visits with other primary care team members and participating in formal and informal conferences with primary care team members and/or other treating professionals following a scheduled member reassessment, significant change in plan of care and/or condition.
6. Collaborate with us when a change in the primary care team is necessary.
7. Give us at least 45 calendar days prior notice when stopping services at a facility where our members live.
8. When admitting our member to a hospital, immediately notify the PCP and UnitedHealthcare Nursing Home Plan or Payer of the admission and reasons for the admission.

Nursing Home Plan and Assisted Living Plan Protocols for Other Provider Types

The Nursing Home Plan Nurse Practitioner (NP), Physician Assistant (PA), and/or Assisted Living Plan Care Team member, (i.e., registered nurse, or ARNP/PA), must follow these additional protocols:

1. Attend training and orientation meetings as scheduled by the plan.
2. Deliver health care to our members at their place of residence in collaboration with a PCP.
3. Communicate with the member's responsible parties, family and/or legal guardian on a regular basis. Participate in conferences with responsible parties to discuss the member's condition, care needs, overall plan of care and goals of care.
4. Collaborate with other members of the primary care team and other care providers to provide and arrange for the provision of covered services for our members. This includes:
   - Making joint visits with others on the primary care team to our members
   - Participating in conferences with primary care team members and/or other treating professionals following a scheduled member reassessment, significant change in plan of care and/or condition
5. Collaborate and communicate with the Director of Clinical Operations to coordinate all inpatient, outpatient and facility care for our members. Forward copies of the required documentation to our office. Work with the director to develop a network of care providers who are aware of the special needs of the frail elderly.
6. Conduct a complete initial assessment for all of our Nursing Home Plan members within 30 calendar days of enrollment (90 days for Assisted Living Plan members), that includes:
   a. History and physical examination, including mini-mental status (MMS) and functional assessment

b. Review previous medical records
   c. Prepare problem list
   d. Review medications and treatments
   e. Review lab and x-ray results
   f. Review current therapies (physical therapy, occupational therapy, and speech therapy)
   g. Update treatment plan
   h. Review advance directive documentation including Do Not Resuscitate: Do Not Intervene (DNR/DNI) and use of other life-sustaining techniques
   i. Contact the family/responsible party within 30 calendar days of enrollment to:
      i. Schedule a meeting at the facility, if possible;
      ii. Obtain further history;
      iii. Agree on type and frequency of future contacts; and
      iv. Discuss advance directives.
   j. Perform clinical and quality initiative documentation as directed

7. Provide care management services to coordinate all the covered services outlined in our member's benefit plan. Examples include:
   - All medically necessary and appropriate facility services
   - Outpatient procedures and consultations
   - Inpatient care management
   - Podiatry, audiology, vision care and mental health care provided in the facility. When a member is admitted, notify the PCP and UnitedHealthcare or Payer immediately if it is for an emergency or observation. If contact information is not available, please call the local office or coordinate communication through the nursing facility clinical staff.
8. Give us at least 45 calendar days notice when discontinuing services at any facility where our members live.

Chapter 9: Our Claims Process

You can learn more about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims on **UHCprovider.com/claims** including: Claim Estimator with bundling logic, training tools and resources including Frequently Asked Questions (FAQs), Quick References, Step-by-Step instructions and tutorials.

Prompt Claims Processing

We know that you want prompt payment. We work hard to process your claims timely and accurately. This is what you can do to help us:

1. Submit the claim to the correct payer by reviewing the member's eligibility as outlined in *Verifying Eligibility, Benefits, and Your Network Participation Status*.

   Note: When we give you eligibility and benefit information, we are not guaranteeing payment or coverage in any specific amount. Actual reimbursement depends on many factors, such as compliance with administrative protocols, date(s) of services rendered, and benefit plan terms and conditions. For Medicare Advantage (MA) benefit plans, reimbursement also depends on CMS guidance and claims processing requirements.

2. Follow the instructions in the *How to Submit Advance or Admission Notifications/Prior Authorizations* section.
3. Prepare complete and accurate claims (see *Claims and Encounter Data Submissions* section or use our reference guides found on **UHCprovider.com/claims**).
4. Submit claims electronically for fast delivery and confirmation of receipt.
   a. Electronic submissions are preferred for sending claims to UnitedHealthcare. View our **Claims Payer List** to determine the correct Payer ID to use.
   b. Our contracts generally require you to conduct business with us electronically. They contain specific requirements for electronic claim submission. Please review your Agreement and follow the requirements. While some claims may require supporting information for initial review, we have reduced the need for paper attachments. We request additional information when needed.
   c. For helpful resources and tips on submitting claims electronically, visit **UHCprovider.com/EDI**.
   d. Check the status of a claim using **EDI 276/277 Claim Status Inquiry and Response** transactions. Contact your vendor or clearinghouse if these transactions are not available or activated in your system.
   e. Learn how to elevate your productivity and savings using EDI at **UHCprovider.com/optimizeEDI**.
   f. If you need assistance using EDI, visit our **EDI Contacts** page.
   g. If you don't have electronic data interchange (EDI) capabilities, you can use the Claim Submission tool on Link. Go to **UHCprovider.com/claims** for more information.

HIPAA Claim Edits and Smart Edits

When claims are submitted using EDI, HIPAA edits are applied by the clearinghouse to help ensure claims contain specific information. Any claims not meeting requirements are rejected and returned back to the care provider to make corrections and resubmit electronically.

Smart Edits are an EDI capability which auto-detects claims with potential errors. Smart Edits may also be applied to help reduce claim denials and improve the claim processing time. You'll have five calendar days to correct claims that reject due to Smart Edits before they are automatically processed.

For more information on claim edits, go to **UHCprovider.com/EDI** > HIPAA Claim Edits and Smart Edits.

Electronic Payments and Statements (EPS)

Optum EPS is a free electronic funds transfer (EFT) and electronic remittance advice (ERA) service brought to you by UnitedHealthcare. It is the standard method for receiving payments and explanation of benefits (EOBs)/remittance advice from us.

EPS delivers electronic payments and provides online remittance advice and 835 files to health care providers, hospitals or facilities.

If you use a billing service company, EPS created a new portal, just for third party billing service companies. The billing service first needs to enroll for EPS access at: **Optum.com/enroll**.

After your billing service enrolls, they are able to setup users on their EPS account and then associate their EPS account with your practice. This enables them to access the claim payment information needed to post and close claims.

You may make electronic payments by direct deposit or EFT into an organization's bank account or by Virtual Card Payment (VCP). With VCP, you do not need your bank account information as you process payments like a credit card transaction. To receive capitation payments by EFT, we require a signed EFT Payments form, detailing the bank account and bank routing information. The EFT initial set-up, or a change in banking information, requires three weeks processing time to take effect.

EPS with Direct Deposit: No Credit Card Processing Fees

When adding funds to your account, we will not debit or deduct claim adjustments from your checking or savings account.

You may also contact your bank to help ensure you have certain controls over the electronic funds transfers to and from your account.

Posting and Balancing With EPS with Direct Deposit:

1. Receive email notifications when we deposit payments to your bank account(s).
2. Log into EPS and view, save, or print remittance advice to post payments manually to your practice management system. You also can auto-post using the free electronic remittance advice 835/ERA.

Enroll with your clearinghouse to receive the 835 file from them.

EPS with Virtual Card Payments:

Process VCPs using the same method your organization uses to process credit card payments. Your current credit card processing fees apply. You can confirm those rates with the merchant processor directly.

- This process does not require you share your banking information with us.

Posting and Balancing with VCP:

1. We send you one or more virtual card numbers (each payer ID has a card number) in the mail. Store in a secure location for future payments.
2. We send email notifications of new claim payments.
3. Log on to EPS and view, save or print remittance advice to post payments manually to your practice management system. You can auto-post using the free electronic remittance advice 835/ERA.

Enroll and Learn More about EPS

To learn more about EPS and to receive electronic funds transfers, visit **optum.com/enroll**. If you have questions about EPS, direct deposit, VCPs or enrollment, call us at **877-620-6194**, to speak with an EPS representative.

Claims and Encounter Data Submissions

You must submit a claim and/or encounter for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the member. If you have questions about submitting claims to us, please call us at the phone number listed on the member's health care ID card.

It is important to accurately code the claim because a member's level of coverage under their benefit plan may vary for different services. To help correctly code your claims, use the Claim Estimator on **UHCprovider.com/claims**. It includes a feature called Professional Claim Bundling Logic. This helps you determine allowable bundling logic and other commercial claims processing edits for a variety of procedure codes. This is not available for all products.

Pricing and payment calculations for professional commercial claims are available under the Pre-Determination of Benefits option. Allow 45 calendar days for us to process your claim, unless your Agreement says otherwise. Check the status on claimsLink before sending second submissions or tracers. If you do need to submit a second submission or a tracer, please submit it electronically no sooner than 45 days after original submission.

Complete claims by including the information listed under the Requirements for Complete Claims and Encounter Data Submission section. We prefer to receive claims electronically, but we do accept claims submitted on paper. Send the completed and appropriate forms to the claims address listed on the back of the member's health care ID card.

If we receive a claim electronically with missing information or invalid codes, we may reject the claim, not process it or, if applicable, not submit it to CMS for consideration in the risk adjustment calculation.

If we receive a similar claim using the paper form, we may pend it to get the correct information. We may also require additional information for particular types of services, or based on particular circumstances or state requirements.

To order CMS 1500 and CMS-1450 (also known as UB-04) forms, contact the U.S. Government Printing Office at **202-512-0455**, or visit the Medicare website at: **cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html**

Requirements for Complete Claims and Encounter Data Submission

We may pend or deny your claim if you do not list:

- Member's name, address, gender, date of birth, relationship to subscriber (policy owner).
- Subscriber's name (enter exactly as it appears on the member's health care ID card), ID number, employer group name and employer group number.
- Rendering care provider's name, signature or representative's signature, address where service was rendered, "Remit to" address, phone number, NPI, taxonomy and federal TIN.
- Referring care provider's name and NPI (for Medicare Advantage), as well as TIN (if applicable).
- Complete service information, including date of service(s), place of service(s), number of services (day/units) rendered, current CPT and HCPCS procedure

codes, with modifiers where appropriate, current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity. It is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item.

- Charge per service and total charges.
- Itemized bill – There may be times when we request an itemized bill to help adjudicate the claim. In an effort to avoid unnecessary delays, please submit itemized bills upon request.
- Detailed information about other insurance coverage.
- Information regarding job-related, auto or accident information, if available.
- Retail purchase cost (or a total retail rental cost) greater than $1,000 for DME.
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure (F2, GR, ML, UN, ME) and NDC units dispensed (must be greater than 0) for all claims submitted with drug codes. Enter the NDC information for the drug(s) administered in the 24D field of the CMS-1500 Form, field 43 of the UB-04 form, or the LIN03 and CTP04-05 segments of the HIPAA 837 Professional or institutional electronic form.
- Method of administration (self or assisted) for hemophilia claims – note the method of administration and submit with the claim form with applicable J-CODES and hemophilia factor, to enable accurate reimbursement. Method of administration is either noted as self or assisted.

Submission of Unlisted Medical or Surgical Codes

Include a detailed description of the procedure or service for claims submitted with:

- Unlisted medical/surgical CPT
- "Other" revenue codes
- Experimental services
- Reconstructive services

Additional Information Needed for a Complete UB-04/CMS-1450 Form:

Your claim may be pended or not processed if you do not include:

- Date and hour of admission
- Date and hour of discharge
- Member status-at-discharge code
- Type of bill code (three digits)
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current four digit revenue code(s)
- Attending physician ID
- For outpatient services/procedures, the specific CPT or HCPCS codes, line item date of service, and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)
- Submit claims according to any special billing instructions that are in your Agreement
- On an inpatient hospital bill type of 11x, use the actual time the member was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, report a nominal monetary amount ($01 or $100) on all other surgical revenue code lines to assure appropriate adjudication
- Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within three calendar days of an inpatient admission and are not related to the admission

Timely Filing

Your claim must be filed within your timely filing limits or it may be denied. If you disagree with a claim that was denied due to timely filing, you will be asked to show proof you filed the claim within your timely filing limits.

Timely filing limits vary based on state requirements and contracts. Refer to your internal contracting contact or Provider Agreement for your specific timely filing requirements.

Risk Adjustment Data – MA and Commercial

U.S. Department of Health and Human Services (HHS) requires risk adjustment for commercial small group and individual benefit plans. Similar to the CMS risk adjustment program for MA benefit plans, HHS uses Hierarchical Condition Categories (HCCs) to calculate an annual patient risk score that represents the specific patient's disease burden. Every year, CMS and HHS require information about the demographic and health of our members. Diagnoses do not carry forward to the following year and must be assessed and reported every year.

The risk adjustment data you give us, including clinical documentation and diagnosis codes, must be accurate and complete. It is critical for you to refer to the ICD-10-CM coding guide to code claims accurately. To comply with risk adjustment guidelines, specific ICD-10-CM codes are required.

- Medical records must support all conditions coded on the claims or encounters you submit using clear, complete and specific language.

- Code all conditions that co-exist at the time of the member visit and require or affect member care, treatment or management.
- Never use a diagnosis code for a "probable" or "questionable" diagnosis. Code only to the highest degree of certainty for the encounter/visit. Include information such as symptoms, signs, abnormal test results and/or other reasons for the visit.
- Specify whether conditions are chronic or acute in the medical record and in coding. Only choose diagnosis code(s) that fully describe the member's condition and pertinent history at the time of the visit. Do not code conditions that no longer exist.
- Carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the member's condition.
- Check the diagnosis code against the member's gender.
- Sign chart entries with credentials.
- All claims and/or encounters submitted to us for risk adjustment consideration are subject to federal and/or UnitedHealthcare audit. Audits may come from CMS, HHS, or us, where we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please give us any requested medical records quickly. Please provide all available medical documentation for the services rendered to the member.
- Notify us immediately about any diagnostic data you have submitted to us that you later determine may be erroneous.

CMS HCC Risk Adjustment

We offer an alternate method of reporting CMS risk adjustment data in addition to the normal claim/encounter submission process. All encounter submissions are required to process 837 Claim Encounter in a HIPAA 5010 compliant format. To supplement a previously submitted 837 Claim/Encounter, you may submit an 837 replacement claim/encounter or send additional diagnosis data related to the previously submitted 837 through the Optum ASM Operations FTP process. If you choose to submit by ASM, you will first need to contact the Optum ASM Operations team at cas_ops@ingenix.com to start the onboarding process.

National Provider Identification (NPI)

HIPAA, federal Medicare regulations, and many state Medicaid agencies require health care professionals to obtain and use a standardized NPI. You are required to use an NPI as identification on electronic transactions as outlined in the instructions for HIPAA electronic transaction x12N Implementation Guides.

State-specific regulations may also require you to submit your NPI on paper claims.

- To avoid payment delays or denials, you must submit a valid billing NPI, rendering NPI and relevant taxonomy code(s) on all claims and encounters. In addition, we encourage you to submit the referring care provider's NPI.

The NPI information you report on your claims and encounters helps us to efficiently process claims and encounters and to avoid delays or denials.

We accept NPIs submitted through:

- **Link:** using the My Practice Profile tool for providers and facilities. Go to "Facility/Practice Profile" and select the TIN. Click "Continue", select the "View/Update NPI Information" tab.
- **Fax:** Using the fax form on UHCprovider.com/mypracticeprofile.
- **Phone:** United Voice Portal (UVP) at 877-842-3210. Select the "Health Care Professional Services" prompt. Say "Demographic Changes" and your call goes to the service center to collect your NPI, health care provider taxonomy codes, other NPI-related information.
- **Credentialing/Contracting:** NPI and National Uniform Claim Committee (NUCC) taxonomy indicator(s) are collected as part of credentialing, recredentialing, new provider contracting and re-contracting efforts.

How to Submit NPI, TIN and Taxonomy on a Claim or Encounter

Information is provided for the location of NPI, TIN and Taxonomy on paper and electronic claims on UHCprovider.com/mypracticeprofile.

Medicare Advantage Claim Processing Requirements

Section 1833 of the Social Security Act prohibits payments to any care provider unless there is sufficient information to determine the "amounts due to such provider." We apply various claims processing edits based on:

- National and local coverage determinations
- The Medicare Claims Processing Guide
- National Correct Coding Initiative (NCCI)
- Other applicable guidance from CMS, including but not limited to, the Official ICD-10-CM Guidelines for Coding and Reporting

These edits provide us with information to determine:

- The correct amount to pay
- If you are authorized to perform the service
- If you are eligible to receive payment

- If the service is covered, correctly coded, and correctly billed to be eligible for reimbursement
- If the service is provided to an eligible beneficiary, and
- If the service was provided in accordance with CMS guidance

Care providers in our MA network must follow CMS guidance regarding billing, coding, claims submission, and reimbursement. For example, you must report Serious Adverse Events by having the Present on Admission (POA) indicator on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims. If you do not report the "Never Event", we try to determine if any charges filed with us meet the criteria as a Serious Reportable Adverse Event. If you do not follow these requirements, we will deny the claim. You cannot bill the member.

There may be situations when we implement edits and CMS has not issued any specific coding rules. In these cases, we review the available rules in the Medicare Coverage Center. We find those coding edits that most align with the applicable coverage rules.

Due to CMS requirements, you are required to use the 837 version 5010 format. We reject incomplete submissions.

Hospice – MA

When an MA member elects hospice, bill claims for:

- Hospice-related services to CMS
- Services covered under Medicare Part A and B (unrelated to the terminal illness) to the Medicare administrative contractor

We are not financially responsible for these claims. We may be financially responsible for additional or optional supplemental benefits under the MA member's benefit plan such as eyeglasses and hearing aids. Medicare does not cover additional and optional supplemental benefits.

Medicare Crossover

Medicare Crossover is the process by which Medicare, as the primary payer, automatically forwards Medicare Part A (hospital) and Part B (medical) claims to a secondary payer. Medicare Crossover is a standard offering for most Medicare-eligible members covered under our commercial benefit plans. Enrollment is automatic for these members.

- For more information on Medicare Crossover, refer to **EDI Quick Tips for Claims** > Secondary/COB or Tertiary Claims > Medicare Crossover.
- More information on Medicare Crossover can be found on the 837 Claims page of **UHCprovider.com/EDI**.

Claim Submission Tips

Do not use EDI or a paper claim form to resubmit claims that were denied or pended for additional information. Please use **claimsLink**.

The Payer ID is an identification number that instructs the clearinghouse where to send your electronic claims or encounters. In some cases, the Payer ID listed on our Claims Payer List may be different from the number issued by your clearinghouse. Validate any errors with your clearinghouse to avoid delays.

- Before submitting your EDI claims to us, refer to the member's health care ID card for the Payer ID.
- If no Payer ID is listed or you do not have access to the member's ID card, refer to our Claims Payer List for the correct Payer ID number.

Submit professional and institutional claims and/or encounters electronically. We accept primary and secondary claims electronically. Find specific information about secondary claims submissions, such as Coordination of Benefits (COB) electronic claim requirements and EDI specifications, on UHCprovider.com/EDI > **Quick Tips for Claims** > Secondary/COB or Tertiary Claims.

The HIPAA ANSI X1 25010 837 format is the only acceptable format for submitting claims and encounter data.

We support other HIPAA EDI transactions to assist you with your revenue cycle process. For a complete list of EDI transactions available to our care providers, see the home page of **UHCprovider.com/EDI**. Locate specific claims with your provider ID or a specific member's ID. You can get a claim summary or line-item detail about claims status.

Estimating Treatment Costs

The Claim Estimator tool (not available for all products) is a fast and simple way to get your commercial professional claim predeterminations through **UHCprovider.com/claims** > Get a Claim/Procedure Cost Estimate. With Claim Estimator, you receive an estimate on whether a procedure will be covered, at what percentage, if any, and what the claim payment will be. Claim Estimator gives you expense information you can share with your patient before treatment.

HRA and HSA Benefit Plans Claims Submission Tips

For faster claims turnaround and more accurate reimbursement with UnitedHealthcare HRAs or HSAs, verify member eligibility and benefits coverage as an EDI 270/271 transaction, or online using **eligibilityLink**. You can also call the member service number on the back of your patient's health care ID card.

For our HRA members: Once logged into the Patient Eligibility & Benefits, the "HRA Balance" field will display if the member is enrolled in any of our consumer-driven health plans. When there are funds available in an HRA account, the current balance will display. The current balance is also returned if you are using EDI.

This amount is based on the most recent information available and is subject to change. The actual balance may differ from what is displayed if there are outstanding claims or adjustments that have not yet been submitted or processed.

Balances for HSA members are not available through eligibilityLink or EDI.

Most UnitedHealthcare HRA and HSA benefit plans do not require copayments. Please do not ask those members to pay a copayment at the time of service unless indicated on their health care ID card.

Submit claims electronically as an 837 EDI transaction or Claims Submission on Link, or to the address on the back of the member's health care ID card.

Please wait until after a claim is processed and you receive your EOB/remittance advice before collecting funds from our members with an HRA/HSA benefit plan. This is because the member responsibility may be reimbursable through their HRA account and paid to you. The remittance advice displays any remaining member balance. We will not automatically transfer the HSA balance for payment. However, the member can pay with their HSA debit card or convenience checks linked to their account balance.

Consumer Account Cards and Qualified Medical Expenses

You may only charge our HRA or FSA consumer account cards for "qualified medical expenses" incurred by the cardholder, the cardholder's spouse or dependent. "Qualified medical expenses" are expenses for medical care that provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for affecting any structure or function of the body.

Examples of non-qualifying expenses include:

- Cosmetic surgery/procedures (i.e., procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), such as:
  - Face lifts
  - Liposuction
  - Hair transplants
  - Hair removal (electrolysis)
  - Breast augmentation or reduction. Surgery or procedures necessary to improve a defect from a congenital abnormality, and reconstructive surgery following a mastectomy for cancer, may qualify.
- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Weight loss programs (disease-specific nutritional counseling may be covered)
- Illegal operations or procedures
- An expense defined as a "qualified medical expense", but might not be covered under a member's benefit plan. For updated information regarding qualified medical expenses, go to: irs.gov or call the IRS at 800-TAX-FORM (800-829-3676).

Pass-through Billing/CLIA Requirements/Reimbursement Policy

If you are a physician, practitioner, or medical group, you may only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

We only reimburse for laboratory services that you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services for which you lack the applicable CLIA certification.

In-Office Laboratory Tests and CLIA Waived Tests

Limit your laboratory tests done in your office to only those urgently needed. As defined by CLIA, waived tests are simple tests with a low risk for an incorrect result. Sites that perform only waived testing must have a CLIA certificate and follow the manufacturer's instructions; other CLIA requirements do not apply to these sites. There is a list of approved in-office tests. You must make sure the test is on the **CLIA Waived Test List**.

All other laboratory tests require a referral to a participating or capitated laboratory. You can find a list of approved codes on CMS.gov > Regulations & Guidance > Legislation > **Clinical Laboratory Improvement Amendments**. Participating laboratories are listed on **UHCprovider.com**.

Note: Some plans are capitated for laboratory services. The capitated laboratory care provider must be used to perform services not allowed in the care provider's office.

In addition, care provider offices granted a CLIA Certificate of Waiver, may conduct a limited number of tests in-house. Tests that may conduct under a certificate of waiver must meet the descriptive criteria specified on CMS.gov > Regulations & Guidance > Legislation > **Clinical Laboratory Improvement Amendments**. We will only reimburse laboratory services if in compliance with state and federal regulatory guidelines to include CLIA.

Claim payment is subject to our payment policies and medical policies, which are available online on **UHCprovider.com/policies** or upon request to your Network Management contact.

Special Reporting Requirements for Certain Claim Types

Anesthesia Services

For detailed instructions, refer to **UHCprovider.com/policies** > Commercial (or Medicare Advantage) Policies > Reimbursement Polices > Anesthesia Services.

Laboratory Claims

Many benefit plan designs exclude outpatient laboratory services if they were not ordered by a participating care provider. Our benefit plans may also cover such services differently when a portion of the service (e.g. the draw) occurs in the care provider's office, but a laboratory care provider performs the analysis. A licensed care provider must order laboratory services.

All laboratory claims and/or encounters must include the referring care provider's name and NPI number, in addition to the other elements of a complete claim and/or encounter described in this guide. All claims for laboratory services must include the CLIA number for the servicing care provider. We reject or deny laboratory claims that do not include the identity of the referring care provider.

This requirement applies to claims and/or encounters for both anatomic and clinical laboratory services. It also applies to claims and/or encounters received from both participating and non-participating laboratories, unless otherwise provided under applicable law. It does not apply to claims for laboratory services done by care providers in their offices.

Report the AMA Claim Designation code or Abbreviated Gene Name in loop 2400 or SV101-7 field for electronic claims or Box 24 for paper claims. When submitting code 81479, unlisted molecular pathology, report the Genetic Test Registry (GTR) unique ID.

Claims that have complied with notification or prior authorization requirements in UnitedHealthcare's Genetic Testing and Molecular Prior Authorization program satisfy the policy's requirements without further provider action, as long as they meet our Genetic Test Lab Registry requirements.

Please also refer to the *Laboratory Services Protocol*, in Chapter 8: Specific Protocols.

Physical Medicine and Rehabilitation Services

Physical Medicine and Rehabilitation (PM&R) services are eligible for reimbursement if provided by a physician or therapy care provider duly licensed to perform those services. If the rendering care provider is not duly licensed, we do not pay for the service.

Assistant Surgeons or Surgical Assistants Claim Submission Requirements

The practice of using non-participating care providers significantly increases the costs of services for our members. We require our participating care providers to use reasonable efforts to find network care providers, including network surgical assistants or assistant surgeons for our members.

Submission of Claims for Services Subject to Medical Claim Review

We have the right to review claims to confirm a care provider is following appropriate and nationally accepted coding practices. We may adjust payment to the care provider at the revised allowable amount. Care providers must cooperate by providing access to requested claims information, all supporting documentation and other related data.

We may pend or deny a claim and request medical records to determine whether the service rendered is covered and eligible for payment.

In these cases, we send a letter explaining what we need.

To help claim processing and avoid delays due to pended claims, please resubmit only what is requested in our letter. The claim letter will state specific instructions for required information to resubmit, which may vary for each claim. You must also return a copy of our letter with your additional documents.

For MA benefit plans, if you are not eligible for payment but the service is covered, we will deny payment. You may not bill the member for the amount denied.

Erythropoietin (For Commercial Members)

For Erythropoietin (EPO) claims, you must submit the Hematocrit (Hct) level for us to determine coverage under the member's benefit plan. For claims submitted by paper to UnitedHealthcare on a Form 1500, you must enter the Hct level in the shaded area of line 24a in the same row as the J-code. Enter Hct and the lab value (Hctxx).

For electronic claims, the Hct level is required in the (837P) Standard Professional Claim Transaction, Loop 2400 – Service line, segment MEA, Data Element MEA03.

Report the MEA segment as follows:

- MEA01 = qualifier "TR", meaning test results
- MEA02 = qualifier "R2", meaning hematocrit
- MEA03 = hematocrit test result Example: MEA*TR*R2*33~

The following J codes require an Hct level on the claim:

- J0881 Darbepoetin alfa (non-ESRD use)
- J0882 Darbepoetin alfa (ESRD on dialysis)
- J0885 Epoetin alfa (non-ESRD use)
- J0886 Epoetin alfa, 1,000 units (for ESRD on Dialysis)
- Q4081 Epoetin alfa (ESRD on dialysis)

For EPO claims submitted on a UB-04 claim form, an Hct level is not required.

Overpayments

If we inform you of an overpaid claim that you do not disagree with, send us the refund check or recoupment request within 30 calendar days (or as required by law or your Agreement), from the date of notification. We may apply the overpayment against future claim payments unless your Agreement states otherwise or as required by law. If you find we overpaid for a claim, please use the **Overpayment Refund/Notification Form**. Call 800-727-6735 with questions related to overpayments. Send refunds to:

Regular Mail
UnitedHealthcare Insurance Company
P.O. Box 101760
Atlanta, GA 30392-1760

Overnight Mail
UnitedHealthcare Insurance Company – Overnight Delivery
Lockbox 101760
3585 Atlanta Ave
Hapeville, GA 30354

Please include documentation that shows the overpayment, including member's name, health care ID number, date of service and amount paid. If possible, also include a copy of the provider remittance advice (PRA) that corresponds with our payment. If the refund is owed because of COB with another carrier, provide a copy of the other carrier's EOB/remittance advice with the refund.

If we find a claim was paid incorrectly, we may make a claim adjustment. You will see the adjustment on the EOB or PRA.

Disagreement

If you disagree with the claim adjustment, or request for an overpayment refund or recoupment, you may submit your disagreement within 30 calendar days (or as required by law or your Agreement) from the date of receipt of notification. You must clearly state the items in your disagreement and include any relevant and supporting documentation.

Direct Connect

Direct Connect is a no-cost web-based platform that helps payers and care providers communicate effectively, automate workflows and drive resolutions. This portal has the ability to replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Track and manage overpayments in a controlled process
- Create a transparent view between care provider and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution time frames
- Real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution method
- Manage and review overpayment disagreements
- Attach images for quick reference

Access Direct Connect using Link. Onsite and online training is available.

Email **directconnectsupport@optum.com** to get started with Direct Connect.

Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and coordination of benefits rules.

1. **Subrogation** — We have the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan.
2. **Coordination of Benefits (COB)** — COB is administered according to the member's benefit plan and in accordance with law. We accept secondary claims electronically. To learn more, go to UHCprovider.com/edi > **EDI Quick Tips for Claims** > Secondary/COB or Tertiary Claims. You can also contact EDI Support at 800-842-1109 or UHCprovider.com > Contact Us > Technical Assistance > **Electronic Data Interchange (EDI) Support**.
3. **Workers' Compensation** — In cases where an illness or injury is employment-related, workers' compensation is primary. If you receive notification that the workers' compensation carrier has denied a claim for services, submit the claim to us. It is also helpful to send us the workers' compensation denial statement with the claim.
4. **Medicare** — If the care provider accepts Medicare assignment, all COB types coordinate up to Medicare's allowed amount. Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary.

Other coverage is primary over Medicare in the following instances:

- Aged employees: For members who are entitled to Medicare due to age, commercial is primary over Medicare if the employer group has 20 or more employees.
- Disabled employees (large group health plan): For members who are entitled to Medicare due to disability, commercial is primary to Medicare if the employer group has 100 or more employees.

End-Stage Renal Disease (ESRD)

If a member has or develops ESRD while covered under an employer's group benefit plan, the member must use the benefits of the employer's group plan for the first 30 months after becoming eligible for Medicare. After the 30 months, Medicare is the primary payer. However, if the

employer group benefit plan coverage were secondary to Medicare when the member developed ESRD, Medicare is the primary payer and there is no 30 month period.

Continuation of Benefits—Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA provides continued group health benefits to workers and families who lost coverage. COBRA generally requires group health plans with employers who have 20 or more employees, in the prior year, to offer continuation of coverage in certain instances where coverage would end. This coverage is available at the group premium rates. Coverage benefits and limitations for COBRA members are the same to those of the group.

- We are not responsible for initiating a terminated member's election of continuation coverage.
- Interested members should contact the subscriber's human resources office for eligibility information.
- Members eligible for COBRA may elect to convert to an individual health plan, where available.
- Additional information on COBRA is available at dol.gov > Topics > **Continuation of Health Coverage - COBRA**.

Coverage begins on the date that coverage would otherwise have been lost and ends at the end of the maximum period. It may end earlier if:

- Premiums are not paid;
- The employer ceases to maintain any group health plan;
- After the COBRA election, the member obtained coverage with another employer-group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if the member obtains other group health coverage prior to electing COBRA , COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election;
- If a beneficiary becomes entitled to Medicare benefits after electing COBRA. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

COBRA specifies certain periods of time that continued health coverage must be offered. It does not prevent plans from offering more health coverage beyond the COBRA period.

Note: In some cases, there may be an extensive period where a continuing member does not appear on the eligibility list. If this occurs, contact your network care provider account manager or provider advocate for assistance.

Claim Correction and Resubmission

Electronic Process:

- Some corrected claims can be submitted electronically as an EDI 837 transaction with the appropriate frequency code. Submit using EDI for the claims that process and pay appropriately.
- The **claimsLink** tool permits care providers to resubmit corrected claims that have been paid or denied.
- If you received a letter asking for additional information, submit it using claimsLink.
- When correcting or submitting late charges on 837 institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim.

Paper Process:

- Submit a new CMS 1500 or UB-04 CMS-1450 indicating the correction made. Please attach the *Claim Reconsideration Request Form* located on **UHCprovider.com/claims**. Check Box number 4 for resubmission of a corrected claim.
- Mail the information to the address on the EOB or PRA from the original claim.

Claim Reconsideration and Appeals Process

Claim reconsideration does not apply to some states based on applicable state law. Refer to *Care Provider Dispute Resolution (CA Delegates OR HMO claims, OR and WA Commercial Plans)* section for more information. Note: For Non-Network Care Providers Claim Appeals and Dispute Process, refer to **UHCprovider.com/plans** > Choose your state > Medicare > Select plan name >Tools & Resources > Non-Contracted Care Provider Dispute and Appeal Rights.

Claim Reconsideration (step one of a two-step process)

A processed claim in which you do not agree with the outcome of the original claim payment, correction, or denial.

Time frame

You must submit both your reconsideration and appeal to us within 12 months (or as required by law or your Agreement), from the date of the EOB or PRA. The two step process as outlined in the Claim Reconsideration and Appeal Process allows for a total of 12 months for timely submission and not 12 months for step one and 12 months for step two.

How to submit your Reconsideration:

If you believe we underpaid you, the first step in addressing your concern is to submit a Claim Reconsideration Request.

1. **Online:** The claimsLink tool. More information is available on UHCprovider.com/claims > Submit a Claim Reconsideration.
2. **Paper:** Use the *Paper Claim Reconsideration Form* on UHCprovider.com/claims. Mail the form to the applicable address listed on the EOB or PRA. The address may differ based on product. Include a copy of the original EOB or PRA. Please see applicable benefit plan supplement for specific contact information.
3. **Phone:** To request an adjustment for a claim that does not require written documentation call the number on the member's health care ID card.

20 or More Claims (Research Request)
If you have a request to reconsider 20 or more paid or denied claims for the same administrative issue (and attachments are not required), you may submit these in bulk online. Use the Claims Research Project tool on Link.

Attachments
If you are submitting medical documentation we requested for a pended claim:

1. **Online:** Use claimsLink tool.
2. **Paper:**
   - Complete the *Claim Reconsideration Request Form* and check "Previously denied/closed for Additional Information" as your reason for request.
   - Provide a description of the documentation submitted along with all pertinent documentation. It is extremely important to include the member name and health care ID number as well as your name, address and TIN on the Claim Reconsideration Request Form to prevent processing delays.

Use claimsLink to submit a Claim Reconsideration Request for a claim denied because filing was not timely:

Please provide one of the following documents:

1. Electronic Data Interchange (EDI) report - include confirmation that it was received and accepted within your filing limit.
2. A submission report from your accounting software to include a screen print to show the date the claim was submitted.
3. A billing software statement to show the claim was submitted timely to the clearing house (if rejected proof is not acceptable).
4. A resubmission form or letter with a statement that you billed the wrong insurance or the member gave you the wrong insurance information. If available, please include any other evidence you may have such as the other insurance carrier's denial or rejection, EOB, letter indicating coverage terminated or member not eligible.

All proof must include documentation that the claim is for the right patient and the correct date of service. For electronic claims, include confirmation that we received and accepted your claim.

Claim Appeal (step two of a two-step process-post service)

If you do not agree with the outcome of the claim reconsideration decision in step one, you may use the following claim appeal process.

Time frame
You must submit your appeal to us within 12 months (or as required by law or your Agreement), from the date of the original EOB or PRA. The two-step process described in the Claim Reconsideration and Appeal Process allows for a total of 12 months for timely submission and not 12 months for step one and 12 months for step two.

Medical Records Request Submission Time frame
If medical records are requested to process an appeal, the following time frames are when the information is due:

- Expedited appeals – within two hours of receipt of the request.
- Standard appeals – within 24 hours of receipt of the request.

This includes providing a copy of the denial notice. Time frames may change based on applicable law or your Agreement.

What to Submit
Attach all supporting materials, such as member-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish included in the appeal review.

We make our decision based on the materials available at the time of formal appeal review. If you are appealing a claim denied because filing was not timely:

- Electronic claims - include confirmation we received and accepted your claim.
- Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.

All proof of timely filing must also include documentation that the claim is for the correct member and the correct date of service.

Where to Send Your Appeal

Online: A claims appeal may be filed using the claimsLink tool on UHCprovider.com/claimsLink. More information is available online. Not available for all care providers in all locations. You may attach medical records and notes as needed.

Paper: Address may differ based on product. Please see applicable benefit plan supplement for specific contact information.

Response details: If the claim then requires an additional payment, the EOB or PRA will serve as notification of the outcome on the review. If the original claim status is upheld, you will be sent a letter outlining the details of the review.

Response details (California only): If a claim requires an additional payment, the EOB or PRA itself does not serve as notification of the outcome of the review. We will send you a letter with the determination. In addition, you must send payment within five calendar days of the date on the determination letter. We will respond to you within the time limits set forth by federal and state law. After the time limit has passed, contact Provider Relations at 877-842-3210 to obtain a status.

If you are disputing a refund request that you received from us, please reference the *Post-audit Procedures* section in Chapter 10.

If a member has authorized you to appeal a clinical or coverage determination on the member's behalf, such an appeal will follow the process governing member appeals as outlined in the member's benefit contract or handbook.

Retroactive Eligibility Changes

Eligibility under a benefit plan may change retroactively if:

1. We receive information an individual is no longer a member;
2. The member's policy/benefit contract has been terminated;
3. The member decides not to purchase continuation coverage;
4. The member fails to pay their full premium within the three month grace period established by the Affordable Care Act (and applicable regulations) for subsidized Individual Exchange members; or
5. The eligibility information we receive is later determined to be incorrect.

If you have submitted a claim affected by a retroactive eligibility change, a claim reconsideration may be necessary, unless otherwise required by state and/or federal law. We list the reason for the claim reconsideration on the EOB or PRA. If you are enrolled in Electronic Payment System, you will not receive an EOB. However, you will be able to view the transaction online or in the electronic file. If we implement a claim reconsideration and request refund, we notify you at least 30 business days prior to any adjustment, or as required by law or your Agreement.

MA Hospital Discharge Appeal Rights Protocol

MA members who are hospital inpatients have the statutory right to request an immediate review by the Quality Improvement Organization (QIO) when UnitedHealthcare and the hospital, with physician concurrence, determine that inpatient care is no longer necessary. The QIO notifies the facility and UnitedHealthcare of an appeal.

- When UnitedHealthcare completes the Detailed Notice of Discharge (DND), UnitedHealthcare delivers it to the facility and to the QIO. The facility will give the DND, on behalf of UnitedHealthcare, to the MA member, or their representative, as soon as possible, but no later than 12 p.m. local time of the day after the QIO notification of the appeal. The facility will also fax a copy of the DND to the QIO.
- When the facility completes the DND, the facility will give the DND on behalf of UnitedHealthcare to the MA member, or their representative, as soon as possible but no later than 12 p.m. local time of the day after the QIO notification of the appeal.

The facility will fax a copy of the DND to the QIO and UnitedHealthcare. If the MA member fails to make a timely request to the QIO for immediate review and remains in the hospital, they may ask for an expedited reconsideration (appeal) by UnitedHealthcare.

Resolving Concerns or Complaints

If you disagree with the outcome of a claim appeal or other disagreement, follow these steps.

If your concern/complaint is regarding:

- Your relationship with us, then send a letter containing the details to the address listed in your Agreement. A representative will look into your complaint and try to resolve it through an informal discussion. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed.
- Our administrative procedures, then follow the procedures set forth in those benefit plans to resolve the concern or complaint. After following these procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described in your Agreement. For disagreements regarding claim payments, you must timely complete the claim reconsideration and appeal process as set forth in this guide before initiating arbitration.
- Your compliance with your Agreement, then we will send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your Agreement. Arbitration proceedings will be held at the location described in your Agreement, or if a location is not specified in your Agreement, then at a location as described in the Arbitration Locations section below.

To start the arbitration process, reach out to your Network Account Manager.

Arbitration Locations:

Unless your Agreement states differently, the following list contains locations where we hold arbitration proceedings. Follow the locations where you provide care:

AL	Jefferson County, AL
AK	Anchorage, AK
AZ	Maricopa County, AZ
AR	Pulaski County, AR
CA	Los Angeles County, CA; San Diego County, CA; San Francisco County, CA
CO	Arapahoe County, CO
CT	Hartford County, CT; New Haven County, CT
DE	Montgomery County, MD
DC	Montgomery County, MD
FL	Broward County, FL; Hillsborough County, FL; Orange County, FL
GA	Gwinnett County, GA
HI	Honolulu County, HI
ID	Boise, ID; Salt Lake County, UT
IL	Cook County, IL
IN	Marion County, IN
IA	Polk County, IA
KS	Johnson County, KS
KY	Fayette County, KY
LA	Jefferson Parish, LA
ME	Cumberland County, ME
MD	Montgomery County, MD
MA	Hampden County, MA; Suffolk County, MA
MI	Kalamazoo County, MI; Oakland County, MI
MN	Hennepin County, MN
MS	Hinds County, MS
MO	St Louis County, MO; Jackson County, MO
MT	Yellowstone County, MT
NE	Douglas County, NE
NV	Clark County, NV; Washoe County, NV; Carson City County, NV
NH	Merrimack County, NH; Hillsboro County, NH
NJ	Essex County, NJ
NM	Bernalillo County, NM
NY	New York County, NY; Onondaga County, NY
NC	Guilford County, NC
ND	Hennepin County, MN
OH	Butler County, OH; Cuyahoga County, OH; Franklin County, OH
OK	Tulsa County, OK
OR	Multnomah County, OR
PA	Allegheny County, PA; Philadelphia County, PA
RI	Kent County, RI
SC	Richland County, SC
SD	Hennepin County, MN
TN	Davidson County, TN
TX	Dallas County, TX; Harris County, TX; Travis County, TX
UT	Salt Lake County, UT
VT	Chittenden County, VT; Washington County, VT; Windham County, VT
VA	Montgomery County, MD
WA	King County, WA
WV	Montgomery County, MD
WI	Milwaukee County, WI; Waukesha County, WI
WY	Laramie County, WY

Member Appeals, Grievances or Complaints

Members may be unhappy with our care providers or with us. We respect the members' rights to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All members receive instructions on how to file a complaint/grievance with us in their Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.

When there is a member grievance or appeal, you are required to comply with the following requirements:

1. Assist the member with locating and completing the Appeals and Grievance Form upon request from the member. This form is located by logging onto MyUHC.com > Claims and Accounts > Medical Appeals and Grievances > Medicare and Retirement Member Appeals and Grievance Form.

Note: An appeal, grievance or complaint process may differ based on product. Please see applicable benefit plan supplement to verify the process for those plan members.

2. Immediately forward all member grievances and appeals (complaints, appeals, quality of care/service concerns) in writing for processing to:

Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) Plans	UnitedHealthcare P.O. Box 6106 Mail Stop CA 124-0157 Cypress, CA 90630
For Medicare and Retirement Prescription Drug Plans (PDP)	UnitedHealthcare P.O. Box 6106 Mail Stop CA 124-0197 Cypress, CA 90630
For Commercial Plans	UnitedHealthcare P.O. Box 30573 Salt Lake City, UT 84130-0573
All Savers Supplement	ASIC Members: Grievance Administrator P.O. Box 31371 Salt Lake City, UT 84131-0371 **Standard Fax:** 801-478-5463 **Expedited Fax:** 866-654-6323 **Phone:** 800-291-2634
UnitedHealthOne Individual Plans Supplement (Golden Rule Insurance Company, UnitedHealthcare Oxford Navigate Individual benefit plans offered by Oxford Health Insurance, Inc.)	Grievance Administrator P.O. Box 31371 Salt Lake City, UT 84131-0370 **Standard Fax:** 801-478-5463 **Expedited Fax:** 866-654-6323 **Phone:** 800-657-8205

3. Respond to our requests for information within the designated time frame. You must supply records as requested within two hours for expedited appeals and 24 hours for standard appeals. This includes, but is not limited to, weekends and holidays.
4. For Medicare member appeal requests, CMS regulation states once an appeal is received, within 60 calendar days of the denial, it must be reviewed under the appeal process. Reopening of an organization determination can only be made due to clerical error and may result in a change to the decision outside of the appeal process. Comply with all of our final determinations.
5. Cooperate with our external independent medical review organization and us. This includes:
   - Promptly forwarding all medical records and information relevant to the applicable health care service to the external review organization
   - Providing newly discovered relevant medical records or any information in the participating medical group/IPA's possession to the external review organization
6. Provide us with proof that reversals of adverse determinations were done within the stated time frames. You must supply proof within:
   - Expedited appeals — two hours of overturn notice.
   - Standard appeals — 24 hours of overturn notice. This applies to all calendar days (no exceptions or delays allowed for weekends or holidays).

Medical Claim Review

We have the right to review claims. This helps ensure that care providers follow nationally accepted coding practices and that we paid at the correct allowance. Please cooperate with our review of claims and payments. We may request access to claim information and supporting documentation.

Chapter 10: Compensation

Reimbursement Policies

We apply reimbursement policies. Our reimbursement policies are available online at:

- UHCprovider.com/policies > Commercial Policies > **Reimbursement Policies for UnitedHealthcare Commercial Plans**
- UHCprovider.com/policies > Medicare Advantage Policies > **Reimbursement Policies for Medicare Advantage Plans**

We use the terms "reimbursement policies" and "payment policies" interchangeably.

Charging Members

Members are only responsible for copayments, deductibles and coinsurance. You may collect copayments at the time of service. For the exact amount of member responsibility, submit the claims first and refer to the Explanation of Benefits (EOB).

Annual Copayment/Deductible Maximum (Commercial)

Annual out-of-pocket maximum is the combined total of annual deductible and annual copayment maximum, as shown on the member's Schedule of Benefits. Cost-share is the amount the member is financially responsible for, such as copayments, coinsurance and deductibles according to their plan benefits. Cost-sharing for certain types of covered services may not apply toward the annual out-of-pocket maximum. Please refer to the member's Schedule of Benefits to determine applicability to the benefit plan.

When an individual member's out-of-pocket expenses has reached the individual out-of-pocket maximum, the member will not have any additional cost-shares for those services that apply to the out-of-pocket maximum for that year.

For benefit plans with both individual and family maximums, no member of the family will owe further cost-share amounts for those services after the family has met the out-of-pocket maximum. When a family's out-of-pocket expenses have reached their family out-of-pocket maximum benefits, plans with benefits that do not apply to the out-of-pocket maximum will still require cost-sharing for those excluded benefits.

Some services may not be covered until the member meets the annual deductible. Only amounts incurred for covered services that are subject to the deductible will count toward the deductible. Benefit plans may have an individual deductible only or both individual and family deductible. No further deductible will be required for the individual member when the individual deductible amount has been satisfied for the year. For plans with both individual and family deductibles, no further deductible will be required for all members of the family unit when members of the family unit reach the family deductible for the year.

As previously indicated, only certain covered services apply to the annual deductible. Other covered services not included in the annual deductible may incur a member cost-share considered separate from and not applied to the annual deductible. The annual deductible applies to the annual out-of-pocket maximum. The amounts applied to the annual deductible are based upon UnitedHealthcare's contracted rates, and percentage copayments (coinsurance).

Annual Out-of-Pocket Maximum (Medicare Advantage)

Annual out-of-pocket maximum is equal to the member's annual copayment maximum (if any), as shown on the member's Evidence of Coverage (EOC).

Cost-sharing for certain types of covered services may not apply toward the annual out-of-pocket maximum. Please refer to the member's Evidence of Coverage to determine applicability to the benefit plan. When an individual member's out-of-pocket expenses has reached the individual annual out-of-pocket maximum, no further cost-share amounts will be due by the member for those services that apply to the annual out-of-pocket maximum. Plans with benefits that do not apply to the annual out-of-pocket maximum will still require cost-sharing for those excluded benefits after the annual out-of-pocket maximum reached.

Cost-share is defined as amounts paid by the member such as copayments, coinsurance and deductibles according to their plan benefits.

Coinsurance Calculation

For all MA products, coinsurance is calculated as follows:

1. For services reimbursed on a service-specific contracted rate, or on a fee-for-service basis, the coinsurance is based on the contracted rate or billed amount, whichever is less or as agreed upon in your Agreement with us.
2. For services reimbursed under a downstream capitation Agreement between your organization and a care provider of the service, and where payment is not issued for each specific service rendered, coinsurance is based on Medicare's allowance for the location at which the service is rendered.

This coinsurance calculation is consistent with the definition of coinsurance as the amount a member pays as their share of the cost for services or prescription drugs.

The methodology is used for all UnitedHealthcare Medicare Advantage plans nationwide. Ensure you have the correct system setup and use consistent coinsurance calculations to help reduce member appeals and complaints.

Additional Fees for Covered Services

Do not charge additional fees for:

- Covered services beyond their copayments, coinsurance, or deductible
- Concierge/boutique practice fees
- Retainers, membership, or administrative fees
- Denied services/claims because you failed to follow our protocols and/or reimbursement policies
- Reductions applied to services/claims resulting from our protocols and/or reimbursement policies

You may charge members for:

- Missed appointments
  - › CMS does not allow you to charge MA members for missed appointments unless the member was aware of that policy

Charging Members for Non-Covered Services

You may collect payment from our commercial members for services not covered under their benefit plan, if you first get the member's written consent. The member must sign and date the consent before the service is done. Keep a copy of this in the member's medical record. If you know or have reason to suspect the member's benefits do not cover the service, the consent must include:

- An estimate of the charges for that service;
- A statement of reason for your belief the service may not be covered; and
- When we determine the planned services are not covered services, a statement that we have determined the service is not covered and that the member knows our determination, and agrees to be responsible for those charges.

For MA members, in addition to obtaining the member's written consent before the service is done, you must do the following:

- If you know or have reason to believe that a service or item you are providing or referring may not be covered, request a pre-service determination from us prior to rendering services.
- If we determine the service or item is not covered, we issue an Integrated Denial Notice (IDN) to the member and you. The IDN gives the member their cost for the non-covered service or item and appeal rights. You must make sure the member has received the IDN prior to rendering or referring for non-covered services or items to collect payment. Per CMS requirements, for you to hold a MA member financially liable for the non-covered service or item, the member must first have an IDN, unless the Evidence of Coverage, or other related materials, clearly excludes the item or service.
- A pre-service organization determination is not required to collect payment from a MA member where the EOC or other related materials is clear that a service or item is not covered.

Use our Provider Authorization and Notification (PAAN) tool on UHCprovider.com/paan to submit an advance notification request. The PAAN tool does not issue denials. It tells you if a procedure code requires a review or not.

You should know or have reason to suspect that a service or item may not be covered if:

- We have provided notice through an article on **UHCprovider.com** including clinical protocols, and/or medical policies; or
- We have made a determination that the planned service or item is not covered and have communicated that determination.
- For MA benefit plans, CMS has published information to help you determine if the service or the item is covered. You are required to review the Medicare Coverage Center. If you do not follow this protocol, you cannot bill our member.

If you followed this protocol and requested a pre-service organization determination and an IDN was issued before the non-covered service was rendered, you must include the –GA modifier on your claim for the non-covered service. Including the –GA modifier on your claim helps ensure your claim for the non-covered service is appropriately adjudicated as member liability.

Do not bill the member for non-covered services in cases where you do not follow this protocol. If you don't follow the terms of this protocol (such as requesting a pre-service organization determination for a MA member or rendering the service to a MA member before we issue the pre-service organization determination), you may receive an administrative claim denial. You cannot bill the member for administratively denied claims.

Balance Billing

You cannot bill members for covered services beyond their normal cost-sharing amounts (copayment, deductible, or coinsurance).

You cannot:

- Bill,
- Charge,
- Collect a deposit,
- Seek compensation,
- Seek remuneration,
- Seek reimbursement, or

- Have recourse against our members, or their representative, or the MA organization.

You must either:

1. Accept payment made by or on behalf of us as payment in full; or
2. Bill the appropriate state source for such cost-sharing amount.

Billing for Dual-Eligibles

Dual-eligible members qualify for both Medicare and Medicaid. If you are a participating care provider in our Medicare Advantage (MA) network, you cannot refuse to see these members. For dual eligibles for whom the state is responsible for covering Medicare cost-sharing, our contract requires that you accept payments made by or on behalf of our MA plans for covered Part A and B services as payment in full. You can bill the appropriate state Medicaid source for the balance.

Cost-sharing for Qualified Medicare Beneficiary (QMB)

Qualified Medicare Beneficiaries (QMBs) are not responsible for Medicare cost-sharing under CMS regulations. Medicare cost-sharing includes the deductibles, coinsurance and copays associated with covered Part A and B services included under MA plans. You cannot bill, charge, collect a deposit from, seek compensation from any MA member who is eligible for both Medicare and Medicaid. You can accept payment from us as payment in full or bill Medicaid for the remaining amount.

Member Financial Responsibility

Members are responsible for paying their copayments, deductibles, and coinsurance. You can collect copayments at the time of service.

To determine the exact member responsibility, submit claims first and refer to the EOB or PRA before billing our members.

If you prefer to collect payment at time of service, you must make a good faith effort to estimate the member's responsibility and collect no more than that amount at the time of services. You must help ensure the member has not exceeded their annual out-of-pocket maximum. Several tools on our website can help you determine member and health benefit plan responsibility, including Claim Estimator (**UHCprovider.com/claims** > Get a Claim/Procedure Cost Estimate) and eligibilityLink, which shows HRA balances. Claim Estimator is available only for professional commercial claims.

If the member pays you more than the amount indicated on the EOB/PRA, you must refund the member.

Preventive Care

The Department of Health and Human Services requires most benefit plans to include certain preventive care services to be covered without any out-of-pocket costs as long as participating care provider provides the service.

We update our Coverage Determination Guideline (CDG) for Preventive Care Services to help you identify and correctly code preventive services. This CDG is on UHCprovider.com/policies > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commerical Plans**.

We update the CDG when we receive new guidance about preventative services and revised codes. The United States Preventive Services Task Force is one of the primary references driving changes to the CDG. We must cover items that have an "A" or "B" rating without cost-share by non-grandfathered benefit plans. This applies to both fully insured and self-funded benefit plans. While grandfathered benefit plans are not required to implement these changes, some grandfathered benefit plans have chosen to cover preventive care services at no cost-share.

This does not apply to members enrolled in government health benefit plans (Medicare/Medicaid) including our MA benefit plans. For information on Medicare coverage of preventive services, please go to UHCprovider.com/policies > Medicare Advantage Policies > **Coverage Summaries** > Preventive Health Services and Procedures. For more information visit:

- Benefit Verification: **eligibilityLink**.
- Health Care Reform: **UHC.com** > Featured Links > United for Reform.

Provider Audits - Extrapolation

We may review paid claims to help ensure payment integrity. If reviewing all medical records for a procedure would burden you, we may select a statistically valid random sample (SVRS) or smaller subset of the SVRS. This gives an estimate of the proportion of claims that we paid in error. The estimated proportion, or error rate, can be projected across all claims to determine overpayment. You may appeal the initial findings. You must supply all requested medical records. Failure to do so may result in an audit failure denial of the entire SVRS and all claims submitted within the review.

Please handle overpayment disagreements as outlined in this guide and in your Agreement.

Provider audits may be a phone call, on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews. We ask that you provide us, or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance.

In general, we notify you in writing no less than two weeks of a pending in-depth audit involving claims review. However, if we suspect that there is fraudulent activity we may conduct an on-site audit without notice. If you refuse to allow access to your facilities, we reserve the right to recover the full amount paid or due to you.

Hospital Audit Services

Facility audits help to identify billing and coding errors. They include a thorough review of critical claim elements, such as medical records and itemized bills. We conduct the audits offsite, unless contractual obligations state otherwise.

Audit Findings

When an audit is completed, the auditor notifies the hospital of the findings. We provide the hospital representative with a copy of the audit findings.

Post-audit Procedures

- Refund Remittance – Following an overpayment request, the hospital remits the amount of the overpayment within 30 calendar days of receipt of the refund request, or as required by state or federal law.
- Audit Findings – If the hospital disagrees with the findings, they submit notification of the disagreement within 30 calendar days of receipt of the audit findings per the terms outlined in our overpayment notification letter. The notification must clearly identify the items in which you disagree and include any relevant documentation to support your position.
- Disagreement Resolution – We respond to audit findings in writing. Time frame varies by state and vendor. For continued resolution, refer to the Claim Reconsideration and Appeals Process in Chapter 9.
- Offsets – When we issue a refund request in connection with an audit, we recoup or offset the identified overpayment, and/or disallowed charge amounts after 35 calendar days from the date of the refund request, except when the hospital:
  - Has given us the amount due within the 35 calendar day repayment period
  - Has provided written notification of its disagreement with the audit findings within the 35 calendar day repayment period
  - Your Agreement or state law says otherwise

Audit Failure Denials

You are required to submit, or provide access to, medical records upon our request. Failure to do so in a timely manner may result in an audit failure denial, resulting in an overpayment. Medical record requests that do not comply with the guidelines in the *Overpayments* section of Chapter 9: Our Claims Process follow the auto failure denial process.

Notice of Medicare Non-Coverage (NOMNC)

You must deliver required notice to members at least two calendar days before termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member's services are expected to be fewer than two calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds two calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or their authorized representative, if the member is incompetent. You must use the most current version of the standard CMS approved notice entitled, "Notice of Medicare Non-Coverage" (NOMNC).

The standardized form and instructions regarding the NOMC may be found on the CMS website at cms.gov > Medicare > Beneficiary Notices Initiative (BNI) > **MA ED Notices** or contact your Quality Improvement Organization (QIO) for information. There can be no modification of this text and all required elements must be present, including but not limited to instructions on how to contact the QIO and the member's MA benefit plan.

Any appeals of such service terminations are called "fast track" appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of calendar day of the day that you are notified by us or the QIO if the member has requested a fast track appeal. This includes weekends and holidays.

Chapter 11: Medical Records Standards and Requirements

Access to Records

Unless otherwise stated in your Agreement, you are required to:

- Send copies of our members' medical, financial, or administrative records
- Supply records within 14 calendar days, free of charge
  - › Supply records faster in certain circumstances
- Maintain and protect records for six years
  - › Some situations may require a longer period; e.g., MA member records must be retained for ten years.
- Give access to records for all dates of service that occurred when you were a contracted provider
- Assist us, or our designee, in completing chart reviews for MA members

Medical Record Standards

Access medical record tools, templates and patient safety resources on **UHCprovider.com/patient**. In the November Network Bulletin, we publish our recommended medical records standards. Locate the Network Bulletins at **UHCprovider.com/news**.

Member Encounters

For every visit, document the:

- Member's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit
- Diagnosis and treatment plans
- Member education, counseling or coordination of care with other care providers
- Date of return visit or other follow-up care, including phone calls
- Review by the primary care provider (initialed) on consultation, lab, imaging, special studies, and ancillary, outpatient and inpatient records
- Follow-up care plans

When coding the encounter, pick the Evaluation and Management (E&M) level from the member's condition at the time of the visit.

Monitoring the Quality of Medical Care Through Review of Medical Records

A well-documented medical record reflects the quality of care delivered to patients. Accreditation and regulatory groups review medical records as part of their oversight activities. Maintain your medical records in a manner that is current, detailed and organized. This allows for effective and confidential patient care and quality reviews.

Correspondence from the Quality of Care Department is considered privileged and confidential. You may not share the information with the patient or member. The involved care provider cannot discuss it with the member or any member representative. You may not file the communication in the patient's medical record.

Medical Records Duplication

Medical Record Copies for Specialist Referrals — The PCP office pays for the cost of duplicating and shipping the records due to a referral. You cannot charge the member for records used during the member's course of treatment.

Member Transfer to Another PCP — Do not charge the member if they need records sent to another PCP.

Member Request for Medical Records — The member, or member's representative, may request copies of records from your office. You can charge a fee of up to $.25 per page plus any reasonable clerical costs incurred, unless state laws indicates otherwise.

Medical Record Guidelines

Medical records must have all information necessary to support claims for your services. You are expected to have written policies for the following:

- Medical records guidelines including maintenance of a single, permanent medical record that is legible, current and detailed
- Process for handling missed appointments
- Non-discrimination of health care delivery
- Staff training on confidentiality and safe record keeping
- Release of information
- Medical record retention
- Availability of medical records if housed in a different location
- Coordination of care between medical and behavioral care providers
- Process for notifying UnitedHealthcare upon becoming aware of a patient safety issue or concern.

General Documentation Guidelines

We expect you to follow guidelines for medical record information and documentation:

- Date all entries and identify the author and their credentials. It should be apparent from the documentation which individual performed a given service.
- Clearly label or document changes to a medical record entry by including the author and date of change. You must keep a copy of the original entry.
- Generate documentation at the time of service or shortly thereafter. Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.
- Include demographic information including name, gender, date of birth, member number, emergency contact name, relationship, phone number(s), and insurance information.
- Include family and social history, including marital status and occupational status or history.
- Prominently place information on whether the member has executed an advance directive. This is critical.
- Include a problem list with medical history, chronic conditions and significant illnesses, accidents and operation. Include the chief complaint and diagnosis and treatment plan at each visit.
- List medication allergies and adverse reactions. Also, note if the member has no known allergies or adverse reaction. This is critical.
- Include name of current medications, dosages, and over-the-counter drugs.
- Reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the care provider.
- Document member history and health behaviors such as:
  - Tobacco habits, including advice to quit, alcohol use and substance use (age 11 and older)
  - Immunization record
  - Preventive screenings/services and risk screenings
  - Screenings for depression and evidence of coordination with behavioral care providers
  - Blood pressure, height and weight, body mass index
  - Physical assessment for each visit
  - Growth charts for children and developmental assessments
  - Physical activity and nutritional counseling
- Clinical decision and safety support tools in place to help ensure evidence based care and follow up care. Examples include:
  - Lab, X-ray, consultation reports, behavioral health reports, ancillary care providers' reports, facility records and outpatient records show care provider review by signature or initials
  - Report from eye care specialist related to medical eye examinations

Record Accuracy Goals

- 90% of medical records will contain documentation of critical measures;
- 80% of medical records will contain documentation of all other elements when those elements are included in quality improvement medical record assessments;
- 100% of medical records will contain documentation of allergies and adverse reactions;

Chart Assessments and Failure to Comply

We have the right to assess care provider records to determine the accuracy of ICD-10-CM and CPT coding. We notify you of the results. We may charge a penalty if you fail to submit the information.

CMS Risk Adjustment and Medical Records

Medical records are important for CMS reimbursement for our members. Records must show all conditions evaluated during the visit. It is important to evaluate all chronic conditions at least annually. You should report the appropriate diagnosis code for all documented conditions that coexist at the time of the visit that require or affect care.

For accurate reporting on ICD-10-CM diagnosis codes, the medical record documentation must describe the member's condition. This should include specific diagnosis, symptoms, problems, or reasons for the visit. You are responsible for making sure ICD-10-CM coding adheres to ethical standards. Member charts are subject to review. We may review the charts to identify chronic diseases not coded on claims. CMS conducts assessments to confirm that the Hierarchical Condition Categories (HCCs) triggered for payment, based on ICD-10-CM coding, are supported by chart documentation. CMS works through us to obtain these records. We require your cooperation with this.

Chapter 12: Health and Disease Management

Clinical and Preventive Health Guidelines

We use evidence-based clinical and preventive health guidelines from nationally recognized sources to guide our quality and health management programs. We hope you use this information for our members. A complete list of clinical guidelines is on UHCprovider.com/policies > Additional Resources > Clinical Guidelines. We publish a list of clinical guidelines in the September Network Bulletin. You can find the Network Bulletins on UHCprovider.com/news.

Health Management Programs

We offer case and disease management programs to support your treatment plans. They also assist members in managing their conditions. By using medical, pharmacy, and behavioral health claims data, we can identify members who are high-risk and a good fit for our programs. A referral from a health risk assessment, the NurseLine, or a member/caregiver can also help identify these high-risk members. You can refer these members to the appropriate program by calling the number on the member's health care ID card. Participation in these programs is voluntary. Upon referral, we assess members for the appropriate level of care for their individual needs. The programs vary based on the member's benefit plan.

Case Management

Our case managers are registered nurses. They engage the appropriate internal, external or community-based resources to support the member's needs. When applicable, we refer to other internal programs such as:

- Disease management
- Complex condition management
- Behavioral health employee assistance
- Disability

Case management services are voluntary. The member can opt out at any time.

Transitional Case Management (TCM): The collaboration of evaluating and coordinating post-hospitalization needs for members who are at risk of re-hospitalization or frequent users of high-cost services.

General Condition Management: Serves members:

- With chronic conditions
- In need of long-term care support
- Who have unmet access
- Who have care plan, psycho-social, or knowledge needs

Commercial Complex Medical Conditions Programs

Transplant Resource Services: Members eligible for this program have access to the Optum Center of Excellence (COE) transplant network.

Congenital Heart Disease Program: Members 18 and younger who have a clinical diagnosis of CHD can join. It offers them clinical management and support throughout the process of selecting a facility, being inpatient, and post-discharge.

Cancer Support Program: Covers all types of cancer and provides case management support from an experienced cancer nurse and includes access to cancer COEs.

Bariatric Resource Services: Helps achieve positive results by using evidence-based guidelines and access to a COE/designated care provider network of quality bariatric centers to help improve clinical and economic outcomes. It also offers clinical case management by a dedicated nursing staff.

Women's Health Services: We offer integrated, connected care strategies to positively influence pregnancy outcomes for both mother and the baby.

- Our Fertility, Maternity, & Neonatal care management programs support members with appropriate guidance, education, and counseling. Members with unique health needs and high-risk pregnancies receive personalized case management support to minimize pregnancy complications.
- Our easy-to-access, multimodal channels allow members to remain engaged with their care team. The new UnitedHealthcare Healthy Pregnancy App delivers personalized content, helps determine risks, and facilitates maternity nurses' support and care during pregnancy.

Decision Support Programs

NurseLine: This program uses a call model and ICUE to help facilitate better health outcomes. Each call becomes an opportunity to address a symptom, and to connect members with the right care, right care provider, right medication and right lifestyle.

Emergency Room Decision Support (ERDS): This is a program that helps identify, educate and assist members whose emergency room (ER) visits are preventable, avoidable or treatable in a lower-care non-emergency setting.

Commercial Health Services, Wellness and Behavioral Health Programs

We offer many types of programs for members. They focus on delivering skilled resources to support members as they seek their personal best health. To access these programs, have the member call the phone number listed on the back of their health care ID card. Programs and health services may vary based on the member's coverage.

Tobacco Cessation: We offer a comprehensive tobacco cessation solution that uses an evidence-based combination of physical, psychological and behavioral strategies to help members overcome their tobacco addiction, including use of electronic nicotine delivery systems (ENDs) or e-cigarettes.

Wellness Coaching: This is an online or phone-based program. It helps members identify and prioritize unhealthy behaviors and set personalized goals that focus on positive, healthy behavior change.

Real Appeal: Real Appeal is a health service that takes an evidence-based approach to support weight loss. This service helps people make small changes necessary for larger, long-term health results. It is based on weight-loss research studies commissioned by the National Institutes of Health.

Wellness Incentive Programs: These programs reward employees with financial incentives when they participate in wellness activities and achieve targeted health outcomes.

UnitedHealthcare Motion: A digital wellness program designed to promote physical activity with compatible activity trackers enabling members to earn incentives for meeting certain daily walking goals.

Behavioral Health Programs: We offer specialized mental health and substance use benefits delivered by our affiliate company United Behavioral Health, operating under the brand Optum®. This may be available to members depending on their health benefit plan. To access these programs, please have the member call the phone number listed on the back of their health care ID card.

Employee Assistance Programs (EAP): The EAP provides confidential support and short-term counseling for individuals who may be struggling with those everyday challenges or for more serious personal concerns such as:

- Depression
- Stress and anxiety
- Relationship difficulties
- Financial and legal advice
- Parenting and family problems
- Child and elder care support
- Dealing with domestic violence
- Substance use and recovery

Commercial Consumer Transparency Tools

An online cost estimator tool is available in some markets at myUHC.com. It is designed to assist members in making informed health care choices based on cost and quality. The tool displays care provider-specific cost estimates together with UnitedHealth Premium physician designations. Information can be found on myuhc.com > Find Care & Costs.

If you would like to review your cost data and a description how Find Care & Costs works, contact your UnitedHealthcare Network Management Representative or Hospital or Physician Advocate.

Medicare Advantage (MA)

Note: Medicare Advantage (MA) may include Dual Special Needs Plans (DSNP).

Clinical Programs: Condition Management and Care Management

Our MA plans provide a full spectrum of care management programs as part of our standard plan offerings. Clinical programs include inpatient care management, care and condition management, specialty care management (e.g., transplant and end stage renal disease (ESRD) management), behavioral health care management, Advanced Illness, HouseCalls (not all members are eligible for this program), and Solutions for Caregivers (available on select MA plans). Participation by the member is encouraged, but voluntary.

Condition Management Programs

These programs help members with chronic conditions, such as diabetes, heart failure, and ESRD, to be their healthiest. We offer education and resources to support optimal health of members actively treated for chronic conditions. Members receive case management and can attend workshops to help manage their condition.

Care Management Programs

- **Inpatient Care Management:** Nurses review the clinical information that outlines the clinical treatment plan for the member. They evaluate appropriateness for admission based on evidence-based medicine and discharge planning needs, including identifying members for post-discharge follow-up and referral to outpatient programs.
- **Behavioral Health:** Led by experienced geriatric psychiatrists and licensed behavioral health clinicians, our program integrates with our medical team to identify, engage and manage members' behavioral health concerns.
- **Community Transitions Program:** Designed to reduce complications by smoothing the transition from hospital

to home, program staff coordinate transitions in care or changes in member health status to avoid potential adverse outcomes and unnecessary readmissions.

- **High Risk Care Management:** Nurses support members who have complex care needs by helping them access care, coordinate services and learn to better manage their chronic conditions.
- **Advanced Illness:** Provides comprehensive care for members facing life-limiting illness generally defined as the last 12 months of life.
- **Transplant Resources:** Our transplant management program drives positive clinical outcomes by addressing the complex needs of members who are facing transplants.
- **Post-Acute Transition Program:** Uses an individualized, whole-person approach to remove barriers to discharge from post-acute care, such as skilled nursing facilities (SNF) so the member can safely return to the least restrictive setting possible.

Special Needs Plans (SNP) Model of Care (MOC)

The MOC is the framework for care management processes and systems that enable coordinated care for SNP members. The MOC includes descriptions of:

- SNP population (including health conditions)
- Care coordination
- Provider network
- Quality measurement
- Performance improvement.

The MOC helps ensure the unique needs of the population are identified and addressed through care management practices. We evaluate MOC goals on an annual basis to determine effectiveness.

To learn more, contact us at: snp_moc_providertraining@ uhc.com.

The Centers for Medicare & Medicaid Services (CMS) requires annual SNP MOC training for all care providers who treat SNP members. The training is reviewed and updated annually to reflect current practices related to care coordination. This includes communication of the Interdisciplinary Care Plan (ICP) for each member. The Annual SNP MOC Provider Training is available at UHCprovider.com/training. We use the Network Bulletin to remind you about the annual training requirement.

Commercial and Medicare Advantage Behavioral Health Information

The U.S. Preventive Services Task Force (USPSTF) recommends that PCPs screen patients for depression, substance use disorder, and alcohol misuse. If left untreated, these disorders can adversely affect quality of life and clinical outcomes. Screening for these disorders is critical to treatment since it can contribute to the patient's readiness to change.

You can help by screening all patients, including adolescents. To assist, we recommend the following screenings:

Depression	Patient Health Questionnaire (PHQ-9)†	CPT 99420
Alcohol Misuse	Alcohol Use Disorders Identification Test (AUDIT) or CAGE	CPT 99420

† PHQ-9 was developed by Drs. Robert L Spitzer, Janet B. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

When doing a screening for depression in adults, remember to include the 99420 CPT Code and the ICD-10-CM Z13.89 code.

Find these screening tools and other resources online at uhcprovider.com > Menu > Resource Library > Behavioral Health Resources.

For more information on depression, alcohol use disorders, opioid use disorders and other behavioral conditions, access the Optum website providerexpress.com > Clinical Resources > Behavioral Health Toolkit for Medical Providers. You may also email your request to BHInfo@uhc.com.

To refer a member to an Optum network care provider for assessment and/or treatment, call the number on the back of the member's health care ID card. A link to the Optum Clinician Directory is on providerexpress.com > Our Network > Directories.

The UnitedHealthcare Preventive Medicine and Screening Reimbursement Policy notes that counseling services are included in preventive medicine services. This policy is available on UHCprovider.com/policies > Commercial (or Medicare Advantage Policies). The Preventive Care Services Coverage Determination Guideline is on UHCprovider.com/policies > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans.

For information on coverage of mental health services and preventive health services for MA members, see the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, and the Medicare Advantage Coverage Summary for Mental Health Services

and Procedures, available on UHCprovider.com/policies > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans.

Depression, Substance Use Disorder/Addiction and Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program Information

Optum has developed online preventive health resources that offer up-to-date information and tools to support treatment of major depressive disorder, alcohol and drug use disorder and attention-deficit/hyperactivity disorder (ADHD). The preventive health website, prevention.liveandworkwell.com, includes:

- A screening tool to help you decide whether to seek care.
- Articles about behavioral health conditions and how they are treated.
- A list of organizations you can contact if you want more information about a condition and its treatment.
- Contact information for self-help groups if you want to talk with others who can provide support and encouragement.
- Information on how to contact us if you have questions or concerns.

Substance Use Disorder Helpline

Optum offers a 24/7 helpline for care providers and patients to:

- Identify local medication-assisted treatment (MAT) and behavioral health care providers
- Provide targeted referrals for evidence-based care
- Educate members/families about substance use
- Find community support services
- Assign a care advocate to provide ongoing support for up to six months, when appropriate

Care providers and patients can call 855-780-5955 or use the live chat feature on liveandworkwell.com > Mind & Body > Substance Use & Addiction > Drugs.

Collaboration between Primary Physicians and Behavioral Health Clinicians

When a member receives services from more than one care provider, collaborate and coordinate effectively to help ensure care is comprehensive, safe and effective. Lack of communication may negatively affect quality patient care. For example, members with medical illnesses may also have mental health or substance use disorders. Continuity and coordination of care is important for members with severe and persistent mental health and/or substance use disorders. This is especially true when the member is prescribed medication and has:

- Coexisting medical/psychiatric symptoms
- Been hospitalized for a medical or psychiatric condition

Please talk to your patients about the benefits of sharing essential clinical information.

Psychiatric and Behavioral Therapy Consults for Medical Patients

Please contact Optum if you:

1. Want to arrange a psychiatric consultation for a member in a medical bed,
2. Are unclear whether a behavioral health consultation is needed, or
3. Want assistance with any needed behavioral health authorization.

Reach Optum by calling the phone number on the back of the member's health care ID card.

Chapter 13: Quality Management (QM) Program

The QM program helps ensure access to health care and services with a review using established quality improvement principles.

We use our QM program to:

- Identify the type of care and services given
- Use clinical guidelines and service standards to monitor and
- Review the quality and appropriateness of services given to our members
- Review the medical qualifications of participating health care professionals
- Continue to improve member health care and services
- Improve patient safety and confidentiality of member medical information
- Resolve identified quality issues

Our board of directors oversees the QM program. The Vice President of Quality and Chief Medical Officer are in charge of day-to-day QM operations.

Quality Management Committee Structure

Committee structure for Medicare and Commercial product lines may include the following:

The Medical Advisory Committee (MAC) oversees, reviews and provides recommendations on QM activities. These include:

- Clinical indicators monitoring
- Analysis of potential/actual barriers to improve clinical performance
- Medical policies
- Pharmacy updates
- Service standards

This committee suggests quality improvement activities based on a review of potential/actual barriers to improving clinical performance found in their regions. They create and implement regional components of the QM work plan.

The Regional Quality Oversight Committee (RQOC) oversees these quality improvement activities.

When there are significant concerns about quality of care, the Regional Peer Review Committee (RPRC) is a forum for physicians to investigate, talk about and take action on these cases. The RPRC can make decisions on behalf of the National Peer Review and Credentialing Policy Committee (NPRCPC).

The NPRCPC is a forum for physicians to talk about and take disciplinary action on member cases involving quality of care concerns that were unresolved through Improvement Action Plans administered by the RPRC.

The National Practitioner Sanctions Committee (NPSC) is a place for physicians to discuss and act on sanction reports about compliance with our credentialing plan and/or patient safety concerns. Sanctions related to Licensed Independent Practitioners are monitored by government agencies and authorities. These include:

- Centers for Medicare & Medicaid Services (CMS)
- Medicaid agencies
- State licensing boards
- The Office of the Inspector General within the federal Department of Health and Human Services.

Program Scope

The QM Program:

- Identifies high-volume and/or high-risk areas of care and service affecting our members.
- Develops clinical practice guidelines for preventive screening, acute and chronic care and appropriate drug usage. These are based on available national guidelines.
- Identifies clinical areas for quality improvement activities using claims and other data analyses. These include frequency and cost breakdown by member's age, sex and line of business. It also includes groupings like episode treatment groups, major medical procedure categories and diagnosis-related groups (DRGs).
- Reviews preventive care delivered using health care audit results.
- Surveys members, care providers and employers to track satisfaction and reason for voluntary care provider disenrollment.
- Measures results against physician service standards like wait times for appointments, in-office care, practice size and availability. We use information from members, Consumer Assessment of Healthcare Providers and Systems (CAHPS) member survey information and GeoAccess analysis.
- Checks to help ensure providers perform QM-related activities as our contracts require.
- Audits records to see if medical record standards and preventive care guidelines were met.

Note: This is not the only reason we audit medical records. Other audits may have different purposes and processes.

- Helps to ensure medical record documentation provides the plan for member care. This includes continuity and coordination of care with other physicians, facilities and health care professionals.
- The RPRC and NPRCPC investigates and resolves member complaints about medical care and services. The investigation may include contact with the member, physician and/or other health care professionals. It may also review medical records and your responses to potential concerns.

UnitedHealth Premium® Program (Commercial Plans)

The UnitedHealth Premium® program provides physician designations based on quality and cost-efficiency criteria. This helps members make more informed choices for their medical care.

This program includes both quality care and cost-efficient care evaluations. Quality is the primary measurement. The emphasis on quality demonstrates our commitment to evidence-based medicine as only those physicians who meet quality standards are evaluated for cost efficiency. The results of these evaluations are used to determine a designation that we publicly display. Quality is evaluated using national standardized measures. Cost efficiency is evaluated using two measures: patient total cost and patient episode cost.

Physicians receive one of these designations:

Premium Care Physician
The physician meets the UnitedHealth Premium program quality and cost-efficient care criteria.

Quality Care Physician
The physician meets the UnitedHealth Premium program quality care criteria, but does not meet the program's cost-efficient care criteria or is not evaluated for cost-efficient care.

Does not Meet Premium Care
The physician does not meet the UnitedHealth Premium program quality criteria so the physician is not eligible for the Premium designation.

Not Evaluated for Premium Care
The physician's specialty is not evaluated in the UnitedHealth Premium program, the physician does not have enough claims data for program evaluation, or the physician's program evaluation is in process.

Physicians may review these designations when referring patients to other physicians and to support their efforts to provide quality and cost-efficient care to their patients. In markets where tiered benefit plans are available, employers may choose to offer their employees a tiered benefit plan. Tiered benefit plans may lower a member's out-of-pocket costs for using Premium Care Physicians.

Some care provider directories may display quality evaluation results only. In those directories, physicians who have met the Premium program's quality care criteria may be displayed as a Quality Care Physician.

For more information regarding the UnitedHealth Premium program, including measures, measurement methodology and how we use the results, go to UnitedHealthPremium.UHC.com or call 866-270-5588.

Star Ratings for MA and Prescription Drug Plans

CMS Star Ratings provide external validation of our MA and Part D benefit plan performance and quality progress. For information on CMS Star Ratings, go to UHCprovider.com/starratings.

Member Satisfaction

A certified National Committee for Quality Assurance (NCQA) vendor conducts our annual survey of member satisfaction using the Consumer Assessment of Healthcare Providers and System (CAHPS) survey. Members rate their experience and satisfaction in multiple areas:

- The health plan
- Their health care and providers
- Access
- Referral process
- Specialty care
- Benefits
- Member service

For more information on CAHPS or other quality improvement programs, go to UHCprovider.com/reports.

Imaging Accreditation Protocol

The Imaging Accreditation Protocol promotes compliance with nationally recognized quality and safety standards.

Accreditation is required for the following Advanced Imaging Studies:

- CT scan
- Echocardiography
- MRI
- Nuclear Medicine / Cardiology
- PET scan

If you fail to obtain accreditation, your reimbursement may be affected. We may do an administrative claim reimbursement reduction for global and technical service claims.

Additional information on this protocol and the required accreditation agencies is on UHCprovider.com/join > Imaging Accreditation.

Chapter 14: Credentialing and Recredentialing

Credentialing/Profile Reporting Requirements

Credentialing Program

We credential physicians, health care professionals, and facilities who want to join our network and be listed in our Provider Directory. We recredential at least every 36 months. Our credentialing program helps us maintain and improve the quality of care and services delivered to our members. Our credentialing standards are fully compliant with and go beyond the National Committee for Quality Assurance (NCQA) and CMS requirements. We have a thorough, written credentialing program, outlined in our Credentialing Plan on **UHCprovider.com/join**. We review and revise our credentialing program at least every two years, or as NCQA, state or federal requirements change.

When we contract with a delegate to carry out credentialing activities, they must meet our standards as outlined in:

- This guide,
- The Credentialing Plan and,
- The delegation Agreement.

We use the Council for Affordable Quality Healthcare (CAQH) process for credentialing application submissions, unless state law requires differently. Care providers applying to join our network, and those scheduled for recredentialing, must use CAQH ProView. Instructions are provided on UHCprovider.com/join > **Credentialing for Care Providers**. Minnesota and western Wisconsin care providers may submit applications to the Minnesota Credentialing Collaborative (MCC) also known as ApplySmart. Log into **credentialsmart.net/mcc** to select UnitedHealthcare as a Preference, complete your application and submit to us. Washington care providers are required to complete the ProviderSource application by logging into **onehealthport.com**.

As a participating care provider, you are responsible for verifying your clinical staff have applicable licenses and other credentials.

Non-Discrimination

Credentialing and recredentialing decisions are not based on a care provider's or health care professional's:

- Race or ethnic/national identity,
- Gender,
- Age,
- Sexual orientation, or
- The types of procedures or members they specialize in.

We may however choose to include care providers in our network because they meet certain demographic, specialty, or cultural needs of our members.

Network Care Providers and Business Needs

When we decide to approve or deny an application/reapplication, we consider:

- Our current network of care providers
- Our business needs
- The care provider's professional credentials and qualifications.

UnitedHealthcare's Discretion

Our credentialing criteria, standards and requirements do not limit our discretion in any way or create rights on the part of care providers who seek to provide health care services to our members. We retain the right to approve, suspend and terminate individual care providers and sites in situations where we have delegated credentialing decision-making.

Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information. Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

Care Provider Rights Related to the Credentialing Process

Care providers applying for participation in our network have the right to:

- Review the information submitted for your application. This excludes personal or professional references or peer review protected materials.
- Correct erroneous information. We let applicants know in writing, by fax or email, if we find any information that varies substantially from the information they provided. Applicants must submit corrections, in writing, directed by the Credentialing Entity within 30 days of the notification of the discrepancy.

- Be given the status of your credentialing or recredentialing application, when you ask for it. Check the status of your application by calling the United Voice Portal at 877- 842-3210, say or enter your TIN, and then say, as prompted: Other Professional Services > Credentialing > Medical > Get Status.

Additional information on our credentialing program can be found by clicking the following links:

- **UnitedHealthcare Credentialing Plan**
- **UnitedHealthcare Credentialing Plan State and Federal Addendum**
- **Join our Network & Credentialing**
- **Credentialing FAQs**

Credentialing Committee Decision Making Process (Non-Delegated)

Determination & Notice of Approval or Denial

After it completes the review and evaluation of all of the credentialing information, the National Credentialing Committee approves or denies participation.

For initial credentialing, we notify care providers of the National Credentialing Committee's decision within 60 calendar days or as required by state law. For recredentialing, we notify care providers if the National Credentialing Committee determines they are no longer eligible to participate in our network within 60 calendar days of the decision or as required by state law. We send written notice of recredentialing approvals to care providers in Maryland, New York and Rhode Island.

Right to See Members

Approved does not mean "active." Care providers may not begin seeing our members until both they and we have signed a contract and are in our systems, or they receive the effective date of their 'Active' status. We send written notice that the contract is active.

Monitoring of Network Care Providers and Health Care Professionals

We monitor sanction activity from state licensing boards, CMS, OIG and other regulatory bodies. If we find a care provider has a sanction that results in loss of license or material restriction, we terminate them from our network.

Care Provider Office Site Quality Review

We have office site standards that you must follow, including:

- Physical accessibility, such as handicapped accessible;
- Physical appearance of the site;
- Adequacy of waiting and examining room space;
- Availability of appointments; and
- Adequacy of treatment record keeping (e.g., secure/confidential filing system).

We continually monitor member complaints relating to these standards against our established complaint threshold. If we receive a member complaint within 60 days of the threshold being met, we conduct a full-assessment site visit.

We use a standardized site visit survey form that lists office-site and medical/treatment record-keeping standards.

Based on the results of the site visit, we start corrective action to improve those office sites that do not meet standards. We conduct a follow up visit to evaluate the effectiveness of those corrections within six months. Should you fail to pass the revisit, we will continue to work with your office until the thresholds are met. We document each step of the process.

Chapter 15: Member Rights and Responsibilities

Our members have certain rights and responsibilities to help uphold the quality of care and services they receive from you. We list the rights and responsibilities in the member materials for commercial and MA benefit plans.

- You can request a copy of the Member Rights and Responsibilities by calling your Provider Advocate at 877-842-3210.
- An online version of member rights is on **UHC.com** > Featured Links > About Us > **Member Rights & Responsibilities**. These apply to all members.
- Member Rights and Responsibilities specifically for MA members can be found on **uhcmedicaresolutions.com** > Our Plans > Medicare Advantage Plans > How Do I Enroll? > What Do I Need to Know? > Medicare Advantage and Special Needs plan information and forms > Other resources and plan information > **Member Rights and Responsibilities**.
- We publish the Member Rights and Responsibilities Statement every year in the Network Bulletin. MA member information is in the March edition. Commercial member information is in the July edition. The monthly bulletins are available on **UHCprovider.com/news**.
- Members have a right to a second opinion. Members should be referred to their benefit plan for specific steps to obtain the second opinion.

Member Appeals and Grievance Complaints

Members have the right to appeal the determination of any denied services or claims by filing an appeal. Time frames for filing an appeal vary depending on applicable state or federal requirements.

We maintain a system of logging, tracking and analyzing issues received from members and care providers. We use the information to measure and improve member and care provider satisfaction. This system helps us fulfill the requirements and expectations of our members and our network care providers. In addition, it supports compliance with the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), The Joint Commission, and other accrediting and/or regulatory requirements.

We acknowledge and enter all written complaints into the complaint database. If we identify a potential quality of care issue within the complaint (using pre-established triggers), we forward the case to the Quality of Care Department to investigate. If the complaint involves an imminent and serious threat to the member's health, the case is referred to Quality Intervention Services for immediate action.

We identify and request relevant medical records and information needed to resolve quality of care investigations. We use the results to assign severity levels and data collection codes. This helps us objectively and systemically monitor, evaluate and improve the quality and safety of clinical care and quality of service provided to our members.

We track and trend care provider complaints and use the information during their recredentialing. We conduct an annual analysis of the complaint data to look for opportunities for improvement. Care provider and member complaints are important to the recredentialing process because they help us attract and retain care providers, employer groups and members.

Member's Request for Confidentiality

The state and federal government allows an individual, other than the subscriber, to request confidential treatment as it relates to:

- Referrals
- Authorizations
- Denials
- Claims payments

We require our members to submit written requests for confidential status to you. The request must include their current address, private phone number, and date and time you received it. Having a written request prevents disagreements regarding the accuracy of their personal contact information. Members are responsible for resubmitting new confidentiality forms if their information changes.

Privacy Regulations

HIPAA Privacy Regulations provide federal protection for the privacy of health care information. These regulations control the internal and external uses of health information. They also create certain individual patient rights. Information related to our privacy practices can be found on uhc.com > **Privacy**.

Advance Directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care prior to a severe illness or injury through an advance directive. Under the federal act, care providers and facilities must:

- Not discriminate against an individual based on whether or not the individual has executed an advance directive.

- Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.
- Educate its staff about its policies and procedures for advance directives.
- Provide for community education regarding advance directives.
- Give patients written information on state laws about advance treatment directives, patients' rights to accept or refuse treatment, and their own policies regarding advance directives.

We also inform members about state laws on advance directives through our member's benefit material. We encourage these discussions with our members.

Information is also available from the Robert Wood Foundation, Five Wishes. The information there meets the legal requirements for an advance directive in certain states and may be helpful to members. Five Wishes is available on **AgingWithDignity.org**.

Chapter 16: Fraud, Waste and Abuse (FWA)

The purpose of our Fraud, Waste and Abuse (FWA) program is to protect the ethical and fiscal integrity of our health care benefit plans and programs. Our program has two main functions:

- UnitedHealthcare Payment Integrity, Optum entities, and others perform our payment integrity functions to help:
  - Ensure reimbursement accuracy
  - Keep up to date on new and emerging FWA schemes
  - Discover methodologies and technologies to combat FWA
- Special Investigations Units (SIUs) perform prospective and retrospective investigations of suspected FWA committed against our benefit plans and programs.

This program is part of our Compliance Program led by our Chief Compliance Officer. Our Compliance Department works closely with internal business partners in developing, implementing and maintaining the program.

For definitions of fraud, waste, or abuse, please refer to the *Glossary* at the back of this guide.

If you identify compliance issues and/or potential FWA, report it to us immediately so we can investigate and respond appropriately. Please see the *Resources and How to Contact Us* section in Chapter 1 for contact information. UnitedHealthcare prohibits any form of retaliation against you if you make a report in good faith.

Medicare Compliance Expectations and Training

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including UnitedHealthcare, 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. As a delegate that performs administrative or health care services, 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. As of Jan. 1, 2019, FDRs are no longer required to complete the specific CMS FWA training modules or retain documentation of the training. However, UnitedHealthcare'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 UnitedHealthcare 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, 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 sub delegates who are involved in or are responsible for the administration or delivery of UnitedHealthcare MA and Part D and Medicaid benefits or services.

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
- Review the exclusion lists every month and disclose to UnitedHealthcare 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, 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; or
- 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 UnitedHealthcare. CMS updates the Preclusion List monthly and notifies MA and Part D plans of the claim-rejection date, the date upon which we reject or deny a care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from the UnitedHealthcare network. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim-rejection date.

As contracted care providers of UnitedHealthcare, you must ensure that payments for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or entities.

For more information on the Preclusion List, visit cms.gov.

Examples of Potentially Fraudulent, Wasteful, or Abusive Billing (not an inclusive list)

Back filling: Billing for part of the global fee before the claim is received for the actual global code.

Billing for services not rendered: Billing for services or supplies that were not provided to the member.

Billing for unauthorized services or equipment: Billing for ancillary, therapeutic or other services without a required physician's order.

Billing while ineligible: Billing for services after care provider's license has been revoked/restricted or after a care provider has been debarred from a government benefits program for fraud or abuse.

Double billing: Billing more than once for the same service.

Falsified documents: Submitting falsified or altered claims or supporting claims with falsified or altered medical records and/or supporting documentation.

Looping: Submitting claims for various family members when only one member is receiving services.

Misrepresentation: Misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for non-covered services.

Patient brokering: Using "brokers" who offer money to subscribers for the use of their ID cards.

Phantom billing: Billing by a "phantom" or non-existent care provider for services not rendered.

Unbundling: Billing each component of a service when one comprehensive code is available.

Up-coding: Billing at a higher level of service than was actually provided.

Waiver of copay: Choosing not to collect copayments or deductibles as part of the payment Agreement.

Prevention and Detection

We help prevent and detect potential FWA through many sources. These include:

- UnitedHealthcare Payment Integrity functions
- Optum Companies within UnitedHealth Group
- Health care providers
- Health plan members
- Federal and state regulators and task forces

- News media
- Professional anti-fraud and compliance associations
- CMS websites: sam.gov/SAM

We also monitor and audit prevention and detection by:

Prospective Detection:
- Pre-Payment Data Analytics
- Data Mining Queries
- Abnormal Billing Patterns
- Other activities to determine if we need additional prospective activities.

Retrospective Detection:
- Post-Payment Data Analytics
- Payment Error Analytics
- Industry Trend Analysis
- Care Provider Audits

Corrective Action Plans

As a part of our payment integrity responsibility we evaluate the appropriateness of paid claims. We may initiate a formal corrective action plan if a provider does not comply with our billing guidelines or performance standards. We will monitor the plan to confirm that it is in place and address any billing/performance problems.

Beneficiary Inducement Law

The Beneficiary Inducement Law is a federal health care program created in 1996 as part of HIPAA. The law makes it illegal to offer money, or services that are likely to influence a member to select a particular care provider, practitioner, or supplier. Examples include:

- Offering gifts or payments to induce members to come in for a consultation or treatment.
- Waiving copayments and deductibles

Care providers who violate this law may be fined up to $10,000 for each wrongful act. Fines may be assessed for up to three times the amount claimed. Violators may also be excluded from participating in Medicare and Medicaid programs.

Allowable Gratuities: Items or services offered to members for free must be worth less than $15 and total less than $75 per year per beneficiary. Never give cash or gift cards to members.

Reporting Potential Fraud, Waste or Abuse to UnitedHealthcare

When you report a situation you believe is fraud, waste or abuse you are doing your part to protect patients, save money for the health care system and prevent personal loss for others. **Taking action and making a report is an important first step.** After your report is made, UnitedHealthcare works to detect, correct and prevent fraud, waste and abuse in the health care system.

You can report to UnitedHealthcare online on uhc.com/fraud or by calling 844-359-7736.

Chapter 17: Provider Communication

Connect with us on social media:   

Network Bulletin and Provider News

The fastest way to communicate with you is electronically. News or updates regarding policy, product or reimbursement changes are generally posted in the Network Bulletin. The Network Bulletin alerts you to new, changed, or updated protocols, policies, programs and administrative procedures. It includes information across all UnitedHealthcare Commercial, Medicaid, and Medicare health benefit plans. The Network Bulletin and other news items are accessible on **UHCprovider.com/news**. Registration is not required.

From the same page, sign up to receive the Network Bulletin by email. Email distribution is not limited to any one person in your office. Anyone interested in receiving the Network Bulletin email can sign up. Read the Network Bulletin throughout the year to view important information on protocol and policy changes, administrative information and clinical resources.

In 2020, the Network Bulletin is available online and through email on the following dates:

Network Bulletin Edition	Publication Date
January	Jan 2
February	Feb 3
March	Mar 2
April	Apr 1
May	May 1
June	Jun 1
July	Jul 1
August	Aug 3
September	Sep 1
October	Oct 1
November	Nov 2
December	Dec 1

Medical Policy Update Bulletin

We publish monthly editions of the *Medical Policy Update Bulletin*. This online resource provides notice to our network care providers of changes to our Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, Utilization Review Guidelines and Quality of Care Guidelines. The bulletin is posted on the first calendar day of every month on UHCprovider.com/policies > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines > **Medical Policy Update Bulletins**. A supplemental reminder to the policy updates announced in the Medical Policy Update Bulletin is also included in the monthly Network Bulletin on **UHCprovider.com/news**.

Other Communications

Where required by law or your Agreement, we provide prior notification of any protocol updates in writing by mail or fax. We communicate with care providers throughout the year by mail, internet, email, and fax to help ensure you are aware of information that affects you. Physician and Facility Advocates are also available for you to talk to. Refer to the *Resources and How to Contact Us* section of this guide.

All Savers Supplement

Applicability of this Supplement

All Savers Insurance Company (ASIC), a UnitedHealthcare company, offers off-Exchange health insurance to employers. This supplement only applies to off-Exchange business. See *Health Insurance Marketplaces (Exchanges)* for more information.

You are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location. Refer to the main guide for anything not found in this supplement.

How to Contact All Savers

Group Number 908867 and 908868

Resource	Where to go	Requirements and Notes
Cardiology Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram	**Online:** UHCprovider.com/cardiology **Link:** UHCprovider.com/paan **Phone:** 866-889-8054	Request prior authorization for services as described in the *Outpatient Cardiology Notification/ Prior Authorization Protocol* section of *Chapter 6: Medical Management*
Claims Submission	**Electronic Claims Submission:** Payer ID 81400 **Paper Claims Submission:** Mail to the address listed on the back of the ID Card.	
Outpatient Injectable Chemotherapy and Related Cancer Therapies	**Online:** UHCprovider.com/priorauth > Oncology **Phone:** 888-397-8129	Policies and instructions
Pharmacy Services	**Prior Authorizations Phone:** 800-711-4555 **Benefit Information:** Call the number on the back of the ID Card.	For information on the Prescription Drug List (PDL), myallsavers.com
Prior Authorization and Notification	**Online:** UHCprovider.com/priorauth (Policies and instructions) **Link:** UHCprovider.com/paan **Phone:** 800-999-3404	Prior authorization and admission notification is required as described in *Chapter 6: Medical Management*. EDI 278A transactions are not available.
Radiology/Advanced Outpatient Imaging Procedures: CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online:** UHCprovider.com/radiology **Link:** UHCprovider.com/paan **Phone:** 866-889-8054	Request prior authorization for services as described in the *Outpatient Radiology Notification/ Prior Authorization Protocol* section of *Chapter 6: Medical Management*

Health Care ID Card

ASIC members receive health care ID cards with information that helps you to submit claims. The cards list the claims address, copayment information, and phone numbers.

Check the member's health care ID card at each visit. Copy both sides for your files. Use ASIC electronic payer ID 81400 to file claims.

A sample health care ID card and more information is in the *Health Care Identification (ID) Cards* section in Chapter 2.

Our Claims Process

Follow these steps for fast payment:

1. Notify ASIC.
2. Prepare a complete and accurate claim form.
3. For ASIC members, submit electronic claims using payer ID number 81400. Submit paper claims to the address on the member's health care ID card.

4. For contracted care providers who submit electronic claims and would like to receive electronic payments and statements, call Optum Financial Services Customer Service line at 877-620-6194 or visit Optumbank.com > Partners > Providers.

Claim Reimbursement (Adjustments)

If you think your claim was processed incorrectly, call the number on the member's health care ID card. If you find a claim where you were overpaid, send us the overpayment within 30 calendar days. If we find a claim was overpaid, payment is due within 30 calendar days.

If you disagree with our decision regarding a claim adjustment, you may appeal.

Claim Reconsideration, Appeals and Disputes

Claim reconsideration does not apply to some states based on applicable state legislation (e.g. Arizona, California, Colorado, New Jersey or Texas). For states with applicable legislation, any request for dispute will follow the state specific process.

There is a two-step process available for review of your concern. Step one is a Claim Reconsideration. If you disagree with the outcome of the Claim Reconsideration, you may request a Claim Appeal (step two).

How to Submit your Reconsideration or Appeal

If you disagree with claim payment issues, overpayment recoveries, pharmacy, medical management disputes, contractual issues or the outcome of your reconsideration review, send a letter requesting a review to:

ASIC Members:
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard Fax: 801-478-5463
Phone: 800-291-2634

If you feel the situation is urgent, request an expedited appeal by phone, fax, or writing:

Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Expedited Fax: 866-654-6323
Phone: 800-291-2634

Time frame
You must submit your claim reconsideration and/or appeal to us within 12 months (or as required by law or your Agreement), from the date of the original EOB or denial. The two-step process allows for a total of 12 months for timely submission, not 12 months for step one and 12 months for step two.

What to Submit
As the care provider of service, you submit the dispute with the following information:

- Member's name and health care ID number
- Claim number
- Specific item in dispute
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved

If you disagree with the outcome of the claim appeal, you may file for an arbitration proceeding. A description of this process is in your Agreement.

Refer to *Claim Reconsideration and Appeals Process* section in Chapter 9: Our Claims Process, for more information.

Notice to Texas Care Providers

To verify ASIC members' benefits, call the number on the back of the member's health care ID card.

ASIC use tools developed by third parties, such as MCG Care Guidelines (formerly Milliman Care Guidelines), to help manage health benefits and to assist clinicians make informed decisions.

As an affiliate of UnitedHealthcare, ASIC may also use UnitedHealthcare's medical policies as guidance. These policies are available on UHCprovider.com/policies.

Notification does not guarantee coverage or payment (unless mandated by law). We determine the member's eligibility. For benefit or coverage information, please call the phone number on the back of the member's health care ID card.

Michigan Law Regarding Diabetes

Michigan law requires us to provide coverage for some diabetic expenses. It also requires us to establish and provide a program to help prevent the onset of clinical diabetes. We have adopted the American Diabetes Association (ADA) Clinical Practice Guidelines.

The program focuses on best practices to help prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. Find the Standards of Medical Care in Diabetes and Clinical Practice Recommendations at care.diabetesjournals.org.

Subscription information for the American Diabetes Journals is available on the website above or by calling 800-232-3472, 8:30 a.m. to 8 p.m. ET, Monday through Friday. Journal articles are available without a subscription at the website listed above.

Capitation and/or Delegation Supplement

This supplement is for participating physicians, care providers, facilities and ancillary providers, and delegated accountable care organizations (ACOs) capitated for certain UnitedHealthcare products. It applies to all benefit plans for members who:

1. Have been assigned to or have chosen a care provider who receives a capitation payment from us for that member, and
2. Are covered under an applicable benefit plan under UnitedHealthcare.

This supplement controls if it conflicts with the main guide. For protocols, policies and procedures not referenced in this supplement, please refer to the main guide.

What is Capitation?

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period of time. We pay you whether or not that person seeks care. In most instances, a capitated provider is a medical group or an Independent Practice Association (IPA). Sometimes, the capitated provider is an ancillary provider or hospital.

For this supplement, we use the term "medical group/IPA" interchangeably with "capitated providers".

Also, capitated providers may be subject to the protocols, policies and procedures related to any or all delegated activities. Refer to your Delegation Grids within the Agreements to determine which delegated activities, if any, you perform on behalf of UnitedHealthcare.

What Is a Delegated ACO?

Delegation is a process that gives another entity the authority to perform specific functions on our behalf. We may delegate:

1. Medical management.
2. Credentialing.
3. Claims.
4. Complex case management.
5. Other clinical and administrative functions.

When we delegate any of these responsibilities to you, you are a delegated provider. This is also called a "delegated entity" or "delegate." We are responsible to external regulatory agencies and other entities for the performance of the delegated activities. To become a delegate, the provider/ACO must be in compliance with our established standards and best practices. To remain a delegate, the provider/ACO must comply with our standards and best practices. If the delegate is non-compliant with our standards and best practices, we may revoke any or all delegated activities.

If you are associated with a delegated medical group, IPA, or other entity, use their office policies and protocols.

This supplement is intended for use by participating physicians, health care providers, facilities and ancillary providers who are delegated for certain UnitedHealthcare activities. This supplement applies to all benefit plans for members whose:

1. Medical group, IPA, or other care provider performs any of the above functions on behalf of UnitedHealthcare, or
2. Care provider is a member of an Accountable Care Organization (ACO), where the ACO performs any of the above functions on behalf of UnitedHealthcare.

How to Contact Us

For phone numbers and websites related to specific products, please refer to *How to Contact Us* in Chapter 1 or in the appropriate supplement.

For specific product information, refer to the appropriate supplement.

Verifying Eligibility and Effective Dates

For information on ways to verify eligibility, please refer to 'Verifying Eligibility, Benefits, and Your Network Participation Status' in *Chapter 2: Provider Responsibilities and Standards*. This helps ensure you:

- Submit the claim to the correct payer.
- Collect copayments.
- Determine if a referral, prior authorization or notification is required.
- Reduce denials for non-coverage.

We can provide you with daily and/or monthly member eligibility information using an electronic file. You must coordinate initiation of electronic eligibility files with your software vendor and us. Advantages of receiving electronic eligibility are:

- Lower cost and effort required to maintain eligibility manually.

- Faster updates loaded into your system.

Refer to *ASC X12 Technical Report Type 3/ Companion Guides* for more information. Or ask your provider advocate.

Commercial Eligibility, Enrollment, Transfers, and Disenrollment

Members must meet all eligibility requirements established by the employer group and us. We may request proof of eligibility requirements.

Enrollment

To enroll, an applicant must complete a UnitedHealthcare enrollment form or an employer enrollment form approved by us. Some larger member accounts may provide open enrollment through electronic means rather than enrollment forms.

Newly eligible members may present a copy of the enrollment form as proof of eligibility. Completing an enrollment form does not ensure enrollment in a Medicare Advantage prescription drug plan. Enrollment may be denied if eligibility requirements are not met. Please see Chapter 2, section 20 of the CMS Medicare Managed Care Manual or Chapter 3, section 20 of the CMS Prescription Drug Benefit Manual for eligibility information. Make a copy of the enrollment form. If unable to verify member eligibility online or through our voice response systems, follow up with member service the next business day. The capitated medical group/IPA is responsible for making sure the contracted network of care providers accepts the enrollment form as temporary proof of eligibility.

Enrollment Periods

Each employer group typically has an annual open enrollment period where current employees elect their health insurance choices for the following benefit year. Jan. 1 is a commonly used benefit start date. However, many employers select different dates throughout the year. Benefit plan codes change throughout the year on your eligibility reports.

Effective Date

Coverage begins at 12:01 a.m. on the effective date.

Selection of PCP or Medical Group/IPA

Members enrolled in some commercial benefit plans, such as HMO or Managed Care Organization (MCO) plans, must choose a primary care provider (PCP). This process is outlined in Chapter 3: Commercial Products: *PCP Selection*.

Newborn Dependents Coverage

Coverage of the subscriber's newborn children begins at birth. The subscriber must submit an enrollment application to the employer group or UnitedHealthcare, as applicable, within 30 calendar days from the date of birth to continue coverage, unless the subscriber's benefit plan says otherwise.

If the mother is the subscriber's dependent, but not their spouse, domestic partner or common law spouse, we will not cover any services provided to the newborn grandchild beginning upon delivery unless coverage is stated in the subscriber's benefit plan.

We do not cover medical or facility services for surrogate mothers who are not our members.

California Commercial: Eligible newborns have coverage for the first 30 days, beginning on their date of birth. If the newborn is not enrolled as a dependent on the subscriber's plan, the newborn has 30 days eligibility with the subscriber's medical group/IPA following birth. However, coordination of benefits may be applied as determined by the birthday rule.

Newborn Enrollment Policy

Unless the subscriber's benefit plan dictates otherwise:

If the mother (subscriber, spouse or domestic partner) is our member, the newborn remains with the mother's medical group/IPA until another PCP or medical group/IPA is selected following the 15/30 rules.

When the father is primary for the newborn per the birthday rule, his plan covers the newborn for the first 30 days, even if the newborn is not enrolled on his plan.

If both the mother's and the father's insurance plans provide coverage for the newborn, coordination of benefit rules apply once the mother is discharged. The medical group/IPA must make sure they handle care coordination appropriately.

If both the mother and father of a dependent newborn are eligible under separate UnitedHealthcare benefit plans, we add the dependent newborn to both plans as determined by the subscribers.

Any subsequent PCP or medical group/IPA transfer of a dependent newborn will follow the 15/30 rules.

Adopted Dependents Coverage

Coverage begins on the first day of physical custody if the subscriber submits an enrollment application to the employer group within 30 calendar days of physical custody of the child, unless the subscriber's benefit plan dictates otherwise.

Surrogate (Newborn Coverage)

We may provide coverage for a surrogate when the surrogate is the subscriber or eligible dependent. Please refer to the UnitedHealthcare benefit plan. However, the newborn dependent(s) may not have coverage at birth. Surrogate cases need individual review. We make decisions on a case-by-case basis. We may issue newborn coverage denials to the facility before the newborn's birth.

Please contact your Provider Relations representative if a surrogate case comes to your attention.

CA: Under California rescission rules, if UnitedHealthcare or the member's care provider or medical group/IPA authorizes surrogate newborn care (beyond 30 days from birth), and the facility relies upon such authorization to render treatment, those claims must be paid.

We may seek recovery of our actual costs from a member receiving reimbursement for medical expenses for maternity services while acting as a surrogate.

Member Transfers

A member may select a new medical group/IPA or PCP by calling Member Service or accessing myuhc.com.

Members may change their PCP within the same medical group/IPA. The change is effective the first day of the following month after the member calls requesting the change, unless the benefit plan says otherwise.

If a member requests a transfer out of the member's medical group/IPA entirely, and the change request is received prior to or on the 15th of the month, we will change the member's medical group/IPA effective the1st day of the following month. If the request to transfer to another medical group/IPA is received after the 15th of the month, the change is effective the first day of the 2nd month following receipt of the request.

If the member expresses dissatisfaction with the proposed effective date, we, in our discretion, may process the member's request as a 'Forward Primary Care Provider Change Request', (if our contract with requested network care provider allows for a "retroactive" transfer). Based on the contract, the network care provider may have the right to refuse to accept the member until the first day of the second month following the request receipt. Some care provider groups may only accept new members during an open enrollment period. If the member meets all eligibility requirements, the change becomes effective the 1st day of the following month, even though the change request was received after the 15th of the month. If the 15th of the month falls on a weekend or holiday, we will allow transfer requests received on the first business day after the 15th to become effective the 1st day of the following month.

Transfers from one participating medical group/IPA to another, or PCP transfers initiated outside a member's open enrollment period, will not be effective until the 1st day of the month following the member's discharge from care, if at the time of the request for transfer or on the effective date of transfer, the member is currently:

- Receiving inpatient care at an acute care facility.
- Receiving inpatient care at a skilled nursing facility, at a skilled level.
- Receiving other acute institutional care.
- In the third trimester of her pregnancy (defined as when the member reaches the 27th week of pregnancy).
- Experiencing a high-risk pregnancy (not applicable to California members).

We do not recommend Commercial members change PCPs while an inpatient in a facility, skilled nursing facility (SNF), or other medical institution, or undergoing radiation therapy or chemotherapy. A change may negatively affect coordination of care.

Involuntary Transfer

If the member/care provider relationship has been seriously impaired, we begin an involuntary transfer from the current PCP/medical group/IPA to another PCP/medical group/IPA based on the following guidelines:

First Occurrence

At the first occurrence, send the member a certified/return receipt-warning letter advising them of the issue and potential consequences of dismissal.

Document the specific information, including your name, date of occurrence, and issue. The letter must tell the member that PCP/medical group/IPA is notifying us regarding the matter and offer the member the right to respond to the allegations. Send a copy of the letter to your provider advocate.

Second Occurrence

Send the member a second certified/return-receipt warning letter advising them of the continued issue and potential consequences of dismissal. Include the additional issues, care provider's name and date of occurrence. The member letter must state the PCP/medical group/IPA's recommendation for cooperation. It must also say the PCP/medical group/IPA will be requesting our intervention in initiating a medical group transfer and offer the member the right to grieve the allegations. Send a copy of the letter and full documentation to your provider advocate.

Third Occurrence

On the third occurrence, notify your provider advocate and ask to remove the member from the PCP/medical group/IPA. Include all prior documentation. We review the PCP/medical group/IPA documentation outlining the continued issues. Based on the documentation, we may reassign the member to a new PCP/medical group/IPA. If so, we contact the member and arrange for a PCP/medical group/IPA transfer or disenrollment from the plan.

If you receive notification of a member's intent to sue, please notify your provider advocate.

Retroactive Member Transfers

Members may retroactively change their medical group/IPA or PCP within the same month if the member calls to request a change within 30 calendar days:

- Of their effective date and has not received services with the originally assigned care provider; or

- Due to a household move over 30 miles, and the member has not received services with the originally assigned care provider.

If the member received services during the current month from you, other than the month requested, a current month change is not permitted.

Transfer Due to Termination of Medical Group/IPA, Facility or Care Provider

If the member's medical group/IPA, PCP, or facility is terminated, we give prior written notice to members as applicable or when required by state or federal law. In such event, the member may qualify for continuation of care as outlined in the Continuity of Care section of this supplement. For individual physician terminations, the medical group/IPA is responsible for providing the notice in the following circumstances:

- PCP terminations in medical group/IPAs where medical group/IPA assigns members to the PCPs; and
- All specialist terminations.

Each commercial member has at least 30 calendar days (exception: 60 calendar days in California) to select another medical group, IPA, PCP or facility.

Each Medicare member has at least 14 calendar days to select another medical group/IPA, PCP, or facility within the member's current medical group/IPA. The member receives a new health care ID card prior to the first of the month in which the transfer is effective.

When a member needs care, and their PCP terminated without proper notice, we transfer the member to another PCP. The new PCP will be in the same medical group/IPA with an effective date retroactive to the first of the current month.

Member Removal

The medical group/IPA agrees we may move a medically stable member to another medical group/IPA or care provider due to a strained relationship between the medical group/IPA and member.

Medicare Advantage Members

For information on PCPs removing Medicare Advantage members from rosters, refer to *Member Dismissals Initiated by a PCP (Medicare Advantage)*, in Chapter 2: Provider Responsibilities and Standards. The Primary Medical Group/IPA is responsible for directing and managing all care until the change or transfer is effective.

Commercial Members

When commercial members refuse treatment or prevent you from delivering care, the medical group/IPA may consider the care provider-member relationship as unworkable. In these cases, the medical group/IPA may believe they need to dismiss the member from their panel.

The medical group/IPA may request a member change medical groups/IPAs in these cases. We evaluate requests based on the interest of the member and accessibility of another medical group/IPA. If we approve the transfer request, we ask the member to choose another medical group/IPA within 30 calendar days. The Primary Medical Group/IPA is responsible for directing and managing all care until the change or transfer is effective.

If the member fails to select another medical group/IPA, we choose another medical group/IPA for them.

If no professionally acceptable alternatives exist, neither UnitedHealthcare nor the medical group/IPA are responsible to provide or arrange for the medical care or pay for the condition under treatment.

Areas of concern for requesting removal of a commercial member from the medical group/IPA include:

- Repeated disruptive behavior or dangerous behavior exhibited in the course of seeking/receiving care.
- Failure to pay required copayments (minimum dollar amount of $200 outstanding).
- Fraudulently applying for any UnitedHealthcare benefits.

After we receive a completed Incident Report for Removal of Members and related documentation, we respond to the member. We copy the PCP or medical group/IPA on all correspondence.

If you receive notification of a member's intent to sue, please tell your provider advocate.

Send copies of all notification letters, request for removal and supporting documentation to your provider advocate.

Criteria and Procedure for Removal of Commercial Members from the Medical Group/IPA

Level I	Level II	Level III
Criteria		
Demanding a payment from medical group/IPA for non-authorized services. Minor disruptive behavior* Failure to pay required copayments** Three or more missed appointments within six consecutive-months without 24-hour prior notice.	Refusal to follow recommended treatment or procedures by care provider resulting in deterioration of member's medical condition. Disruptive behavior, verbal threats of bodily harm toward medical group/IPA personnel and/or other members, provided the conduct is not a direct result of the member's medical condition or prescribed medication.+	Member fraudulently applies for any UnitedHealthcare benefits. Dangerous behaviors exhibited in the course of seeking or receiving care provided the conduct is not a direct result of the member's medical condition or prescribed medication. Need an eyewitness willing to formally document the incident in writing.
1st Occurrence:		
Medical group/IPA must counsel with and send the member a certified letter saying such behavior is unacceptable; Discussions need documentation. Send copies to UnitedHealthcare, which sends a warning letter outlining behavior and possible consequences.	Medical group/IPA must counsel with and send the member a certified letter saying such behavior is unacceptable; Discussions need documentation. Send copies to UnitedHealthcare, which will send warning letter outlining behavior and possible consequences.	Medical group/IPA requests immediate removal of subscriber/member from medical group/IPA. Incident must be, formally documented by medical group/IPA; Send written notification to member in a certified letter. Mail copies of documentation and member letter to UnitedHealthcare for review.
2nd Occurrence:		
Medical group/IPA must counsel with and send second letter to member expressing concern regarding their unacceptable behavior; Send copies to UnitedHealthcare, which sends warning letter outlining continued behavior and possible consequences.	Send UnitedHealthcare a request to immediately remove subscriber/member from the medical group/IPA. UnitedHealthcare reviews the medical group/IPA documentation outlining continued unacceptable behavior.	
3rd Occurrence:		
Send us a request to immediately remove a subscriber/member from the medical group/IPA. We review the medical group/IPA documentation, which outlines continued unacceptable behavior.		

* Minor disruptive behavior: unruly behavior, use of abusive and/or profane language directed toward medical group/IPA and/or other members.

** UnitedHealthcare West will not consider the removal of a member unless the unpaid copayment balance exceeds $200.00.

+ Disruptive behavior: physical or verbal threat of bodily harm toward medical group/IPA personnel and/or other members or property, and/or use of unacceptable behavior relative to drug and/or alcohol misuse.

Dangerous behavior such as; attempted physical abuse, display of weapon or damage to property, use of unacceptable behavior relative to drug and/or alcohol misuse, and/or chronic demands for unreasonable services.

Notification of Platform Transitions or Migrations

A delegated entity agrees to provide at least 120 days advance written notice to UnitedHealthcare and its contract administrator or provider advocate of its intent to:

1. Change administrative platforms for impacted delegated functions or upgrade current platform, including migrations or versions
2. Make material changes in existing administrative platforms impacting delegated functions.

If you are unsure of what a material change is, please contact your delegation oversight representative. Some changes may require pre-cutover evaluation by UnitedHealthcare delegation oversight team(s).

Medicare Advantage (MA) Enrollment, Eligibility and Transfers, and Disenrollment

For more information and instructions for confirming eligibility refer to *Verifying Eligibility and Effective Dates*.

Eligibility Lists

Upon your request, we send each medical group/IPA a monthly eligibility list of all its assigned members. This list contains the members' identification information, their enrollment date, and benefit plan information. This includes benefit plan type and effective date and any member cost-sharing.

Eligibility reports are available electronically. We send them to the capitated care provider through a file transfer protocol. You may view them on **UHCprovider.com**. We provide eligibility information once per month. We may provide it daily or weekly if needed.

Eligibility (MA)

Medicare beneficiaries who join an MA plan must:

- Be entitled to Medicare Part A and enrolled in Medicare Part B.
- Reside in our MA service area. To maintain permanent residence, the beneficiary must not continuously reside outside the applicable service area for more than six months (nine months if using the UnitedHealth Passport® benefit).
- Not have End Stage Renal Disease (ESRD). Under certain scenarios, beneficiaries with ESRD may enroll. See Chapter 2, section 20.2 in the CMS Medicare Managed Care Manual for more information.

MA plans include a Contract ID, Plan ID (the plan benefit package or PBP) and Segment ID from CMS that corresponds to CMS filings, including CMS OD universe submissions. If you need help finding a Contract ID or Plan ID email us at **odag_universe@uhc.com**.

Change of Membership Status (MA)

If a Medicare beneficiary is an inpatient at these facilities when their membership becomes effective, the previous carrier pays for Part A services (inpatient facility care) until the day after the member is discharged to a lower level of care:

- An acute facility.
- A psychiatric facility.
- A long–term care facility.
- A rehabilitation facility.

The member's assigned medical group/IPA pays for Part B services (medical care) on their membership effective date. If the member is an inpatient at a skilled nursing facility at the time of their effective date, the medical group/IPA and capitated facility is financially responsible for Part A and Part B services on the member's effective date.

If a member's coverage terminates while the member is an inpatient at any of these facilities, the medical group/IPA is no longer financially responsible for Part B (medical care) services. The capitated facility remains financially responsible for Part A (inpatient facility care) services until the day after the member's discharge to a lower level of care (e.g., home health, skilled nursing facility).

Refer to the UnitedHealthcare MA Coverage Summary titled Change of Membership Status while Hospitalized (Acute, LTC and SNF) or Receiving Home Health on UHCprovider.com/policies > Medicare Advantage Policies > **Coverage Summaries for Medicare Advantage Plans**.

Benefit Plan Changes

A benefit plan change occurs when the member:

- Moves from one service area to another. If an MA member permanently moves outside of the service area (regardless of state), or the plan receives indication that the member may have moved outside the service area, the plan will disenroll the member at:
  1. The end of the month in which they report/confirm the move
  2. The end of the month in which they move (if they report the move in advance)

  If a member fails to respond to an address confirmation request, the plan will disenroll the member at the end of the sixth month following notification of potential move from the service area. See Chapter 2, sections 50.2-50.2.1.5 in the CMS Medicare Managed Care Manual for more information.
- Changes from one benefit plan to another. If the member does not return a completed form, they remain on the existing plan. The member may only change benefit plans using their CMS-defined annual enrollment period from Oct. 15-Dec. 7, or during the open enrollment period from Jan. 1-March 31 each year.

If the member has exhausted these elections and does not qualify for a Special Election Period, they are locked in the current benefit plan for the remainder of the calendar year.

CMS requires us to treat a member whose benefit plan changes as a new member, rather than as an existing member, for the purpose of determining the new plan's effective date. Therefore, the member's enrollment to another PCP or medical group/IPA is effective the first of the month following receipt of the completed form.

Enrollment

An applicant must enroll in a UnitedHealthcare MA plan.

Enrollment Periods

Individual

CMS has specific enrollment periods during which individual plan members may enroll in a health plan, change to another health plan, change benefit plans, or return to Medicare. Details on the types of enrollment periods and the requirements of each type are outlined on **cms.hhs.gov**.

Group Retiree Plans

Enrollment periods for UnitedHealthcare Group MA members are dictated by the employer group's annual renewal date with us. Employers may establish their own enrollment dates. See Chapter 2, section 30.4.4, item 1 - SEPs for Exceptional Conditions in the CMS Medicare Managed Care Manual for more information. A group retiree annual enrollment period aligns with the employer's annual enrollment cycle.

Enrollment requests received by the end of the month are processed for eligibility on the first of the following month. Plan effective dates vary based on the election period used and applicant Medicare Part A/B eligibility dates.

Effective Date

Coverage begins at 12:01 a.m. on the effective date if the enrollment request form we received is complete.

We may process a group retiree member's enrollment into UnitedHealthcare Group MA plan with a retroactive effective date. The window allows the group retiree member to enroll with an effective date up to 90 calendar days retroactive. The effective date may never be earlier than the signature date on the enrollment request form.

We let the member know the effective date in writing in an enrollment confirmation letter.

Selection of PCP or Medical Group/IPA

For most plans, the member must select a PCP or medical group/IPA as outlined in Chapter 4: Medicare Products, *Medicare Product Overview Tables*.

Disenrollments

Member-Elected Disenrollment

If a member requests disenrollment from our benefit plan through you, refer them to Member Services. Once we process the disenrollment, we send the member a letter with the effective date. If the member submits a request for disenrollment during the month, the disenrollment is effective the first day of the following month.

Authorization Guarantee

Authorization Guarantee Procedure

Authorization Guarantee procedure limits the medical group/IPA's risk of rendering care or incurring financial risk for services provided to ineligible members where the individual's lack of eligibility is only determined after services are provided. It offers reimbursement to the medical group/IPA providing covered services to a member who:

1. We identified as eligible before the date of service through our eligibility determination and verification processes.
2. Is later determined to be ineligible for benefits on the date of service.
3. We provided an authorization to whom we confirmed as eligible prior to the date of service but later determined to have been ineligible on the date of service ("Authorization guarantee").

Authorization Guarantee Billing Procedures

Medical group/IPA provides or arranges for health care services for an eligible member through our eligibility determination and verification processes. If authorization is provided, and the individual was not a member when the health care services were provided, medical group/IPA may seek reimbursement for such services:

- The medical group/IPA must submit the following information to our care provider Dispute Team for reimbursement consideration. Their address is in the *UnitedHealthcare West Bulk Claims Rework Reference Table*. Include:
  - Cover sheet.
  - Copy of the itemized bill for services rendered.
  - A record of any payment received from any other responsible payer.
  - Amount due based on medical group/IPA's cost of care rate, less any payment received from any other responsible payer.

Authorization Guarantee Reimbursement

The medical group/IPA must follow the Authorization Guarantee billing procedures. Eligible services must be reimbursed within 45 business days of receipt of information. Reimbursement should be at the cost of care rates listed in the contract, no greater than the full uncollected balance. The medical group/IPA must reimburse the care provider.

Care Provider Responsibilities

Demographic Updates

To help ensure we have your most current directory information, submit any changes to:

For Delegated Providers: Please contact your local Network Account Manager or Provider Advocate.

For Non-Delegated Providers: Visit **UHCprovider.com > Find a Provider** for the Provider Demographic Change Submission Form and further instructions.

For delegated Medicare Advantage care providers, if you expect any significant changes to your network, notify your provider advocate prior to the third quarter of the calendar year. This helps our members select the correct care provider during the annual enrollment period from October to December. It also reduces provider directory errors.

Electronic Data Interchange (EDI)

EDI is our preferred choice for conducting business transactions with care providers and health care industry partners. We accept EDI claims submission for all our product lines. Find information and help with EDI on **UHCprovider.com/EDI**. Also see the *EDI* section of Chapter 2: Provider Responsibilities, which includes information about ASC X12 Technical Report Type 3 publications, companion guides, and a list of standardized HIPAA-compliant EDI transactions.

ASC X12 Technical Report Type 3/Companion Guides

The ASC X12 Technical Report Type 3 (TR 3 also known as HIPAA Implementation Guides) publications are the authoritative source for EDI Transactions. You may purchase the ASC X12 Technical Report Type 3 publications from Washington Publishing at **wpc-edi.com**.

We developed guides to provide transaction specific information we require for successful EDI submissions. These Companion Guides are available for viewing and download from **UHCprovider.com/edi**.

The following table includes standardized HIPAA-compliant EDI transactions available at UnitedHealthcare:

ANSI ASC X12N* Transactions	HIPAA EDI Transactions Acceptable UnitedHealthcare Versions	Available at UnitedHealthcare Transaction Descriptions
270/271	005010X279A1	Eligibility Benefits Inquiry and Response (Real Time and Batch)
276/277	005010X212	Claim Status Inquiry and Response (Real Time and Batch)
820	005010X218	Premium Payment
834	005010X220A1	Benefit Enrollment and Maintenance
835	005010X221A1	Claims Payment and Remittance Advice
837	005010X222A1	Healthcare Claim/ Encounter Professional
837	005010X223A2	Healthcare Claim/ Encounter Institutional

Changes in Capacity

The medical group/IPA shall provide us with at least 90 calendar days written notice prior to any changes to the medical group/IPA or network care providers. Include in the notice:

- Inability of medical group/IPA to properly serve more members due to lack of PCPs.
- Closing or opening the PCP's practice to more members.
- Closure of any office or facility the medical group/IPA, PCPs or other network care provider and health care professional uses.

The medical group/IPA, its care providers and other licensed independent health care professionals shall continue to accept members during the 90-day notice. For purposes of this section, a new member may be a member who has switched health plans and/or coverage plans. This includes a member who switches from a Fee-For-Service (FFS) plan to a Commercial HMO/MCO plan.

California Requirements for Capacity Reporting
We require capitated providers to give us updates within five business days if capacity changes affect your ability to accept new members. If we receive notification your information is inaccurate, you will be subject to corrective action.

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.

Non-Discrimination

You must not discriminate against any patient with regard to quality of service or accessibility of services because they are our member. You must not discriminate against any patient on the basis of:

- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Claims experience
- Medical history
- Evidence of insurability
- Disability
- Genetic information
- Source of payment
- Medicaid status for Medicare members

You must maintain policies and procedures to demonstrate you do not discriminate in the delivery of service and accept for treatment any members in need of your service.

Inclusion of Notice of Availability of Language Assistance in Non-Standard Vital Documents Issued by Delegated Care Provider Groups (CA Commercial Members Only)

The delegated care provider group must include the California Department of Managed Health Care's (DMHC) approved Notice of Availability of Language Assistance with each vital document containing member-specific information issued to UnitedHealthcare's Language Assistance Program (LAP) members. The Notice must be included in UnitedHealthcare's threshold languages (English, Spanish and Chinese). Vital documents include UM modification, delay, or denial letters issued to our members by the delegated care provider group. We review compliance with this requirement during the annual assessment of delegated medical management.

UnitedHealthcare worked with Industry Collaborative Effort (ICE) to standardize the inclusion of the required notice.

ICE instructions include two options available at iceforhealth.org:
Option 1: UnitedHealthcare of California Notice of Availability of Translative Services as a separate document

Option 2: UnitedHealthcare California-Specific Templates, Commercial Service Denial Notice (CSDN), and Commercial Delay-Extension containing LAP Notice of Translation Documents

Interpretive/Auxiliary Aide Services
Delegated care providers must have mechanisms to help ensure the provision of auxiliary aides. This includes sign language interpreters to sensory-impaired members as required to provide members with an equal opportunity to access and participate in all health care services.

If the member requests interpretive/auxillary aide services, you must arrange these services promptly to avoid a delay in care at no cost to the member.

Members have the right to a certified medical interpreter or sign language interpreter to translate health information accurately. The interpreter must respect the member's privacy and keep all information confidential. Friends and family of limited English proficiency or hearing-impaired members may arrange interpretive services only after our standard methods have been explained and offered by the care provider, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

Hospital Incentive Program (HIP) Professional Capitation

In a professional capitation Agreement, the medical group/IPA receives capitation for medical services. We pay selected facility services out of the HIP. The HIP provides an incentive for the medical group/IPA to use facility services such as inpatient activity, in-area emergency services and other selected outpatient services provided to our members efficiently. The HIP calculates overages and deficits based on an annual comparison of accumulated actual costs based on the terms of the UnitedHealthcare medical group/IPA Agreement.

This section provides general information for a professional capitation arrangement on the following:

- How are HIP results calculated?
- What services are included in the HIP?
- What information is available to assess HIP performance?

Budget (CA Only)

The Integrated Healthcare Association (IHA) P4P Value Based Incentive Program for commercial members is not a component of the capitation Agreement. It is under a separate letter of Agreement.

The budget for the Medicare Advantage Hospital Incentive Program (MAHIP) for Medicare members is based on a percent of premium, less the reinsurance premium. Aside from the budget, all other aspects of the HIP apply to the MAHIP.

Reinsurance

Reinsurance is required to protect the HIP budget and medical group/IPA against catastrophic cases.

Actual Costs

The Division of Financial Responsibility (DOFR) section of the Agreement defines the actual HIP costs. It typically includes the following:

- Inpatient costs for facility services rendered to our members by network care providers valued at the actual costs we incur.
- Other facility services given to our members by network care providers other than inpatient services, valued at actual costs we incur.
- The actual amount paid for facility services, which are rendered by non-network care providers.

- A percentage of all facility services incurred during the period but not yet processed (for the interim calculation), minus:
  - Reinsurance recoveries; and
  - Third-party recoveries received during calculation.

Monitoring Performance

We monitor the medical group/IPA performance through:

- Records of authorized services.
- Claims paid/denied reports.
- HIP financial report for the settlement period. The report details:
  - Total number of member months.
  - Total budget allocation for the member months.
  - Total expenses paid during the period.
  - A description of each amount of expense allocated to the risk arrangement by member ID number, date of service, description of service by claim codes, net payment, and date of payment.

Settlement Calculations

We perform interim settlements, the final settlement and reconciliation of the HIP.

We provide a quarterly incentive program report to the medical group/IPA within 45 calendar days of the close of each calendar quarter. The incentive program report contains the monitored information.

Split Capitation

In a split capitation Agreement, the medical group/IPA receives capitation for the provision of medical services. The facility receives capitation for facility services and selected outpatient services. The medical group/IPA and facility may create and administer their own facility incentive program under a split capitation Agreement.

Rider Contracts

A "rider contract" is a contract the medical group/IPA obtains for services covered under capitation or paid for out of the facility incentive program. The medical group/IPA must submit copies of rider contracts to us.

The most common examples of services for which rider contracts are established include specialist services, ancillary services and outpatient facility services.

Contract Criteria

The rider contract must be signed by both parties. The medical group/IPA must submit the following required information, along with an original, signed letter saying the care provider may access rates as described in the Agreement to pay claims for our members assigned to the medical group/IPA, even if the Agreement includes assignability language:

- Address.
- TIN, IRS number.
- NPI.
- Phone number.
- Name and title of contact person at care provider's office.
- Care provider specialty.

This contractual documentation needs submission:

- Cover page of the contract.
- Definition section.
- Rate pages, including any withholds, exclusions or special arrangements.
- Effective date of rates.
- Signature page (signed by both parties).
- Payment terms (e.g., due in 45 or 60 calendar days).
- Rate renewal terms (e.g., automatically or renegotiated).
- Late penalty terms.
- Claims timely filing language.

Contract Entry

We review the rider contract. Based on the contract criteria and other considerations, we determine if the rider contract qualifies for data entry into our claims payment system.

If the rider contract qualifies, we enter it into the claims payment system with an effective date beginning the first of the month following a 60-day load and review period. We will not retroactively adjust claims paid prior to receipt, data entry of the contract or the effective date used in our claims payment system.

Let us know if you terminate a rider contract or change the terms of the rider contract relative to reimbursement or claims payment turnaround time. In addition, confirm annually the rates and provisions previously submitted have not changed.

Monthly Reporting

We either post online or distribute to each medical group/IPA, a monthly-shared risk claims report. It lists the actual costs incurred and denied during the previous month for services included in the HIP. Review this report each month to make sure the claims were processed and/or paid correctly.

The following tools will help the medical group/IPA analyze the Shared Risk Claims Report:

- Claims Code Sheet.
- Place of Service Mapping — this document cross-references the CMS place of service codes to UnitedHealthcare's internal place of service codes.

Discrepancy Report

Use the Discrepancy Report to request research of the payment or denial of a claim we processed. After reviewing the Monthly Shared Risk Claims Report, complete all fields

in the Discrepancy report. Submit it electronically to our Network Care Provider Management department. If all required fields are not completed, we return the files to the medical group/IPA. The required fields include:

- Member ID number (seven-digit number).
- Member ID number suffix (two-digits) (e.g., 01, 02).
- Claim number.
- Expected care provider reimbursement.
- Care provider comments — why the medical group/IPA is disputing the payment.

Discrepancy Report Timely Filing
The medical group/IPA must submit Discrepancy Reports monthly. We do not pursue recoveries of overpayments you submit late based on your Agreement with us or by state law.

We reserve the right to deny/reject any request for review submitted beyond the timely filing limit.

Individual Stop Loss and Reinsurance Programs (Stop Loss Protection)

Individual Stop Loss (ISL)/Reinsurance (REI) limits the medical group's/IPA's/facility's financial risk for medical and facility services beyond a specified dollar amount per member, per calendar year. This program applies to services for which we capitated the medical group/IPA/facility.

The ISL program is updated annually. Each medical group/IPA/facility may take part each year.

The medical group/IPA may purchase ISL/reinsurance from us or an outside carrier.

We determine our premium for ISL based on our experience. We convert the calculated premium for stop loss to either a percentage of premium or flat per member per month (PMPM) rate based on the medical group's/IPA's Agreement. Every month, we subtract the result from the total capitation.

We reimburse a medical group/IPA that purchases ISL through us for services that exceed the ISL deductible at the ISL program rates specified in the Agreement or the ISL election letter for the applicable contract year, minus the medical group's ISL coinsurance amount.

We reimburse a facility that purchases reinsurance through us for services that exceed the reinsurance deductible at the reinsurance program rates specified in the Agreement or the reinsurance election letter for the applicable contract year, less the facility's reinsurance coinsurance. The facility must identify all reinsurance claims before submission. The facility reinsurance program is updated annually.

The medical group/IPA or facility may elect to opt out of the UnitedHealthcare ISL/reinsurance program by purchasing ISL/reinsurance coverage through a third-party insurance carrier. Such coverage must be through an entity we approve of and in the amounts required by UnitedHealthcare and state and federal law. Refer to your Agreement for details.

Notification of ISL/Reinsurance Claims
The medical group/IPA or facility provides written notification to us when services for a member equal 50% of the ISL/reinsurance deductible. The written notification submission needs to be to us no later than the 15th day of the month following the month in which the claim amounts reach the 50% threshold.

ISL/Reinsurance Claims Submission Procedure
Submit all ISL/reinsurance claims having met the ISL/reinsurance deductible to us annually but no later than 90 calendar days after the end of the calendar year.

To receive reimbursement under the ISL/reinsurance program, follow these steps:

- Submit the ISL/reinsurance claims by spreadsheet to Individual_stoploss@uhc.com. Please scan and email all hard-copy images. Include these on the submission spreadsheet:
  - Service care provider name.
  - Date of service.
  - Service description.
  - Correct RBRVS or CPT codes and description of services if required.
  - Billed charges.
  - Place of service.
  - Medical group/IPA paid amount.
  - Other insurance information.
  - Discount adjustments.
  - ICD-10-CM diagnosis codes.
  - Proof of payment (copies of cancelled checks).
- Each spreadsheet submission sheet must be for one member only. We do not accept combined submissions for a family or for more than one member.
- For capitated services rendered outside the medical group/IPA/facility, we require copies of canceled checks showing actual amounts paid. Upon request, submit copies of all referral bills and/or copies of consultation and operative reports.
- We may ask you to submit a brief member history (copy of a consultant report and/or history dictation). We do not require lab results, X-ray results or records.
- These are excluded from the calculation of ISL/reinsurance claims:
  - Member copayment amounts.
  - Non-covered services.
  - Services paid by Workers' Compensation.

- Services paid by other health plans.
- Services paid through third-party reimbursement.

Our Claims Production Unit reviews the claim for completeness and tells medical group/IPA/facility if it needs any other information. It may need supporting records for ISL/reinsurance claim verification. After review, if the claim is accepted, we make a payment within 60 calendar days. Please submit ISL/Reinsurance claims to Individual_stoploss@uhc.com.

Delegated Credentialing Program

Delegated Credentialing Requirements

This information is supplemental to the credentialing requirements outlined in *Chapter 14: Credentialing and Re-Credentialing*. Delegated entities and capitated providers are also subject to the following requirements.

We maintain standards, policies and procedures for credentialing and recredentialing of care providers and other licensed independent health care professionals, facilities and other organizational care provider facilities that provide medical services to our members. We may delegate credentialing activities to a medical group, IPA, PHO, hospital, etc. that complies with our Credentialing and Recredentialing Plan.

The delegate must maintain a written description of its credentialing program that documents the following activities, in a format that meets the Credentialing Entity's standards:

- Credentialing.
- Recredentialing.
- Assessment of network care providers and other licensed independent health care professionals.
- Sub-delegation of credentialing, as applicable.
- Review activities, including establishing and maintaining a credentialing committee.

Monitoring Sanction Activity

If a capitated provider is sanctioned, loses their license or has a material restriction, the termination date is retroactive to the first day of the month of the sanction.

Confidentiality

Delegated entities must not share credentialing and recredentialing information to anyone without the care provider's written permission or as required by law.

Initial Credentialing Process

When credentialing is delegated, applicants must use the medical group's/IPA's application form and process or as prescribed by law.

Delegation Oversight

We perform an initial assessment to measure the delegate's compliance with the established standards for delegation of credentialing. Every year after that, we assess the delegate to monitor its compliance with established standards. This includes NCQA standards and state and federal requirements. If needed, we may conduct a focused assessment review based on specific delegate activity.

Improvement Action Plans

If delegates are not compliant, we may require an improvement action plan. If compliance is not reached within a determined time frame, we continue oversight. We may revoke delegated functions if delegates remain non-compliant with our credentialing standards.

Credentialing Reporting Requirements for Delegates

In addition to complying with state and contractual requirements, we require all delegates to adhere to the following standards for notification procedures. The delegate provides prior written notice to us of the addition of any new care providers or other licensed independent health care professionals. For all new and current care providers with changes to credentialing information, please include these in your notice:

- Demographic information including name, gender, specialty and medical group/IPA address and locations.
- License.
- DEA registration.
- Education and training, including board certification status and expiration date.
- Facilities with admitting privileges, or coverage arrangements.
- Billing information — to include:
  - Legal entity name.
  - Billing address.
  - TIN.
- Product participation (e.g., Commercial, Medicare Advantage).
- Languages spoken and written by the care provider or clinical staff.

Reporting Changes

The delegate must provide to the credentialing entity current demographics for their care providers and/or changes to a status. Changes include:

- Address.
- TIN.
- Status of accepting patients: open, closed or existing patients.
- Product participation.

Report all demographic changes, open/closed status, product participation or termination to your local Network Account Manager, Provider Advocate or the My Practice Profile app on Link.

Delegate Reporting of Terminations
The delegate must notify us, in writing, of any terminations of care providers or other licensed independent health care professionals. Send notice 90 calendar days before the termination effective date. It is imperative we receive such notices on a timely basis to comply with our regulatory obligations related to the terminations of care providers and other licensed independent health care professionals.

Effective dates of termination must be the last day of the month to properly support group capitation. We do not accept mid-month terminations.

Termination notice requires:

- Reason for termination.
- Effective date of termination.
- Direction for reassignment of members (for PCP terminations, if UnitedHealthcare does assignment).
- Product participation.

When a PCP terminates affiliation with a delegate, our members have two options:

- Stay with their existing medical group/IPA and change care providers.
- Transfer to another medical group/IPA to stay with the existing care provider.

If the delegate fails to indicate the reassignment preference, we assign the member to another PCP within the same medical group/IPA, based on the medical group/IPA's direction for reassignment. We make exceptions to this policy on a case-by-case basis. Members may change their care provider as described in their benefit plan.

Negative Actions Reporting Requirements
The delegate must notify us, in writing, of any of the following actions taken by or against a PCP, specialty care provider or other licensed independent health care professional:

- Surrender, revocation, or suspension of a license or current DEA registration.
- Exclusion of care provider from any federal program (e.g., Medicare or Medicaid) for payment of medical services.
- Filing of any report regarding care provider, in the National Practitioner Data Bank, or with a state licensing or disciplinary agency.
- Change of care provider's status that results in any restriction or limitations.
- When the delegate reasonably determines serious deficiencies in the professional competence, conduct or quality of care of the network care provider that affects, or could adversely affect, the health and safety of the member.
- External sanction or corrective action levied against a provider by a government entity.

Virtual Visits (Commercial HMO Plans CA only)

UnitedHealthcare of California members can use Virtual Visits for primary care services, such as the diagnosis and treatment of low-acuity medical conditions. Virtual Visits provide communication of medical information in real time between the member and a care provider or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (e.g., home or work). When covered by a member's benefit plan, the Virtual Visit benefit has a separate defined copayment.

Commercial HMO members may access Virtual Visits from a Designated Virtual Network Care Provider. We prefer members to access Virtual Visits through their selected PCP or medical group/IPA, if available. If the member's medical group/IPA or PCP does not offer Virtual Visit services, we make a nationally contracted Virtual Visit care provider available. The network care provider groups offering Virtual Visit services must comply with the service standards.

Service Standards

Access—When the care provider group develops Virtual Visit technology, it may offer services to assigned members who have the coverage as a part of their benefit plan. We pay for Virtual Visit primary care services delivered by care providers covered under professional capitation. Not all UnitedHealthcare West benefit plans have the Virtual Visit benefit option. The care provider group must confirm member eligibility and cost-share for Virtual Visit service. This applies only if medical group/IPA develops its own virtual visit technology.

24 Hour/Seven Day Availability—Virtual Visit technology services are available 24 hours a day, seven days a week.

Staffing Credentials—All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education and/or experience based on state and federal laws.

Staff Orientation and Ongoing Training—The care provider group must take part in a written orientation plan with documented skill demonstrations. It must also have initial and ongoing training programs, including policies and procedures. The care provider group will pursue accreditation of its Virtual Visit program with the American Telemedicine Association.

Service Response Time—Within 30 minutes after a member requests a visit, the care provider group contacts the member to either schedule or hold a Virtual Visit.

Technology Security—The care provider group conducts all member Virtual Visits using interactive audio and/or video telecommunications systems on a secure technology platform that meets state and federal law requirements for security and confidentiality of electronic member information. It maintains member records in a secure medium that meets state and federal law requirements for encryption and security of electronic member information.

Professional Accreditation—The care provider group pursues applicable accreditation by the American Telemedicine Association (or other mutually agreed upon accreditation body) to become accredited within one year after the accreditation program release date.

Continuous Quality Improvement (CQI)—The care provider group must have a documented CQI program for identifying data opportunities for time-measured improvement in areas of core competencies. There must be demonstrated ties between CQI findings and staff orientation, training, and policies and procedures.

Member Complaints—The care provider group logs, by category and type, member complaints with specific improvement action plans for any patterns. There should be complaints registered on less than 2 percent of member cases.

Regulatory Assessment Results—If we ask, the care provider will allow access to any applicable regulatory audit results.

Utilization—The care provider group submits Virtual Visit encounters with proper coding as part of its existing encounter submission process.

Electronic Billing/Encounter Coding—The care provider group will submit Virtual Visit encounters or claims with proper coding as part of its existing encounter submission process.

Eligibility Verification—The care provider group uses existing eligibility validation methods to confirm Virtual Visit benefits.

Case Communication—The care provider group will support member records management for Virtual Visits using existing EMR systems and standard forms. Keep required medical information in EMR records, including referrals and authorizations.

Joint Operating Committee—The care provider meets with us up to quarterly at our request to review data reports and quality issues. We also address any administration issues.

Professional Environment — The care provider group helps ensure that, when conducting Virtual Visits with members, the rendering care provider is in a professional and private location. The care provider group (rendering care providers) may not conduct member Virtual Visits in vehicles or public locations.

Medical Director—The care provider employs or engages a licensed care provider as medical director. The medical director is responsible for clinical direction.

Virtual Visits (Medicare Advantage)

Some UnitedHealthcare Medicare Advantage (MA) plans offer virtual visits for medical and/or mental health care as a plan benefit.

Care providers deliver virtual visits outside of medical facilities using online technology. Members can access virtual visits right from their computer, tablet or smartphone.

Virtual Visits (Medical)

This additional supplemental benefit is offered through American Well (AmWell) on most MA plans offering the benefit. With this benefit, members can talk with a doctor online 24 hours a day, 7 days a week for treatment of non-critical illnesses such as cold, flu, sore throat and skin rashes. Members can ask the doctor questions, get a diagnosis and receive a prescription.

Plans in a few markets offer virtual visits through locally contracted providers. Members can connect with one of the care providers in their primary medical group using that group's telemedicine technology. Members of these plans should contact their PCP to learn how to access their virtual visits benefit.

Virtual Visits (Mental Health)

This benefit is offered through Optum Behavioral Health. With this benefit, members can talk to an OptumHealth licensed therapist or psychiatrist online for the evaluation and treatment of general mental health conditions such as depression and anxiety. Members can schedule their appointment online or call the care provider directly to schedule. Mental health virtual visits are usually held during regular business hours similar to on-site mental health visits.

Referrals & Referral Contracting

Direct Access Services

Members may receive certain services without prior authorization or referrals. Please refer to *Chapter 5: Referrals* for details about direct access services.

Access to Participating Eye Care Providers (CA and CO Only)

If the medical group/IPA is delegated for vision services, it must allow the member direct access to any eye care provider participating and available under the plan. An eye care provider is a licensed network optometrist or ophthalmologist. The medical group/IPA may require

the eye care provider to submit requests for approval of surgical vision-related procedures.

Access to Participating Chiropractor (WA Only)
If the medical group/IPA is delegated for chiropractic services, they must allow the member direct access to any participating chiropractor available under the plan. The medical group/IPA may use managed care cost and containment techniques.

PCP and Care Provider Responsibilities

We assign each member a PCP at the time of enrollment if the member does not select one. The PCP coordinates the member's overall health care, including behavioral health care, and the appropriate use of pharmaceutical medications.

The delegated medical group/IPA sets its own policies regarding care provider responsibilities.

Out-of-Network Care Provider Referrals (Commercial HMO and Medicare Advantage)

When medically necessary, the PCP refers the member to in-network care providers. If the needed care provider is not available in-network, not available within the needed time frame or too far away, the PCP needs to request an out-of-network care provider review. The delegated medical group/IPA reviews this request. If approved, the member is not responsible for costs over their applicable in-network cost-sharing.

Referral Contracts (Medicare Advantage)

We encourage the medical group/IPA to establish contracts with care providers so they may refer our members for specialty services. Each contract must have the specific parts described in this section. The medical group/IPA may establish written contracts with referral care providers. They may use existing UnitedHealthcare contracts unless they are delegated for claims processing. Delegated medical group/IPAs must negotiate their own contracts. These contracts must comply with this guide:

- No contractual arrangement between the delegate and any subcontracting care provider may violate any provision of law.
- The delegate helps ensure all provisions of its Agreement with any care provider who provides services to MA members includes all provisions required under the delegate's MA Agreement and regulatory requirements and applicable accreditation standards.
- If a care provider has opted out of the Medicare program, the delegate does not contract with them to provide services to MA members.

Establishing Contracts for Specialty Services
Any medical group/IPA delegated for claims processing must negotiate contracts with individual specialists or group practices to facilitate the availability of appropriate services to members. All contracts must be in writing and comply with state and federal law, accreditation standards and the MA Agreement.

Depending upon the delegate's contract with us, this may include contracting for services with hospitals, home health agencies and other types of facilities.

Subcontract Review (MA)
CMS requires us to check the written agreements the medical group/IPA has with its care providers. We check them at least annually. We recommend the medical group/IPA reviews their subcontracts annually. These checks help ensure compliance with federal law and CMS regulations. We require an Improvement Action Plan (IAP) for any medical group/IPA who has non-compliant contracts. The IAP lists our findings and expected time frame to reach compliance.

Referral Authorization Procedure

The delegated medical group/IPA may initiate the referral authorization process when asked to refer a member for services. Please refer to their Notification/Prior Authorization list. These capitated medical services may need a referral authorization:

- Outpatient services.
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA's facility).
- Specialty consultation/treatment.
- Facility admissions.
- Out-of-network services.

The medical group/IPA, PCP and/or other referring care provider verifies eligibility and participating care provider listings on all referral authorization requests. This helps ensure they refer a member to the appropriate network care provider. The medical group/IPA must comply with the following procedure:

- When a member requests specific care provider services, treatment or referral, the PCP or treating care provider reviews the request for medical necessity.
- If there is no medical indication for the requested treatment, the care provider discusses an alternative treatment plan with the member.
- If the member's treatment option requires referral or prior authorization, the PCP or treating care provider submits the member's request to the delegate's Utilization Management Committee or its designee for a decision. The PCP or treating care provider includes appropriate medical information and referral notes about why the requested service is medically necessary. Information should include results of previous treatment.
- If the request is not approved in whole, the medical group/IPA (or if not delegated, UnitedHealthcare) issues a denial letter to the member. It states the requested

services, treatment or referral and complies with applicable state and federal requirements.

Standing Referral/Extended Referral for Care by a Specialist

The delegated entity must have specialty care referral procedures. They need to explain standing and extended referrals for specialists and specialty care centers. The entity needs a standing referral if the member requires:

- Continued care from a specialists or specialty care center for a prolonged time.
- Extended access to a specialist for a life-threatening, degenerative or disabling condition.

There may be a limit to the number of specialist visits or time authorized. The specialist may need to provide regular reports to the PCP.

For an extended specialty referral, the PCP and specialist must determine which health care service each manages. The PCP should handle primary care and keep records of the reason, diagnosis, and treatment plan for the referral.

HIV/AIDS Extended Referrals (CA Commercial Only)
The delegated medical group/IPA must have a written process for extended referrals to HIV/AIDS specialists when the PCP and medical group/IPA medical director agree the diagnosis and/or treatment of the member's condition requires an HIV/AIDS specialist's expertise. To comply with the state laws and regulations, the delegated medical group/IPA must identify care providers within their group who qualify as HIV/AIDS specialists. If no such care providers are in the medical group/IPA, the medical group/IPA must have a way to refer members to a qualified HIV/AIDS specialist outside of the group. The qualification of an HIV/AIDS specialist are outlined in the **California Health and Safety Code 1374.16**.

Referral and/or Authorization Forms

The delegate may design its own request for referral and/or authorization forms without our approval. When the forms communicate approvals to the member, use at least 12-point Times New Roman font. If the form is not at least 12-point font, the delegate needs to send a written notification that is. For MA members, we provide an approval template letter.

At a minimum, include all the following components in the form or written notice:

- Member identification (e.g., member ID number and birth date).
- Services requested for authorization including appropriate ICD-10-CM and/or CPT codes.
- Authorized services including appropriate ICD-10-CM and/or CPT codes.
- Name, address, phone number and TIN of the care provider the member is referred to.
- Proper billing procedures, including the medical group/IPA address.
- Verification of member eligibility.

The delegate provides copies of the referral and/or authorization form to the:

- Referral care provider.
- Member.
- Member's medical record.
- Managed care administrative office.

Looking for more information about notification requirements? .
See section on *Non-discrimination Taglines for Section 1557 of the Affordable Care Act* in this supplement.

Member Requests for Services Carved Out of UnitedHealthcare (MA)

CMS regulations allow a member to make a direct request for services from either the MA plan or the entity making the determination, which is the utilization management/Medical Management delegated medical group/IPA. This applies to both standard and expedited pre-service Initial Organization Determinations (IODs). The established requirements for pre-service standard and expedited IODs apply.

Delegated medical groups/IPAs handle the timely processing of all pre-service organization determination requests, including the delegate's requests that are UnitedHealthcare's responsibility. The medical group/IPA must have explicit policies and procedures for the following:

- Starting the referral or authorization processes when a member contacts the delegate to request services, or when a care provider requests a service of the delegate that is UnitedHealthcare's responsibility. The medical group/IPA must use the date and time the member or care provider first called as the received date and time of the request to comply with required turn-around times.
- Working with UnitedHealthcare on service referrals or authorizations where a member or care provider has contacted us to request services. The medical group/IPA must use the date and time of the request to UnitedHealthcare as the received date and time of the request for compliance with turnaround times.

Looking for more information on referrals?
Additional detailed information and requirements for referrals can be found in *Chapter 5: Referrals*

Coordination of Care between Medical and Behavioral HealthCare

Capitated/delegated medical groups/IPAs providing behavioral health services must collect information about how to improve coordination of care with the behavioral

health care providers. Based on the data collected, the medical group/IPA must work with those care providers to make improvements. The medical group/IPA submits this report annually to their quality improvement or appropriate committee. The medical group/IPA must have procedures describing how it will complete this cycle. We look at the process and report during our annual review of the capitated medical group/IPA.

A capitated medical group/IPA providing and paying for behavioral health services must also review members' experiences at least annually. This includes a member survey. Based on the survey results, the medical group/IPA identifies areas for improvement and makes necessary changes. The medical group/IPA then measures the effectiveness of these changes. It submits this report to its quality improvement or appropriate committee. We look at the process and report during our yearly review.

Medical Management

The protocols in this section are unique to capitated and/or delegated medical management entities. The protocols in *Chapter 6: Medical Management* may also apply if we are financially responsible for the service.

If we are financially responsible for the service, or responsible for processing the claim, ask us if we require an authorization.

Clinical Delegation Oversight

We monitor the performance of delegated activities. We hold our delegates to the requirements outlined in the Provider Administrative Guide. We perform clinical assessments of those activities prior to the approval of delegation to make sure the potential delegate meets those requirements. Once we approve the delegate, and they are implemented, we make sure they remain compliant. We provide our delegates with information they need to meet regulatory and contractual requirements and accreditation standards.

Pre-contractual or Pre-delegation Assessments

When an entity – usually a medical group/IPA – expresses interest in contracting to perform delegated activities, we begin an assessment process to confirm the entity can perform those activities. Clinical reviewers request documented processes (e.g., programs, policies and procedures, work flows or protocols) and supporting evidence prior to an onsite visit. Supporting evidence may include materials (e.g., letter templates, scripts, brochures or website) and reports (or the demonstrated ability to produce required reports). Clinical reviewers arrange an onsite visit to further assess systems and processes, staffing and resources. We report assessment results and delegation recommendations to the Delegation Oversight Governance Committee, which decides whether to proceed with delegation and determines any contingencies for delegation.

Post-contractual or Post-delegation Clinical Assessments

We conduct another assessment within 90 calendar days after the contract or delegation effective date. Assessments are based on documented processes, materials, reports and case records or files specific to the delegated activities. Further assessments are performed at least annually, within 12 calendar months after the last annual assessment. The clinical reviewer informs the delegate of assessment results at an exit conference. We follow up with formal written notice of results and the delegation decision based on those results.

Clinical Delegation Improvement Action Plans

If a delegate does not meet an assessment criteria, we require improvement action and remediation within 30 calendar days of the written notice of deficiencies. The concerns are detailed in Improvement Action Summary and Operational Assessment Summary reports along with the delegation letter. The delegate must submit a written improvement action plan (IAP) stating how and when it will meet the requirements. The clinical reviewer follows up with the delegate at least weekly. We expect the delegate to put ongoing controls into place to measure its adherence to expectations. We periodically reassess the delegate's progress toward adherence.

If the delegate does not demonstrate adherence by the IAP completion date, we escalate the IAP to delegate leadership and within UnitedHealthcare to facilitate remediation. Continued non-adherence may result in the de-delegation process. This does not limit the contractual rights and remedies available to UnitedHealthcare.

Criteria for Determining Medical Necessity

UnitedHealthcare and medical group/IPAs delegated for utilization/medical management review nationally recognized evidence-based criteria to determine medical necessity and appropriate level of care for services whenever possible. UnitedHealthcare and delegates use several resources and guidelines to determine medical necessity and appropriate level of care.

Hierarchy of Criteria Use

When using criteria to make decisions about service requests, the delegate must use the following criteria appropriate to the benefit plan:

Commercial

1. Eligibility and benefits
2. State-specific guidelines or mandates
3. Guidelines or mandates referenced in UnitedHealthcare's medical policies
4. Evidence-based criteria such as MCG Care Guidelines and InterQual
5. Other evidence-based criteria such as Hayes or evidence-based literature

Medicare Advantage

1. Contract ID, Plan ID and Segment ID
2. CMS criteria
   a. National Coverage Determination (NCD)
   b. Local Coverage Determination (LCD) used only for the area specified
   c. Local Coverage Medical Policy Article
   d. Medicare Benefit Policy Manual
3. UnitedHealthcare or health plan criteria (i.e., Coverage Summaries, Policy Guidelines)
4. Evidence-based criteria such as MCG Care Guidelines and InterQual
5. Other evidence-based criteria such as Hayes or evidence-based literature

Community Plan (UnitedHealthcare Medicaid)

1. Eligibility and benefits
2. National or state-specific Medicaid guidelines
3. UnitedHealthcare Community Plan medical policies
4. Evidence-based criteria such as MCG Care Guidelines or InterQual
5. Other evidence-based criteria such as Hayes or evidence-based literature

With limited exceptions, we do not reimburse for services that are not medically necessary, or when you have not followed correct procedures (e.g., notification requirements, prior authorization, or verification guarantee process). Delegates may institute the same policy.

Accreditation standards require all health care organizations, health benefit plans, and medical group/IPAs delegated for utilization/medical management to distribute a statement to all members, physicians, health care providers and employees who make utilization management (UM) decisions stating:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Practitioners or other individuals are not rewarded for issuing denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and the attending physician.

If you and a member decide to go forward with the medical service once UnitedHealthcare or the delegate has denied prior authorization (and issued a denial notice to the member and physician as appropriate), neither UnitedHealthcare nor the delegate reimburse for the denied services. Medical directors are available to discuss their decisions and our criteria with you. Find medical policies and guidelines on **UHCprovider.com/policies** or from the delegated medical group/IPA as applicable.

Level of Specificity — Use of Codes

To track the specific level of care and services provided to its members, UnitedHealthcare requires you to use the most current service codes (i.e., ICD-10-CM, UB and CPT codes). We also require you to make sure the documented bill type is appropriate for the type of service provided.

Care Provider Responsibilities for Participation in Medical Management

You must participate, cooperate and comply with our Medical Management policies. You must render covered services at the most appropriate level of care, based on nationally recognized criteria.

We may delegate medical management functions to a medical group/IPA or other entity that demonstrates compliance with our standards. Care providers associated with these delegates must use the delegate's medical management office and protocols. We may retain responsibility for some medical management activities, such as inpatient admissions and outpatient surgeries. When a care provider is not associated with a delegate, or when we are responsible for the specific medical management activity, the care provider must comply with our medical management procedures.

For medical management functions retained by us, you have to confirm we have authorized a request for services before rendering services for a member. If you have not requested a prior authorization, submit the request within three business days before providing or ordering the covered service. The exception is emergency or urgent services.

To confirm prior authorization has been approved by UnitedHealthcare, use the Prior Authorization and Notification app on Link, or **UHCprovider.com/paan**. If the member is assigned to a delegated medical group/IPA, check with that medical group/IPA for confirmation.

For urgent or emergent cases, we notify you within 24 hours of services rendered, or an admission.

If you don't get prior authorization when required or tell us within the appropriate time frame, we may deny payment.

The delegated medical group/IPA sets its own policies about care provider responsibilities.

If you do not get a prior authorization, neither us (or our delegate) nor our member can be held responsible to reimburse care providers for medical services, admissions, inappropriate facility days, and/or not medically necessary services. Receiving an authorization does not affect the payment policies or determining reimbursement.

Continuity of Care

Continuity of care provides a short-term transition period so members may temporarily continue to receive services

from a non-network care provider. The time frames and conditions vary based on state regulations. In general, continuity of care is available to:

- New members with an acute episode of care while making the transition to UnitedHealthcare.
- Existing members with an acute episode of care when:
  - A network care provider terminates its Agreement with us.
  - A care provider contracted with a participating medical group/IPA terminates its Agreement. This occurs when the medical group/IPA holds the contract with its care providers.

A condition that warrants a request for continuity of care requires prompt medical attention for a short time. It is not enough that the member prefers receiving treatment from a former care provider or other non-network care provider, even for a chronic condition. A member should not continue care with a non-network care provider without formal approval by us or the delegate. Except for emergencies or urgent out-of-area (OOA) care, if the member does not receive prior authorization from us or the delegate, the member pays for services performed by a non-network care provider.

We (or the medical group/IPA delegated for continuity of care) review all requests for continuity of care on a case-by-case basis. We consider the severity of the member's condition and the potential clinical effect on the member's treatment and outcome of the condition under treatment, which may result from a change of care provider.

A member may request to continue covered services with a care provider for continuity of care when the care provider:

- Terminates from UnitedHealthcare, other than for cause or disciplinary action.
- Agrees, in writing, to be subject to the same contractual terms and conditions as network care providers. This includes credentialing, facility privileging, utilization review, peer review and quality assurance requirements.
- Agrees, in writing, to compensation rates and methods of payment similar to those we use and current local network care providers providing similar services who are not capitated.

A member must be undergoing an active course of treatment to be considered for continuity of care.

Prior Authorization Protocol

For any service that requires a prior authorization, the admitting care provider initiates an authorization request online at least three business days prior to the scheduled date of service.

- When required by the state, you must complete and submit the appropriate prior authorization request forms. We do not accept incomplete or incorrect forms, or submissions with incomplete medical records. You may find the list of forms on **UHCprovider.com/priorauth**.
- Our Medical Management team documents the information, responds to the authorization request, and provides a decision within required regulatory time frames. If approved, we issue an authorization number. If denied, we forward the reason for denial to you and the member.
- In the case of a denial, you may speak with a medical director to discuss the case.
- The authorized care provider who delivers care to the member should share documentation of the recommended treatment with the member's PCP.

The authorized care provider submits a claim with the authorization number in the usual manner to the appropriate address.

If you are a network care provider for a delegated medical group/IPA, follow the delegate's protocols. Delegates may use their own systems and forms. They must meet the same regulatory and accreditation requirements as UnitedHealthcare.

Emergency Services and/or Direct Urgent Facility Admissions

Tell us of a member's emergency admission within 24 hours of admission, or as soon as the member's condition has stabilized. The Medical Management Department receives admission notifications 24 hours a day, seven days a week at:

Online: **UHCprovider.com/paan**

Phone: 800-799-5252

Fax: Commercial: 844-831-5077
Medicare Advantage & Medicare Dual Special Needs: 844-211-2369

The delegate sets its own policies regarding notification and authorization for these services.

Service Area

The medical group/IPA/facility is financially responsible for providing all approved medical and facility services within a designated service area as well as illness or injury that arises while a member is outside of the medical group/IPA's contracted service area. The contract service area is typically defined as being within 30 miles or less from medical group/IPA site based on the shortest route using public streets and highways but can be based on other contractual terms. Refer to your Agreement for your delegated entity service area. For Medicare Advantage members, please refer to the CMS regulatory access requirements.

Urgent or emergency services provided within the medical group/IPA/facility service area are the financial risk of the capitated entity regardless of whether services are

rendered by the medical group/IPA/facility's network of care providers unless your Agreement states otherwise.

Out-of-Area (OOA) Medical Services
OOA medical services are emergency or urgently needed services that treat an unforeseen illness or injury while a member is outside of the medical group/IPA's contracted service area. These would have been the medical group/IPA's financial responsibility if they had been provided within the medical group/IPA service area.

- UnitedHealthcare is accountable for managing OOA cases unless otherwise contractually defined. Refer to the Division of Financial Responsibility (DOFR) section of your Agreement to determine risk for OOA medical services.
- Medical services provided outside of the delegated medical group/IPA defined service area that the member's medical group/IPA arranges or authorizes are the delegate's responsibility. They are not considered OOA medical services. This includes out-of-network (OON) care provider services referred by a care provider affiliated with the delegated medical group/IPA, whether or not that care provider received appropriate authorization. In such cases, the delegated medical group/IPA performs all delegated medical management activities, including issuing appropriate authorization and denials.
- Members referred by the delegated medical groups/IPA for out-of-network outpatient consultation, who are then found through their evaluation to require medically necessary inpatient care, are the referring medical group/IPA's responsibility. They do not meet the OOA criteria.
- The delegated medical group/IPA must issue appropriate denials for member-initiated non-urgent, non-emergency medical services provided outside the medical group/IPA's defined service area.
- The medical group/IPA notifies UnitedHealthcare OOA department of all known OOA cases no later than the first business day after receiving member notification of an OOA admission, procedure and/or treatment.
- Failure to notify us within this time frame may result in UnitedHealthcare holding the medical group/IPA financially responsible for the OOA care and service.
- Once a UnitedHealthcare member's PCP or medical group/IPA identified specialist speaks with the OOA attending care provider to determine the member's stability for transport to an in-area facility, member's PCP, or medical group/IPA identified specialist:
  - Determines the appropriate mode of transportation and obtains any required authorization.
  - Determines the appropriate level of care or facility for the member's care and obtains any required authorization.
  - Arranges for a bed at the accepting in-area facility.
- If the member is found stable for transfer to an in-area facility, the medical group/IPA must collaborate with the health plan to return the member to a network care provider and facility in a timely fashion.
- The medical group/IPA facilitates the return of the member to a network care provider by making sure the following process occurs in a timely fashion:
  - The medical group is responsible for transfer and care coordination planning with the OON care provider to an in-network care provider, as medically appropriate, as soon as the medical group is aware of the OOA admission.
  - If the medical group/IPA delays the transfer of a member considered medically stable for transfer to move, we may hold the medical group/IPA financially responsible for any OOA charges incurred as a result of the delay.
  - If an accident or illness occurs within the medical group/IPA contracted service area, and emergency personnel transport the member to a facility outside the contracted service area for treatment. These services are not considered OOA and are handled by the medical group/IPA in the same manner as in-area services. The medical group/IPA must authorize and direct the member's care as if the member were receiving services at the affiliated facility or care provider facility.

Travel dialysis is not considered an OOA medical service unless contractually defined. It is the medical group/IPA's responsibility.

Injectable Medication Used in a Member's Home

The delegated medical group/IPA is responsible for authorizing and arranging medically necessary services. If the DOFR assigns risk for injectable medications to a medical group/IPA, the medical group/IPA authorizes and pays for all injectable medications, whether self-injected or given with the aid of a health professional in the home.

Trauma Services

Trauma services are medically necessary, covered services rendered at a state-licensed, designated trauma facility or a facility designated to receive trauma cases. Trauma services must meet county or state trauma criteria.

The medical group/IPA reviews and authorizes trauma services using the applicable provision review criteria.

Transplant Services/Case Management

Optum serves as our transplant network. For medical groups/IPAs who have risk for transplant services, notify the Optum case management department when a member is referred for evaluation, authorized for transplant and admitted for transplant and/or may meet criteria for service denial. Medical groups/IPAs who do not have risk for transplant services must refer members into Optum

transplant case management program who have been identified as:

- Requiring evaluation for a bone marrow/stem cell, including chimeric antigen receptor T-cell (CAR-T) therapy in certain hematologic malignancies or solid organ transplant.
- Undergoing a transplant evaluation.
- Receiving a transplant.
- Receiving post-transplant care within the first year following the transplant.

You may submit referrals to Optum by:

- **Phone:** 866-300-7736
- **Fax:** 888-361-0502

The transplant case manager works with the member's transplant team, PCP, and other clinicians to assess the member's health care needs, develop, implement, and monitor a care plan. They also coordinate services and re-evaluate the member's care plan.

- Get prior authorization for transplant evaluations and transplant surgery, regardless of financial risk.
- Transplant evaluations and surgery must be performed at one of Optum Centers of Excellence or a facility approved by UnitedHealthcare/Optum medical directors.
- For medical groups/IPAs who do not have risk for transplant services, Optum handles the authorization and management for all transplant-related care and services. This includes the evaluation, transplant procedure, and one year post-transplant unless dictated by the member's benefit or federal/state law.
- Optum oversees the authorization and management of donor care and services related to transplants. This starts from the date of stem cell/bone marrow collection or 24 hours prior to organ donation surgery. It ends 60 calendar days after the transplant or as member's benefit plan or state law dictates.
- Optum manages authorization and reimbursement of all travel expenses per the member's benefit plan.
- Authorization and management of all non-transplant related (e.g., medically necessary, covered services for the member) the delegated medical group/IPA's responsibility. Non-transplant related services include those services needed to treat the member's underlying disease and maintain the member until transplant can be completed. (e.g., ventricular assist devices or mechanical circulatory support devices). Financial responsibility for non-transplant related, medically necessary covered services remain as described in the DOFR.
- Medical groups/IPAs must comply with our transplant protocols, policies and procedures. We may modify these protocols, policies and procedures from time to time.

Ventricular Assist Device (VAD)/Mechanical Circulatory Support Device (MCSD) Services/Case Management

Notify the case management department when you refer a member for evaluation for VAD/MCSD and admit a member for VAD/MCSD and/or may meet criteria for service denial.

Perform VAD/MCSD evaluations and surgery at a facility in Optum VAD Network, or a facility approved by our medical directors, to align with heart transplant service centers.

Second Opinions

Members have the right to second opinions. The delegate provides a second opinion when either the member or a qualified health care professional requests it. Qualified health care professionals must provide the member with second opinions at no cost. We also allow a third opinion.

When a member meets the following criteria, they may be authorized to receive a second opinion consultation from an appropriately qualified health care professional:

- The member questions the reasonableness or necessity of a recommended surgical procedure.
- The member questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, bodily function, or substantial impairment (including a serious chronic condition).
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt due to conflicting test results.
- The treating care provider cannot diagnose the condition.
- The member's clinical condition is not responding to the prescribed treatment within a reasonable period of time given the condition, and the member is requesting a second opinion.
- The member attempted to follow the treatment plan or consulted with the initial care provider and still has serious concerns about the diagnosis or treatment plan.

PCP Second Opinions

When the PCP is affiliated with a delegated medical group/IPA, and the member requests a second opinion based on care received from that PCP, the medical group/IPA is responsible for second opinion authorization. If delegated for claims, the medical group/IPA is responsible for claims payment.

A second opinion regarding primary care is provided by an appropriately qualified health professional of the member's choice from within the medical group/IPA group's network of care providers.

- California regulations allow E&I SignatureValue HMO members to obtain second and third opinions from out-of-network care providers. The delegate sends to UnitedHealthcare all requests for second and

third opinions from providers not participating in the delegate's network.

If the request for a second medical opinion is denied, the medical group/IPA tells the member in writing and provides the reasons for the denial. The member may appeal the denial. If the member gets a second medical opinion without prior authorization from the delegate and/or UnitedHealthcare, the member is financially responsible for the cost of the opinion.

When the PCP is not affiliated with any participating medical group/IPA but is independently contracted with us, the member may request a second opinion from a care provider or specialist listed in our care provider directory on UHCprovider.com/findprovider.

The approved care provider documents the second medical opinion in a consultation report, which they will make available to the member and the treating participating care provider. The second opinion care provider reports any recommended procedures or tests they believe are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by UnitedHealthcare, and the delegate or UnitedHealthcare (as appropriate) determines if the recommendation is medically necessary, then the delegate or UnitedHealthcare arrange the treatment, diagnostic test or service.

Note: Although a second opinion may recommend a particular treatment, diagnostic test or service, this does not mean the recommended action is medically necessary or covered. The member is responsible for paying any applicable cost- sharing amount to the care provider who gives the second medical opinion.

Specialist Care Second Opinions
The member has the right to request a second opinion consultation based on care received through an authorized referral to a specialist within the medical group/IPA network.

The second opinion may be provided by any practitioner of the member's choice from any medical group/IPA within the UnitedHealthcare network care provider of the same or equivalent specialty.

- Medicare Advantage members: second and third opinions, whenever possible, should be provided in-network. The delegate or we consider authorizing care providers outside of the delegate's network if there is no available or appropriate network care provider.
- California regulations allow Commercial HMO members to obtain second and third opinions from out-of-network care providers. The delegate sends to UnitedHealthcare all requests for second and third opinions from care providers not participating in the delegate's network.

If the health care professional is part of the member's assigned medical group/IPA, the medical group/IPA authorizes the second opinion consultation. The medical group/IPA is also responsible to pay claims if it is delegated for claims.

If approved, we pay the claim for the non-participating health care professional's second opinion consultation.

A second opinion consists of one office visit for a consultation or evaluation only. The care provider's opinion is included in a consultation report after completing the examination. The member must return to their assigned medical group/IPA for all follow-up care and authorizations.

If a second opinion consultation differs from the initial opinion, coverage for a third opinion must be provided if requested by the member or care provider, following the same process as for second opinions.

If the request for a second medical opinion is denied, the medical group/IPA tells the member in writing and provides the reasons for the denial. The member may appeal the denial.

Turnaround Time for Second or Third Opinions
We process requests for second opinions in a timely manner to support the clinical urgency of the member's condition. We follow established utilization management procedures and regulatory requirements. When a member's health is seriously threatened, we (or the delegate) make the second opinion decision within 72 hours after receipt of the request. An imminent and serious threat includes the potential loss of life, limb, or other major bodily function. It can also exist when a delay would be detrimental to the member's ability to regain maximum function.

Clinical Trials, Experimental or Investigational Services

Experimental items and medications have limited coverage. We do not delegate coverage determinations for experimental/investigational services or clinical trials.

For capitated providers, the member's care provider is responsible for these tests, unless stated differently in your contract.

We only cover experimental/investigational services when they meet Medicare requirements. Do not authorize or deny services.

Contact:

Cancer Resource Services
Phone: 866-534-7209 x 38303
Fax 855-250-2102

Transplant Resource Services:
Phone: 888-936-7246
Fax: 855-250-8157

For all other clinical trials, contact the prior authorization department at 877-842-3210 or visit UHCprovider.com/paan.

Delegates on the NICE platform may also visit UHCprovider.com to submit carve-out services on Link

as a prior authorization submission, outlining commercial clinical trials request.

Looking for more information on clinical trials?
You can find additional information and requirements in Chapter 6: Medical Management > *Clinical Trials, Experimental or Investigational Services*, and on UHCprovider.com/policies > Commercial Policies > **Medical and Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans** > Clinical Trials - or Medicare Advantage Policies > **Coverage Summaries for Medicare Advantage Plans** > Experimental Procedures and Items, Investigational Devices and Clinical Trials.

Commercial Medical Management Intensity Modulated Radiation Therapy (IMRT)

(Commercial, for Services Carved Out of Capitation)

This policy applies if UnitedHealthcare has financial responsibility (carved out of capitation) for IMRT covered under a commercial member's medical benefit.

Prior Authorization Process for IMRT
Prior authorization is required for CPT codes 77385 and 77386 and HCPCS codes G6015 and G6016.

We review the request for IMRT services for compliance with the UnitedHealthcare Commercial IMRT Program Requirements. Non-compliant services are not eligible for coverage. If the care provider medical group (medical group/IPA) fails to obtain this review and receive prior authorization from us for IMRT services before starting we deny reimbursement for the IMRT services.

Prior Authorization Necessary for Payment to be Processed
The medical group/IPA must make the request for prior authorization for Commercial IMRT services by phone or fax using a Prior Authorization form or on **UHCprovider.com/priorauth**. You can also obtain forms by contacting your provider advocate.

Prior authorization staff will not process the request or make a decision until they receive all necessary information from the medical group/IPA. They make a decision and contact the medical group/IPA within the applicable time frame.

We authorize IMRT services following the member's benefit design, provided the member has not exceeded their benefit restrictions.

Looking for more information on IMRT?
Go to:
1. **UHCprovider.com/Oncology**, or
2. UHCprovider.com/policies > **Commercial Policies** > Reimbursement Policies or Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans.

Pharmacy

Pharmacy information and requirements for commercial and MA plans are in *Chapter 7: Pharmacy*.

Medications Not Covered Under Capitation (Medicare Advantage)

We may delegate decisions to authorize specific pharmacy services based on your Agreement.

A member or care provider may request authorization from you for medication carved out of your Agreement terms. Notify the member you are not responsible for the authorization of these services. Recommend the member refer to any Part D coverage they may have.

Prior Authorization is Necessary for Payment to be Processed

The care provider medical group (medical group/IPA) must request prior authorization for select drugs. Get prior authorization forms on **UHCprovider.com/priorauth** or by contacting your provider advocate or clinical contacts at UnitedHealthcare. Our staff will not process the request until we receive all necessary information. Once we make a determination, we notify you within the correct time frame.

We make authorizations following benefit design, provided the member does not exceed benefit restrictions (applied to the requested agents/therapeutic class, and the prior authorization process).

We fax the case resolution to you. For denials, we send a letter to the member and care provider stating why we denied the requested medication. The letter outlines the process for filing standard and expedited appeals.

Prior Authorization Process for Medications Carved Out of Capitation

If UnitedHealthcare has financial responsibility for medications currently covered under the commercial member's medical benefit, this policy applies to those medications listed in your Agreement.

UnitedHealthcare uses a prior authorization process to review any medication carved out of capitation. This authorization process affects medical groups/IPA providing care to UnitedHealthcare members when UnitedHealthcare has retained financial responsibility for these medications.

We review the administration of these medications for compliance with the National Comprehensive Cancer Network's Drugs & Biologics Compendium (NCCN Compendium®) recommended uses for the drug, as it pertains to treatment regimen and/or line of therapy. Non-compliant services are not eligible for coverage or payment reimbursement by UnitedHealthcare. If the medical group/IPA does not get this review and receive prior authorization from us before administering these drugs, we deny reimbursement. This policy does not apply to bevacizumab (Avastin) used for non-oncological indications.

Prescription Drug Appeals Process

Members may initiate an appeal for coverage of a prescription drug if the initial determination is adverse to them. They may start an appeal in the following circumstances:

- The requested drug is not on the formulary.
- The drug is not considered medically necessary.
- The drug is furnished by an out-of-network care provider pharmacy.
- The drug is not a drug for which Medicare will pay under Part D.
- A coverage determination is not provided in a timely manner.
- The delay would adversely affect the health of the member.
- A request for an exception is denied.
- The member is dissatisfied with a decision regarding the copayment required for a prescription drug.

Facilities

Notification Requirements for Facility Admissions (Delegated Care Providers in Shared Risk Groups)

Contracted facilities must provide timely notification to both the delegate and UnitedHealthcare within 24 hours of admission for all inpatient and observation status cases. This includes changes in level of care that affect billing category.

For maternity cases, provide notification before the end of the mandated period (48 hours for normal vaginal delivery or 96 hours for C-section delivery). We require notification if the newborn stays longer than the mother does. In all cases, we require separate notification immediately when a newborn is admitted to the NICU.

The delegate must have a clearly defined process with the facility whereby it provides the medical group/IPA and UnitedHealthcare with the facility information on all admissions, updates in member status, and discharge dates daily.

UnitedHealthcare and the medical group/IPA require timely notification of admission so we can verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning.

For emergency admissions, provide notification once the member's condition is stabilized in the emergency department. For timely and accurate payment of facility claims, we require proper notification on the day of admission.

Authorization Log and Denial Log Submission (Delegated Care Providers in Shared Risk Groups Only)

Submit authorization logs for all inpatient acute, observation status, Skilled Nursing Facility (SNF) cases and Denial Logs at least twice a week to the Authorization Log Unit at clinicaloperations@uhc.com, by fax at 866-383-1740 or EDI transmission.

We also require specific markets to submit Outpatient Prior Authorization Logs. For new submitters, please arrange a log delivery schedule with the Authorization Log Unit prior to the first submission.

The Authorization Log Unit must agree in writing and in advance with changes to your submission schedule. Any medical group/IPA undergoing a system change or upgrade that may affect delivery of authorization logs must notify the Authorization Log Unit prior to change date and work with us to help ensure a seamless transition.

Logs must be compliant with state and federal regulations and include all concurrent IP and SNF admissions between the previous and current log submission:

- Cases generated upon admission.
- Length of stay changes/extensions.
- Discharged cases.
- Submit completed outpatient authorization cases on a separate log.
  - If there are no applicable cases to report, the medical group/IPA must submit a weekly authorization log indicating either "no activity" or "no admissions" for each of the designated admission service types for the applicable reporting time.
- Logs must include:
  - Member name
  - Member date of birth
  - Authorization/reference number
  - Requesting care provider (name, address, TIN or NPI)
  - Attending/servicing care provider (name, address, TIN or NPI)
  - Facility care provider (name, address, TIN or NPI)
  - Admitting diagnosis (ICD-10-CM or its successor code)
  - Actual admission date
  - Actual discharge date
  - Status (approved/denied)
  - Service start date
  - Service end date
  - Clearly defined level of care description (i.e., Acute IP, Mental Health, Acute Rehabilitation, LTAC, Skilled Nursing, Observation, outpatient procedures at acute

facilities, codes must be submitted with descriptions of LOC.)

- Approved length of stay (number of days)
- Denied length of stay (number of days)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Planned admission date
- Planned discharge date
- Service type
- PMG/IPA
- Insurance (Commercial/Medicare)

The medical group/IPA must have a clearly defined process for determining medical necessity and authorizing outpatient services. These services are paid as either shared risk or plan risk per the medical group/IPA contract.

The medical group/IPA must be capable of submitting, pursuant to our request, authorization or denials for all shared risk or plan risk services for which the group has authorized or denied care on behalf of UnitedHealthcare.

Post-Stabilization Care

A member is stabilized or stabilization has occurred when, in the opinion of the treating care provider, the member's medical condition is such that, within reasonable medical probability, no material deterioration of the member's condition is likely to result from, or occur during, a transfer of the member.

UnitedHealthcare and any of its delegates must:

- Have a process to respond to requests for post-stabilization care.
- Respond to requests for authorization of post-stabilization services within 30 minutes for commercial and within one hour for Medicare Advantage members.
- If UnitedHealthcare or our delegate does not respond within the required time frame, care is viewed as authorized until:
  - Member is discharged,
  - A network care provider arrives and assumes responsibility for the member's care, or
  - Treating care provider and the organization, defined as the plan or its delegate, agree to another arrangement.

Based on the contract, the delegated entity may be financially responsible for:

- ER and post-stabilization services in area.
- OOA services.

Post-Stabilization Care (MA)

CMS defines post-stabilization care as services:

- Related to an emergency medical condition,
- Provided after a member is stabilized, and
- Provided to maintain the stabilized condition, or under certain circumstances to improve or resolve the member's condition.

UnitedHealthcare or its delegates must:

- Have a process to respond to requests for post-stabilization care, and
- Respond to requests for authorization of post-stabilization services within one hour.

Medical Observation

Typically, observation status rules out a diagnosis or medical condition that responds quickly to care. Facility observation status is generally designed to assess a member's medical condition to determine the need for inpatient admission, or to stabilize a member's condition. UnitedHealthcare or our delegate will authorize facility observation status when medically indicated and the case meets nationally recognized evidenced based guidelines. A member's outpatient observation status may later be changed to an inpatient admission if medically necessary and if appropriate criteria have been met.

We expect our medical management delegates to support compliance with the review of criteria. The delegated medical group/IPA must issue a facility denial when the inpatient stay does not meet nationally recognized evidence-based guideline. This happens when:

1. It receives notification of the admission.
2. It receives a post-service request for admission authorization prior to claims submission. It determines the admission does not meet medical necessity criteria, including relevant Medicare inpatient admission requirements and is not on the CMS list of HCPCS codes that would be paid only as inpatient procedures.
3. There is no inpatient order matching the date of the inpatient admission for Medicare members.

Facility Denial Process

When we delegate services for authorization and concurrent review, we expect the delegate to issue a facility denial letter to the contracted facility when the facility's medical record or claim fails to support the LOC or services rendered. This may be determined through concurrent or retrospective review.

There are three types of facility denial letters:

- Delay in inpatient services.
- Delay in change of LOC within the same facility.
- Delay in facility discharge.

The delegated medical group/IPA must comply with our protocols, policies and procedures for denials. This includes turnaround times for issuing, delivering and submitting facility denial letters to UnitedHealthcare.

When UnitedHealthcare is responsible for paying facility services, the delegated medical group/IPA must comply with UnitedHealthcare's protocols, policies and procedures for submitting facility denial letters to UnitedHealthcare. Whether a denial is issued by UnitedHealthcare or its delegate, the UnitedHealthcare Provider Dispute Resolution process manages any facility disputes.

If the delegated medical group/IPA is responsible for paying inpatient facility services, then the delegate need not submit copies of facility denials to UnitedHealthcare. Facility denials are not sent to the member and must specifically exclude the member from liability for the denied LOC and/or services. Under these circumstances, the delegated medical group/IPA's care provider dispute resolution process manages any care provider facility disputes.

Delegate must provide a copy of the facility denial letter to the member, if requested.

Therapeutic Radiation Services

(For Services Carved Out of Capitation)

This policy applies if UnitedHealthcare has financial responsibility for the following outpatient MA services. Prior authorization is required for:

- Intensity Modulated Radiation Therapy (IMRT).
- Radiosurgery (SRS).
- Body Radiation Therapy (SBRT).

We use National Coverage Decision (NCD), Local Coverage Decision (LCD) and UnitedHealthcare medical policies and guidelines to determine eligibility of coverage. We require authorization before the start of therapy and each time a member starts a new IMRT, STS or SBRT treatment regimen.

Prior Authorization Required to Process Payment

Initiate a prior authorization request for outpatient therapeutic radiation services (IMRT, STS, and SBRT) carved out of capitation on **UHCprovider.com/paan**. We do not process the request or make a determination until we have received all necessary information. Then we make a decision within the applicable time frame.

For Medicare Advantage plans, the time frame to review and render a decision begins upon receipt of the initial request.

We authorize therapeutic radiation services based on the member's benefit design provided the member does not exceed their benefit restrictions.

UnitedHealthcare may, at its sole discretion, use a nationally contracted vendor for utilization management to administer the prior authorization program for all Therapeutic Radiation Services. The nationally contracted vendor uses the NCDs, LCDs and the UnitedHealthcare MA Coverage Summaries for managing the program.

We fax the case resolution to the medical group/IPA for each case serviced. Denials require a letter sent to both member and care provider stating why we denied the requested service. The letter outlines the process for filing standard and expedited appeals.

For a list of CPT and HCPCS codes requiring authorization, please refer to UHCprovider.com/Oncology > **Medicare Advantage Therapeutic Radiation**

Denials, Delays or Adverse Determinations

Delegates that receive requests for services must make decisions and provide notification within applicable regulatory and accreditation time frames. We hold the delegate to the most stringent requirements for approvals, extensions of decision turnaround times, denials, delays, partial approvals and modification of requested services.

Find additional information in Chapter 6: Medical Management, *Medical Management Denials/ Adverse Determinations*.

Qualifications of Who Can Deny or Make Adverse Determinations

Only physicians or appropriately licensed clinical personnel can deny or make adverse determinations based on medical necessity. This physician reviewer may be a physician, doctoral level clinical psychologist or pharmacist as appropriate to the requested service.

The physician reviewer must have a current unrestricted license. Delegates must provide evidence of verification according to credentialing requirements.

For MA, the delegate must verify the physician reviewer has experience showing knowledge of Medicare coverage criteria. Evidence of verification may include content of curriculum vitae, training as part of onboarding process, training after onboarding, or interaction between our medical director and the delegate's physician reviewers. Evidence may also include review of denial records or files indicating appropriate use of criteria applicable to the request for services and member's condition.

Oral or Verbal Notification

We have various requirements for oral or verbal notification of approvals or denials. This may vary from state to state or by request type (such as pre-service, expedited or concurrent). The delegate must document efforts to provide oral notification and meet written notification requirements as well.

Written Denial Notice

The written denial is an important part of the member's chart and the delegate's records. Regardless of the form used, the denial letter documents member and care provider notification of:

- The denial, delay, partial approval or modification of requested services.

- The reason for the decision, including medical necessity, benefits limitation or benefit exclusion.
- Member-specific information about how the member did not meet criteria.
- Appeal rights.
- An alternative treatment plan, if applicable.
- Benefit exhaustion or planned discharge date, if applicable.

CMS requires the use of the **CMS Integrated Denial Notice** (IDN) for Medicare Advantage and Medicaid plan members. Do not alter this template except to add text to the requested areas.

Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare provides appropriate and approved templates to the delegates.

Minimum Content of Written or Electronic Notification
A notice to deny, delay or modify a health care services authorization request must include:

- The requested services.
- A reference to the benefit plan provisions to support the decision.
- The reason for denial, delay, modification, or partial approval, including:
  - Clear, understandable explanation of the decision.
  - Name and description of the criteria or guidelines used.
  - How those criteria were applied to the member's condition.
- A statement the member can get a free copy with the benefit provision, guideline, protocol or other criterion used to make the denial decision.
- Contractual rationale for benefit denials.
- Alternative treatments offered, if applicable.
- A description of additional information needed to complete that request and why it is necessary (for delay of decision).
- Appeal and grievance processes, including:
  - When, how and where to submit a standard or expedited appeal.
  - The member's right to appoint a representative to file the appeal.
  - The right to submit written comments, documents or other additional relevant information.
  - The right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable.
- The name and phone number of the health care professional responsible for the decision included in the care provider's notice. This is not required in the member's notification.
- Any state-mandated language (commercial)
- ERISA information as applicable (commercial)
- Ombudsman information (commercial)

Find address and contact information for medical management appeals in the *Resources and How to Contact Us* table in *Chapter 1: Introduction*, or similar tables in the applicable supplement.

CMS Reasonable Outreach

For information regarding reasonable outreach, refer to **CMS.gov**.

Delegation of Complex Case Management and Disease Management

We may delegate the functions of complex case management (CCM) or disease management. Requirements are based on NCQA accreditation standards.

If these functions are delegated to a medical group/IPA or other organization, we conduct pre-contractual and post-contractual assessments. If assessments identify deficiencies, we require delegates to undergo improvement action. The oversight process mirrors the delegation oversight process for medical management.

Non-Discrimination Taglines for Section 1557 of the Affordable Care Act

The U.S. Department of Health and Human Services published final non-discrimination rules from Section 1557 of the Affordable Care Act. The final rule clarifies and codifies existing nondiscrimination requirements and sets standards for including non-discrimination notices on significant communications sent to health plan members. This includes member-facing letters (e.g., IDN, NOMNC, service denials), documents, notices, newsletters, and brochures sent to the member.

We provide our delegates with our required taglines: a short form and a long form. The delegate must attach the short form to communications one to two pages in length and the long form to communications three or more pages in length. The tagline does not have to be added into the body of the communication. It may be included as a separate sheet in the mailing envelope. Only a single tagline sheet must be included in every mailing, even if the envelope contains multiple communications.

Claims Processes

Delegated or Capitated Claims Process

We may delegate claims processing to entities that have requested delegation and have shown through a pre-

delegation assessment they are capable of processing claims compliant with applicable state and/or federal regulatory requirements, and health plan requirements for claim processing.

Delegated entities must develop and maintain claims operational and processing procedures that allow for accurate and timely claim payments. Procedures must properly apply benefit coverage, eligibility requirements, appropriate reimbursement methodology, etc. and meet all applicable state and/or federal regulatory requirements, and health plan requirements for claim processing.

Complete Claims Requirements

Submit a clean claim by providing the required data elements, along with any attachments and additional elements. Also include any revisions to data elements, of which you properly notified, and any coordination of benefits or non-duplication of benefits information if applicable. Please refer to *Requirements for Complete Claims and Encounter Data Submission* in Chapter 9: Our Claims Process, for further details.

Medical Claim Review (Delegated Medical Group/IPAs)

A delegated medical group/IPA must implement and maintain a post-service/retrospective review process consistent with UnitedHealthcare processes.

We define a post-service/retrospective/medical claim review as the review of medical care treatments, medical documentation and billing after the service has been provided.

We perform a medical claim review to provide fair and consistent means to review medical claims and confirm delegates meet the following criteria:

- Medical necessity determinations.
- Admission, length of stay and LOC are appropriate.
- Eligibility was verified.
- Follow-up for utilization, quality and risk issues was needed and initiated.
- Billing is correct.
- Claims-related issues as they relate to medical necessity and UnitedHealthcare claims payment criteria and/or guidelines are identified and resolved.

We also perform medical claim reviews on claims that do not easily allow for additional focused or ad-hoc reviews, such as:

- High-dollar claims.
- Claims without required authorization.
- Claims for unlisted procedures.
- Trauma claims.
- Implants not identified on our Implant guidelines used by our claim department.
- Claim check or modifier edits based on our claim payment software.
- Foreign claims.
- Claims with level of service (LOS) or LOC mismatch.

The delegated medical group/IPA is accountable for conducting the post-service review of emergency department claims and unauthorized claims. Review presenting symptoms, as well as the discharge diagnosis, for emergency services.

Consideration of emergency department claims must include:

- Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
- Coverage of emergency services if an authorized representative, acting for the organization, has authorized the provision of emergency service.
- Appropriate care provider review of presenting symptoms, as well as the discharge diagnosis.

Medical group/IPA monitors appeals and overturn rates for emergency department claims. They develop and execute improvement action plans when they identify deficient performance or processes.

Compliance Assessments

We have policies and procedures designed to monitor the delegated entities' compliance with state and federal claims processing requirements. Our auditors perform claims processing compliance assessments. We review delegated entities at least annually. Our auditors also review for:

- Assessment results indicate non-compliance.
- Self-reported timeliness reports indicate non-compliance for two to three months.
- Non-compliance with reporting requirements.
- Lack of resources or staff turnover.
- Overall performance warrants a review (claims appeal activity, claims denial letters or member and care provider claims-related complaints).
- Allegations of fraudulent activities or misrepresentations.
- Information systems changes or conversion.
- New management company or change of processing entity.
- Established Management Service Organization (MSO) acquires new business.
- Significant increase in members or volume of claims.
- Significant increase in claims-related complaints.
- Regulatory agency request.
- Significant issues concerning financial stability.

As part of our compliance assessment, we request copies of the delegated entity's universal claims listing for all care providers. The auditor reviews the reports and selects random claims for further review. The delegated entity must be ready for the auditor at the time of assessment. We review:

- Timeliness assessment.
- Financial accuracy (including proper benefit application, appropriate administration of member cost-share accumulation).
- Administrative accuracy.
- Customer Denial Accuracy and Denial Letter Review.
- Care Provider Denial Assessment.
- Non-Contracted Care Provider Payment Dispute Resolution (Overturns and Upholds) Claims Assessment.
- Fraud, Waste and Abuse Inspection.
- Maximum Out-of-Pocket (MOOP) Administration.
- Timely forwarding of misdirected claims.

Non-Compliant Assessments

When we find a delegated entity is not compliant with state and/or federal regulations, and/or UnitedHealthcare standards for claims processing, they must provide a remediation plan describing how the deficiencies will be corrected. The remediation plan should include a time frame the deficiencies will be corrected. Delegated entities who do not correct deficiencies may be subject to additional oversight, remediation enforcement and potential de-delegation.

If the delegated entity is non-compliant, we require them to develop an Improvement Action Plan (IAP) to correct any deficiency. Problems include, but are not limited to:

- Processing timeliness issues.
- Failure to pay interest or penalties.
- Failure to submit Monthly/Quarterly Self-reported Processing Timeliness reports.
- Canceling assessments.
- Failure to submit requested claims listings.
- Failure to have all documentation ready for a scheduled assessment.
- Failure to provide access to canceled checks or bank statements.

When we put a delegated entity on an IAP, we place them on a cure period. A cure period is the time frame we give a delegated entity to demonstrate compliance or remain in the cure period until they achieve compliance. The cure period is based on the Agreement but typically up to 60 days. A critical deficiency requires cure within 30 days. We conduct frequent reviews during the cure period. We may place delegated entities who do not achieve compliance within the established cure period on remediation enforcement. Remediation enforcement may consist of conducting an on-site operational assessment, stringent weekly and monthly oversight and monitoring, onsite claims management, revocation of delegated status, and/or enrollment freeze. We bill the delegated entity for all remediation enforcement activities.

Claim Denial Letters

When a delegated entity receives a claim for a commercial or MA member, they must assess the claim for the following before issuing a denial letter:

- Member's eligibility status with UnitedHealthcare on the date of service.
- Responsible party for processing the claim (forward to proper payer).
- Contract status of the care provider of service or referring care provider.
- Presence of sufficient medical information to make a medical necessity determination.
- Covered benefits.
- Authorization for routine or in-area urgent services.
- Maximum benefit limitation for limited benefits.
- Prior to denial for insufficient information, the medical group/IPA/capitated facility must document their attempts to get information needed to make a determination.

Member Denials

When a member is financially responsible for a denied service, UnitedHealthcare or the delegated entity (whichever typically holds the risk) must provide the member with written notification of the denial decision based on federal and/or state regulatory standards.

For Medicare Advantage members, the delegated entity must use the most current CMS approved Notice of Denial of Payment letter template to accurately document and issue a claim denial letter, with appeal rights, to a member. Send the denial letter within the appropriate regulatory time frames.

For Commercial members, if the member is enrolled in a benefit plan subject to ERISA, a member's claim denial letter must clearly state the reason for the denial and provide proper appeal rights. The denial letter must be issued to the member within 30 calendar days of claim receipt. For non-ERISA members, issue the appropriate denial letter within 45 working days.

The delegated entity remains responsible to issue appropriate denials for member-initiated, non-urgent/ emergent medical services outside their defined service area.

Care Provider Denials

When the member is not financially responsible for the denied service, the member does not need to be notified of the denial. You must receive notification of the denial and their financial responsibility (i.e., writing the charges off for the claims payment).

UnitedHealthcare or the delegated entity's claims department (whichever holds the risk) is responsible for providing the notification.

The denial notice (letter, EOP, or PRA) issued to any non-contracted care provider of service must state:

1. Their appeal rights.
2. The member is not to be balance billed.

When the member has no financial responsibility for the denied service, the denial notice issued to any contracted care provider of service must clearly state the member is not billed for the denied or adjusted charges. In addition, the contracted care provider notifies the member of their right to dispute the decision or discuss it with a care provider reviewer.

Time Limits for Filing Claims

Submit clean claims per the time frame listed in your Agreement or per applicable laws. We, or our capitated provider, allow at least 90 days for participating care providers and 180 days for non-participating care providers from the date of service to submit claims. If we, or our capitated provider, are not the primary payer, we give you at least 90 days from the day of payment, contest, denial or notice from the primary payer to submit the claim.

If a network care provider fails to submit a clean claim within the outlined time frames, we reserve the right to deny payment for such claim. You cannot bill a member for claims denied for untimely filing. We have established internal claims processing procedures for timely claims payment to our care providers.

Timely Filing

The claims "timely filing limit" is the calendar day period between the claims last date of service or payment/denial by the primary payer, and the date by which UnitedHealthcare, or its delegate, receives the claim.

Determination of the date of UnitedHealthcare's or its delegate's receipt of a claim, the date of receipt shall be regarded as the calendar day when a claim, by physical or electronic means, is first delivered to UnitedHealthcare's specified claims payment office, post office box, designated claims processor or to UnitedHealthcare's capitated care provider for that claim. We use the following date stamps to determine date of receipt:

- UnitedHealthcare HMO Claims department date stamp primary payer claim payment/denial date as shown on the Explanation of Payment (EOP).
- Delegated care provider date stamp.
- Third-party administrator date stamp.
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender.

Medicare Advantage claims must use the oldest received date on the claim. Refer to the official CMS website for additional rules and instructions on timely filing limitations.

For Commercial claims, refer to the applicable official state-specific website for additional rules and instructions on timely filing limitations.

Date Stamp

Delegated entities must have a clearly identifiable date stamp for all paper claims they receive. Electronic claims date stamps must follow federal and/or state standards.

Date of Receipt and Date of Service

"Date of receipt" means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to UnitedHealthcare's capitated provider for that claim.

"Date of Service," for the purposes of evaluating claims submission and payment requirements, means:

- For outpatient services and all emergency services and care: the date the provider delivered separately billable health care services to the member.
- For inpatient services: the date the member was discharged from the inpatient facility. However, UnitedHealthcare or the capitated provider must accept separately billable claims for inpatient services at least bi-weekly.

Misdirected Claims

We identify, batch and forward misdirected claims to the appropriate delegated entity following state and/or federal regulations. We send the care provider of service, or their billing administrator, a notice that we forwarded the member's claim to the appropriate delegated entity for processing.

We forward misdirected claims to the proper payer following state and federal regulations. If care providers send claims to a delegated entity, and we are responsible for adjudicating the claim, the delegated entity must forward the claim to us within 10 working days of the receipt of the claim.

The delegated entity must identify and track all claims received in error. Tracking must include, but is not limited to, the following relevant information:

1. The name of the entity of where the claim was sent.
2. The received date of the claim by the delegate, and the date mailed (date of forwarding the misdirected claim).

The delegated entity must then forward the claims to the appropriate payer and follow state and/or federal regulatory time frames.

When the claim is adjudicated, the delegated entity must notify the care provider of service who the correct payer is, if known, using the Explanation of Payment (EOP) they give to the care provider.

For UnitedHealthcare West membership ONLY: If you, the delegated entity, received a claim directly from the billing provider, and you believe that claim is the health plan's responsibility, please forward it to your respective UHC Regional Mail Office PO Box, which is found on the back of the member's ID card. NOTE: For Medicare Advantage member claims only, please include the timestamp of your original receipt date on the claim submission.

If you, the delegated entity, believe a claim we forwarded to you is the health plan's financial responsibility, please return the claim with the appropriate Misdirected Claims cover sheet and provide a detailed explanation why you believe these claims are the health plan's responsibility.

You can download the cover sheet at **uhcprovider.com/claims**. Please send all required information, including the claim and Misdirected Claims cover sheet, to:

P.O. Box 30984

Salt Lake City, UT 84130-0984.

Out-of-Area (OOA) Urgent or Emergent Claims
In most contractual arrangements, UnitedHealthcare has financial responsibility for urgent or emergent out-of-area medical and facility services provided to our members. We follow laws and regulations regarding payment of claims related to access to medical care in urgent or emergent situations. If we determine the claims are not emergent or urgent, we forward the claims to the capitated/delegated care provider for further review. Medical services provided outside the medical group/IPA's defined service area and authorized by the member's medical group/IPA are the medical group/IPA's responsibility and are not considered OOA medical services.

Payment Methodology

Delegated entities must ensure appropriate reimbursement methodologies are in place for non-contracted and contracted care provider claims.

For payment of non-contracted network care provider services, the letter, EOP, or PRA issued must notify them of their dispute rights if they disagree with the payment amount. You may not bill members for the difference of the billed amount and the Medicare allowed amount. MA contracted care provider claims must be processed following contract rates and within state and federal regulatory requirements.

Interest Payment

Delegated entities must automatically pay applicable interest on claims based on state and/or federal requirements.

Maximum Out-Of-Pocket (MOOP)

Delegated entities must have a method of tracking individual member out-of-pocket expenses in their claim processing system. In addition, member cost-share may not be applied once a member has met their out-of-pocket maximum. This helps ensure members pay their appropriate cost-sharing amount. Additional information can be found on page 129.

ERISA Claims Processing

For claims falling under the Department of Labor's ERISA regulations, you must deny within 30 calendar days. You must issue denials within 30 calendar days of receipt of the complete claim. You must issue payments within 45 working days or within state regulation, whichever is more stringent. The legislation does not differentiate between clean or unclean, or between participating and non-participating claims. Interest must be automatically paid on all uncontested claims not paid within 45 working days after receipt of the claim. Interest accrues at the rate established by state regulatory requirements, per annum, beginning with the first calendar day after the 45 working day period. It must be included with the initial payment. If interest is not included, there is an additional penalty paid to the care provider in addition to the interest payment.

Submission of Claims for Medical Group/IPA Reimbursement

Insured Services
Insured services are those service types defined in the Agreement to qualify for medical group/IPA reimbursement, assuming the qualifications of certain designated criteria. The medical group/IPA pays the claim and submits it to UnitedHealthcare for reimbursement. Examples of an insured service could include eligibility guarantee, AIDS, or preexisting pregnancy.

Indemnified Services
UnitedHealthcare may retain financial risk for services (or service categories) that cannot be submitted through the regular claims process due to operational limitations. These limitations include ambiguous coding and/or system limitations which may cause the claim to become misdirected. Misdirected claims are a risk to both organizations in terms of meeting regulatory compliance and inflating administrative costs.

Claims for insured or indemnified services qualify for payment to the capitated entity as defined in the medical group/IPA or facility Agreement. Should you have additional questions surrounding this process, please speak with your provider advocate.

Medicare Advantage Claim Processing

MA contracted care provider claims must be processed based on agreed-upon contract rates and within applicable federal regulatory requirements. Claims are adjudicated within 60 calendar days of oldest receipt date of the claim.

Medicare Advantage non-contracted care provider claims are reimbursed based on the current established locality-specific Medicare Physician Fee Schedule, DRG, APC, and other applicable pricing published in the Federal Register. Non-contracted, clean claims are adjudicated within 30 calendar days of oldest receipt date. Non-clean claims are adjudicated within 60 calendar days of oldest receipt date.

Medicare Advantage Interest Payment Requirements

CMS requires an interest payment on clean claims submitted by non-contracted care providers if the claim is not paid within 30 calendar days. Find information on this requirement on CMS.gov.

Claims Disputes and Appeals

Contracted Care Provider Disputes

Contracted care providers who have a claim dispute with a delegated medical group/IPA must make sure they have followed all guidelines set forth by the medical group/IPA.

Overpayment Reimbursement for a Medical Group/IPA/Facility (CA Only)

A request for reimbursement for any overpayment of a claim completed in compliance with state and/or federal regulations must:

- Provide a clear, accurate, written explanation.
- Be issued within 365 calendar days from the last date of payment for the claim.
- Commercial claims—Give the care provider 30 working days to send written notice contesting the request for reimbursement for overpayment.

Medicare Advantage Non-Contracted Provider Disputes

Non-Contracted Care Provider Disputes — CMS Non-Contracted Care Provider Payment Dispute Resolution Process (applicable to non-contracted MA paid claims)

A non-contracted care provider can use the CMS non-contracted care provider Payment Dispute Resolution (PDR) process for any decision where they contend the amount paid by the organization (i.e., the delegated entity) for a covered service is less than the amount which would have been paid under Original Medicare. This PDR process also includes disagreements between a non-contracted care provider and the delegate about the delegate's decision to pay for a different service than that billed (i.e., bundling issues, rate of payment, DRG payment dispute). The care provider must submit a payment dispute within 120 calendar days from the date of the original claim determination. At a minimum, the delegate must have the following requirements and processes in place when handling claim payment disputes with an MA non-contracted care provider:

- Well-defined internal payment dispute process that includes:
  - A system for receiving PDRs.
  - Proper identification of payment disputes. Care providers must clearly state what they are disputing and why, supply relevant information that will help support their position, including description of the issue, copy of submitted claim, supporting evidence to demonstrate what Original Medicare would have allowed for the same service, etc.
  - A system for tracking disputes.
  - Monitoring their PDR claims inventory.
- A requirement to communicate the time frame of 120 calendar days from the original claim determination to submit a payment dispute to the non-contracted care provider at time of claim payment.
- Information on how to submit an internal claim payment dispute to the organization communicated to the non-contracted care provider at time of claim payment, including their mailing address for submitting disputes and other dispute information (e.g., email addresses, phone numbers).
- Requirements to process and respond (i.e., to finalize the PDR claim) to the non-contracted care provider within 30 calendar days from the date the PDR claim is received (oldest received date of the PDR claim).
- Help ensure correct calculation of interest payments on overturned PDRs. Interest payment is required on a reprocessed non-contracted care provider clean claim if the group made an error on the original determination. Interest is only applied on the additional amount paid only if the original claim was clean, and calculated from the oldest receive date of the original claim until the check mail date of the additional amount paid.
- Provide a complete and clear rationale to the non-contracted care provider for upheld PDRs.
- Help ensure the care provider Remittance Advice (PRA) or Explanation of Payment (EOP), and Uphold PDR Determination Letter has the right information and meets requirements.
- Include information on how to contact the organization in notices of upheld or overturned payment disputes if the non-contracted care provider has questions.
- Include information in the notices of upheld or overturned payment disputes on how to contact the organization if the non-contracted care provider has questions.
- If the root-cause of overturned PDRs is system-related, have a process in place to update their claims system so future claims will reimburse appropriately.
- Have a process in place that identifies trends that contract year for any non-contracted care provider who

submitted a payment dispute to help ensure they are paid correctly.

- Have an ongoing training program in place for any piece of the internal claim PDR process that educates all areas of the organization, such as customer service, claims, appeals.
- Monitor internal compliance to help ensure CMS requirements are met.
- Follow an end-to-end quality review process. It should start when a dispute is received from the non-contracted care provider until the dispute decision is sent to the non-contracted care provider.

Excluded From the Payment Dispute Resolution

The following are examples of issues excluded from the PDR process:

- Instances in which a member filed an appeal, and you filed a dispute regarding the same issue. In these cases, the member's appeal takes precedence. You can submit a care provider dispute after the member appeal decision is made. If you are appealing on behalf of the member, the appeal processes as a member appeal.
- An Independent Medical Review initiated by a member through the member appeal process.
- Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply good cause for the delay.
- Any delegated claim issues not reviewed through the delegated payer's claim resolution mechanism.
- Any request for a dispute, which involves reviews by the delegated medical group/IPA/payer or capitated facility/care provider and does not involve an issue of medical necessity or medical management.

Delegated Claims Reporting

All States: Use the most updated Medicare Advantage and Commercial Monthly Timeliness Report (MTR) you received from the Claims Delegation Oversight Department.

1. MTR forms, both monthly and quarterly reports, are due by the 15th of each month or the following business day if the due date falls on a weekend or holiday.
2. MA CMS Universe Reports (Claims, DMRs and Dismissals) are due on the 10th of each month or the following business day if the due date falls on a weekend or holiday.
3. PDR quarterly reports are due:
   - First Quarter: April 30
   - Second Quarter: July 31
   - Third Quarter: Oct. 31
   - Fourth Quarter: Jan. 31

If the due date for the PDR falls on a weekend or holiday, provide the following business day.

Delegated entities must complete an Action Improvement Plan (IAP) and submit it to the health plan for submitting untimely reports containing inaccurate or incomplete information.

All delegated entities must upload their MA CMS Universe Reports (Claims, DMRs and Dismissals) and MTR forms to the **ECG Connect Portal**.

Upload monthly MTR forms to the ECG Connect Portal by the 15th of each month. Upload MA CMS Universes to the ECG Connect Portal by the 10th of each month.

CA: Based on state regulatory requirements, UnitedHealthcare shall verify on a quarterly basis that our delegated entities have the administrative and financial capacity to meet contractual obligations through routine reviews of financial indicators and monitoring financial solvency deficiencies. UnitedHealthcare requires delegated entities to provide copies of quarterly financial statements, including a balance sheet, income statement and statement of cash flow. Prepare these based on generally accepted accounting principles within 45 calendar days of the end of each calendar quarter.

Submit copies of assessed annual financial statements together with copies of all auditors' letters to management in connection with such reviewed annual financial statements submissions within 150 calendar days of the end of each fiscal year. If these financial statement submissions have deficiencies in financial solvency grading criteria defined by state regulations, submit a self-initiated Improvement Action Plan (IAP) proposal in an electronic format (template may be found on the **Iceforhealth.org** website) to UnitedHealthcare within 45 calendar days of the end of the reporting period for which the deficiency was reported. In addition, submit quarterly progress reports to UnitedHealthcare within 45 calendar days of the end of each subsequent reporting period until compliance with all financial grading criteria achievement.

Email financial statements and IAPs to UnitedHealthcare at **financialstatementsubmission@uhc.com**.

Both UnitedHealthcare and the delegated entity must provide compliance oversight of the delegated entity's financial reporting IAP.

Other UnitedHealthcare West Delegated States (AZ/CO/NV/OK/TX): The delegated entities in these states must submit the Monthly Self-Reported Timeliness Reports within 15 calendar days following the month being reported.

CA Commercial NPI

The California Department of Managed Health Care (DMHC) Timely Access to Non-Emergency Health Care Services Regulation applies to California Commercial HMO membership only. The regulation establishes time-elapsed standards or guidelines to make sure members

have timely and appropriate access to needed health care services, including a 24/7 telephonic triage or screening requirement. Health plans must comply with certain provisions of the regulation and provide an annual report detailing the status of the plan's network care provider and enrollment, which includes the care provider's NPI. To comply with this regulation, UnitedHealthcare requires all California Commercial HMO care providers to include their NPI with all care provider additions or when submitting a claim.

Claims Research and Resolution (CR&R) (Commercial in OK & TX Only)

The CR&R process applies:

- If you do not agree with the payment decision after the initial processing of the claim; and
- Regardless of whether the payer was UnitedHealthcare, the delegated Medical Group/IPA or other delegated payer, or the capitated facility/care provider, you are responsible for submitting your claims to the appropriate entity that holds financial responsibility to process each claim.

UnitedHealthcare will research the issue to identify who holds financial risk for the services. We will abide by federal and state legislation on appropriate timelines for resolution. We work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, direct all care provider-driven claim payment disputes to the delegated payer care provider Dispute Resolution process.

For UnitedHealthcare West Claims Disputes
Additional information, requirements, and mailing addresses regarding claims disputes for UnitedHealthcare West members can be found in the *UnitedHealthcare West Supplement*, *UnitedHealthcare West Bulk Claims Rework Reference Table*.

PDR Requirements for Delegated Commercial Claims (CA Only)

A delegated entity that is contractually delegated to process claims or approve referrals for service must have a fair, fast and cost-effective dispute resolution mechanism. This process must help manage contracted and non-contracted care provider disputes based on state and federal regulations.

If the dispute request is for services payable by the delegated entity, we determine if the appropriate payer has reviewed the request for dispute. If the appropriate payer has not reviewed the dispute request, we forward the dispute request to the appropriate payer. We notify the care provider of service of the forwarding dispute request to the delegated entity for processing.

The delegated entity must submit all required information to us and the appropriate state agency based on state and federal regulations. All delegated claims processing entities are required to report PDR processing compliance results quarterly based on state and federal regulations. Submit quarterly reports no later than the 30th day following the end of the quarter.

We regularly conduct a compliance assessment of the PDR Process of each delegated entity. We review care providers at least annually.

As part of the compliance assessment, we request copies of Delegated Entity Provider Dispute report. The auditor reviews the reports and randomly selects finalized disputes for review. The auditor also requires a copy of the delegated entity's PDR Policy and Procedures and evidence of the availability of the PDR mechanism. If the capitated medical group/IPA or capitated facility is non-compliant with UnitedHealthcare state or federal requirements, the delegated entities must develop an IAP designed to bring them back into compliance.

We sanction care providers who do not achieve compliance within the established time frames until they reach compliance. PDR processing is a delegated function subject to revocation. Sanctions may consist of additional/enhanced reviewing, onsite claims/PDR management, and/or revocation. There may be costs to the delegated entity depending on the sanction put in place.

If you continue to have a commercial claims dispute with the delegated entity related to medical necessity and utilization management, forward all claim information and correspondence between the delegated entity and you to UnitedHealthcare for review. We do not begin the review until we receive the supporting documentation.

Commercial care provider claims must be processed based on agreed-upon contract rates or member benefit plan and within state and federal requirements.

Note: Date stamps from other health plans or insurance companies are not valid received dates for timely filing determination.

Commercial interest rates and time frames for processing may vary, depending on the applicable state requirements. In some states, an additional penalty for late claims payments may also apply and be paid by the delegated medical group/IPA/facility.

Contractual and Financial Responsibilities

Compliance with CMS

As an MA plan, UnitedHealthcare and its network care providers agree to meet all laws and regulations applicable to recipients of federal funds. The medical group/IPA and capitated facility acknowledge they must comply with certain laws applicable to entities and individuals receiving federal funds.

Changes During Inpatient Admissions

An inpatient admission includes:

- Inpatient acute care.
- Skilled Nursing Facility (SNF).
- Detoxification.
- Medical rehabilitation.
- All related services.

Partial Risk to Shared Risk

If a member's assigned care provider is partial risk at the time of admission and then changes to shared risk prior to the member's discharge, all claims related to this confinement from admission through discharge are processed according to the partial risk DOFR in effect at the time of the admission.

Shared Risk to Partial Risk

If a member's assigned care provider is shared risk at the time of admission and then changes to partial risk prior to the member's discharge, all claims related to this confinement from admission through discharge processed according to the shared risk DOFR will be in effect at the time of the admission.

Collection of Fees

When a member needs one of the following forms for reasons other than medical reasons, you may collect a fee, in addition to the office visit copayment, for completion of these forms (unless the member's benefit plan or applicable law dictates otherwise):

- DMV forms.
- Camp or school forms.
- Employment or insurance forms.
- Adoption form.

You cannot collect an additional fee, copayment, or surcharge for:

- Completion of Prior Authorization form for non-formulary drugs.
- Completion of disability forms.
- Missed appointments/no shows or late cancellations.
- Times when a member cannot pay office visit copayment at the time of visit for basic health care services. The medical group/IPA may reschedule the member's appointment. If the member requires urgently needed care or emergency care, the medical group/IPA must render care.

You can collect copayments when professional services are rendered by a:

- Licensed medical doctor or doctor of osteopath as defined by the state.
- Care provider's assistant.
- Nurse practitioner.

Do not collect copayments when there is no actual office visit. For example:

- Injections administered by a nurse or medical assistant.
- Routine immunizations administered by a nurse or medical assistant.

Member Out-of-Pocket/Deductible Maximum

We are required to monitor and track each member's annual individual out-of-pocket/deductible maximum amount. The member's annual individual out-of-pocket/deductible maximum accumulation calculated through member's cost-share data collected from all or some of the following sources:

- Medical group/IPA/capitated hospital encounters.
- Prescription related encounters.
- Behavioral Health-related encounters.
- Claims processed by UnitedHealthcare or its delegates.

UnitedHealthcare and its capitated care providers share responsibility to monitor the member's individual out-of-pocket/deductible maximum. For additional information on reporting available from UnitedHealthcare, see *Chapter 10: Compensation* of this guide. When a member meets their annual individual out-of-pocket/deductible maximum, UnitedHealthcare tells the member's capitated care provider in writing. Capitated care providers are responsible for updating their claims systems within two business days of receiving the notification. They must help ensure members are not charged for copayments or coinsurance/deductibles once the annual maximum out-of-pocket expense is met.

If the member exceeds their annual individual out-of-pocket/deductible maximum due to the capitated care provider collecting member cost-share amounts after the member has met their annual individual out-of-pocket/deductible maximum, the capitated care provider must:

- Re-process the member claims to adjust the cost-share amounts and confirm transactions with UnitedHealthcare within seven days.
- Submit the corrected encounter data to UnitedHealthcare within 30 days.
- Refund the member any cost-share amounts collected in excess of the member's annual individual out-of-pocket and deductible maximums.
- Verify the member received all appropriate reimbursements.

UnitedHealthcare monitors the capitated care provider's compliance with this policy to help ensure all requests for claims reprocessing and member reimbursement are completed timely.

If necessary, we work with the capitated care provider to help ensure each member is reimbursed for any amounts collected in excess of the member's annual individual out-of-pocket/deductible maximum amounts as specified in the member's benefit plan.

If the capitated care provider fails to reimburse a member for amounts collected in excess of the member's annual individual out-of-pocket/deductible maximum, we may reimburse the member directly and recover the payment by capitation deduction as specified in your Agreement.

Member Cost-Share

- Cost-share information comes from different sources derived through claims and encounter data submissions.
- Cost-share totals are gathered from these sources.
- Delegated entities can view cost-share information on **UHCprovider.com**.
- Delegated entities can contact **oop@uhc.com** for any member out-of-pocket inquiries.
- The following reports are available to view the member's Cost-Share accumulation:
  - EL915 M: Shows additional cost-share fields such as total copay or deductible and maximum reached dates.
  - EL917: Daily Member Cost-Share report shows the cost-share for all members assigned to a care provider who reached their maximum out-of-pocket. Available in both CSV and data formats.
  - EL918: Daily Member Cost-Share report shows the cost-share information for all active members assigned to a care provider. Available in both CSV and data formats.
  - IVR: Interactive Voice Response - a technology that enables a computer to respond to voice and DTMF tones input using a keypad.
  - 5010 version of the 270/271 — refer to the EDI companion guide.
- Delegated entities are responsible for updating their systems within two business days of receiving the notification from UnitedHealthcare that a member met their maximum out-of-pocket costs. This helps ensure members not charged for copayments, coinsurance and deductibles once the annual maximum is met.
- We conduct assessments to help ensure appropriate administration of member cost-share accumulation.

Delegated entities must work with UnitedHealthcare to address member issues related to out-of-pocket balances. This includes:

- Responding to a UnitedHealthcare request for data on care services provided to a member:
  - Within two business days on escalated issues.
  - Within five business days on standard issues.
- For claims identified by UnitedHealthcare to be re-processed by the delegated entity:
  - Within seven days, adjusting cost-share amounts, reprocessing the claims and confirming transactions with UnitedHealthcare.
  - Within 30 days, submitting the corrected encounter data.

Annual Copayment/Deductible Maximum

Refer to *Chapter 10: Compensation* for information related to annual copayments, deductibles, and out-of-pocket maximums.

Financial Risk Disputes between UnitedHealthcare and the Delegated Entity

To help ensure timely processing of service provider claims, delegated entities are responsible for working with UnitedHealthcare to address financial risk dispute issues. This includes:

- When UnitedHealthcare requests data from the delegated entity on claim processing status and/or clarification on claim financial risk determinations, you must respond within:
  - Two business days on escalated issues.
  - Five business days on standard issues.
- When UnitedHealthcare identifies claims to be re-processed by the delegated entity to resolve service provider or member issues:
  - Reprocess the claims and confirm transactions with UnitedHealthcare within seven business days.
  - Submit the corrected encounter data within 30 days.

Encounter Data Requirements

Professional and institutional encounter data consist of an itemization of medical group/IPA/capitated facility, capitated and sub-capitated services provided to our commercial or Medicare Advantage members.

We encourage you to submit your encounter data weekly. We welcome your encounter submissions more frequently. Frequent encounter submissions allows us to support various state and federal regulatory requirements for reporting.

Send Encounter data using current ASC X12 format to Payer ID 95958 or check with your clearinghouse.

We continuously monitor encounter data submissions for quality and quantity. Submission levels below the monthly threshold of 100% are non-compliant. The capitated medical group/IPA or other submitting entity must correct any encounter errors identified by a clearinghouse or trading partner at least weekly. As you are processing claims on our behalf, we expect all encounter submissions

to accurately reflect the original claim received without exception. Delegates are required to send replacement or void encounters for both Commercial and Medicare Advantage lines of business, if applicable. Delegates send a replacement encounter when information on the original logged encounter at UnitedHealthcare was not previously sent or needs to be corrected. A void submission is required to eliminate a previously submitted logged encounter at UnitedHealthcare. Delegates should not send replacements and voids when the original encounter is rejected by a clearinghouse.

For examples of when a replacement or void encounter should be submitted and the required details on submitting them within the 837P and 837I ASC X12 EDI format, please refer to section 6.1 of the Electronic Claim Submission Guidelines in the UnitedHealthcare Companion Guides or contact **encountercollection@uhc.com**. All encounter data submitted to UnitedHealthcare are subject to state and/or federal audit. We have the right to perform routine medical record chart assessments on any or all of the medical group's/IPA's network care providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data ICD-10- CM and CPT coding. We notify the medical group/IPA in writing of audit results for coding accuracy.

The delegate may be subject to financial consequences if it or another submitting entity fails to submit or meet encounter data element requirements. In addition, the delegate may be required to perform a complete medical record chart review of its network care providers with notice from UnitedHealthcare.

Commercial Encounter Data Requirements

The capitated medical group/IPA, or other submitting entity, must certify the completeness and truthfulness of its encounter data submissions as required by the state regulatory agency. The medical group/IPA, or other submitting entity, must submit all professional and institutional encounter data for UnitedHealthcare members to:

- Comply with the Affordable Care Act for Essential Health Benefits (EHB) and NCQA-HEDIS® reporting requirements.
- Provide the medical group/IPA, or other submitting entity, with comparative data.
- Facilitate settlement calculations if applicable, and oversight of utilization management and quality management.
- Report member out-of-pocket maximums.

We require capitated medical group/IPAs and capitated facilities to submit timely and compliant encounter data. Include the member cost-share amount on the encounter data submissions based on the member's benefit plan, not the amount the member paid at the time of service. The encounter should clearly distinguish between copayment, coinsurance and deductible amounts within the Claim Adjustment Segments (CAS) segment of Loop 2430, as indicated on the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned commercial members.

The Affordable Care Act dictates reporting requirements. To comply with those requirements, we require all contracted care providers to submit all diagnosis and procedure codes to the highest level of specificity relevant to the encounter data submission.

If you have other questions, email the Encounter Data Collection Team at **encountercollection@uhc.com**.

Medicare Advantage (MA) Encounter Data Requirements

CMS reimburses all MA plans based on the member's health status. They use the diagnosis codes from the MA claims and/or encounter data (inpatient, outpatient and care provider) to establish each member's health status or Hierarchical Condition Category (HCC). CMS uses the HCC to help calculate Medicare reimbursement payments for each member.

As a result, we are required to send all adjudicated claims and capitated encounter data for MA members to CMS. These claims and encounters must pass all the edits CMS applies to its fee-for-service HIPAA 5010 837 and CMS-1500 and UB-04 submissions.

To reduce rejected claims, delegates must process MA claims and encounters in the same manner as their Medicare fee-for-service bills. Delegates are subject to the specific claims submission and other requirements stated in this guide.

If the claim data does not pass the CMS edits, which our systems mirror, we let you know. You will need to resubmit the claim or encounter to us. CMS may at any time audit our submission. The medical record must support the diagnoses you submit. Only the care provider can change or submit new CMS- 1500 or UB-04 data, so your cooperation is required for us to submit the correct data.

We require the medical group/IPA/capitated facility or other submitting entity to submit all professional and institutional claims and/or encounter data for MA members to:

- Comply with regulatory requirements of the CMS Balanced Budget Act (BBA), and NCQA-HEDIS reporting requirements.
- Submit to us for risk adjustment reporting and accurate Medicare reimbursement so we can submit to CMS.
- Provide the submitting entity with comparative data.
- Facilitate utilization management oversight, quality management oversight and settlement calculation, if applicable.

- Support Services 75 FR 19709 -Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B.

To comply with the CMS regulation 75 FR 19709 to report member cost-sharing as well as out-of-pocket maximums, we require contracted care providers to submit current, complete and accurate encounter data. This includes member cost-sharing/revenue, within the CAS segment of the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned MA members. Send encounter data using current ASC X12 format to Payer ID 95958 or check with your clearinghouse.

Per CMS regulation requirements, an EOB for Part C benefits must report total costs incurred by the health plans (us) for capitated and/or delegated provider services.

Medicare Advantage Organizations (MAOs) are required to report the total costs incurred for capitated and/or delegated provider services. MAOs must populate dollar amounts for capitated and/or delegated providers in the "Total cost" and "Plan's share" columns in the Monthly or Quarterly Summary EOB. The "Total cost" field on the member EOB includes what the member pays and what the health plan pays.

Medicare Managed Care Service Organizations (MSOs), capitated medical groups, facilities, and ancillary care providers must submit the payer amount paid at the claim level, the Service Line Paid Amount, and the member cost-sharing for all professional and institutional Medicare encounter data. The payer amount paid submitted in the encounter should not be a zero unless the claim was denied.

We also refer to the payer amount paid as the contracted rate, Medicare Fee Schedule Rate, or Calculated Capitation Rate less any applicable member responsibility.

For more information on CMS EOB requirements, refer to CMS.gov > **Medicare** > Health Plans.

We continuously monitor encounter data submissions for quality and quantity. Submission levels below the monthly threshold of 100% are non-compliant. The capitated medical group/IPA or other submitting entity must correct any encounter errors identified by a clearinghouse or trading partner weekly. As you are processing claims on our behalf, we expect all encounter submissions to be an accurate reflection of the original claim received, including provider billing information, along with all adjudication details.

All encounter data submitted to UnitedHealthcare are subject to state and/or federal assessment. We have the right to perform routine medical record chart assessments on any or all of the medical group's/IPA's network care providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data, ICD-10-CM and CPT coding. We notify the medical group/IPA in writing of audit results for coding accuracy.

The delegate may be subject to financial consequences if it or another submitting entity fails to submit or meet encounter data element requirements. In addition, the delegate may need to perform a complete medical record chart review of its network care providers with notice from UnitedHealthcare.

For further details on UnitedHealthcare encounter data submission requirements, please refer to the UnitedHealthcare Companion Guides at **UHCprovider.com/edi** > EDI Companion Guides.

Capitation Reports and Payments

Capitation Reports

UnitedHealthcare runs capitation reports by process month for both commercial and MA products. Typically, each month's capitation report and payment reflects all current activity and retroactivity up to the standard six-month system window. The Agreement may define a non-standard eligibility window for less than the standard six-month system window. This non-standard eligibility window will override the standard six-month system window. For MA plans, the non-standard eligibility retro window will not limit the retroactivity related to premium increases/decreases from CMS.

Capitation reports and first-of-the-month eligibility reports run from the same snapshot of membership data. The actual date of this snapshot varies but typically occurs on or around the 15th calendar day of the prior month for Commercial and during the last week of the prior month for MA.

The reports mentioned throughout this section are available online and provide detailed information regarding each care provider's capitation payments. The types of reports available include:

- Flat file — Contains approximately 198 data elements in CSV (Comma Separated Value) format.
- Image reports — In PDF format and are at both the member and summary levels.
- Supplemental care provider reports — Details any non-standard deductions from capitation (i.e., claims that are the financial risk of the care provider and paid by UnitedHealthcare).

Reports are available on **UHCprovider.com/reports** on the date specified in your Agreement. If the due date falls on a non-business day, the reports are available the next business day.

- **Reports** —View image reports in a PDF format (Adobe Acrobat is required.) or download the file.
- **Data Files** — Download the flat files from a zipped file format.
- **All** —Download image reports and flat files in one zipped file.

Claims Withhold Reports and Data Files

Supplemental care provider Reports for Claims Withhold are available online. These reports have two capitation reporting options described below: reports and data files.

Medical Drug Benefit Reports and Data Files

Medical Drug Benefit reports are available online.

The Claims Withhold and Medical Drug Benefits reports are one month behind the current Capitation Report month. For example, all claims on the Claims Withhold and Medical Drug Benefit reports that paid in April will process in May capitation. To reconcile May capitation, view the April Claims Withhold and April Medical Drug Benefits Reports.

The Shared Risk Claims Report is also dated one month behind the current Capitation Report month. For example, all Shared Risk claims paid in May will process in the June capitation.

We maintain capitation and eligibility reports online for the current month and the previous two months.

We recommended you complete your capitation download in a timely manner to make sure you have complete and accurate capitation information.

Hierarchical Condition Category (HCC) and Capitation Reporting

CMS payments are based on the HCC Reporting. This payment methodology requires MA health plans to submit accurate diagnosis information at the greatest level of specificity available.

CMS HCC Risk Adjustment

We offer an alternate method of reporting CMS risk adjustment data in addition to the normal claim/encounter submission process. All encounter submissions are required to process the 837 Claim/Encounter in a HIPAA 5010-compliant format. To supplement a previously submitted 837 Claim/Encounter, submit an 837 replacement Claim/Encounter, or send additional diagnosis data related to the previously submitted 837, through the Optum ASM Operations FTP process. If you choose to submit via ASM, you first need to contact the Optum ASM Operations team at **cas_ops@ingenix.com** to start the onboarding process.

Access care provider reports on **UHCprovider.com/reports**, or using the Document Vault app on Link.

Capitation Processing

Capitation is typically a per member per month (PMPM) payment to a medical group/IPA or facility that covers contracted services for assigned members. This is an alternative to the fee-for-service arrangement. Capitation payments made whether or not the member seeks services from the capitated care provider.

- Under a shared risk arrangement, the medical group/IPA receives capitation for professional services rendered to its assigned members.
- Under a partial risk contract, the facility also receives capitation for institutional services rendered to their assigned members.

Refer to the Division of Financial Responsibility (DOFR) grid in your Agreement for a detailed listing of capitated services. Services not specifically excluded from capitation are included in the capitation payment made to the medical group/IPA or facility.

15/30 Rule

The capitation system uses a 15/30 rule to determine whether capitation is paid for the full month or not at all. If the effective date of a change falls between the first and 15th of the month, the change is effective for the current month, and capitation paid for that month. However, if the effective date falls on the 16th or later, the change reflected the first of the following month and capitation paid for the following month.

For capitation payments, we add members on the first day of the month, or terminated on the last day of the month. Newborns are added on their dates of birth. We pay or recoup commercial capitation for full months.

Retroactive Add

A member added retroactively between the first and the 15th of the month would generate a capitation payment for the entire month. However, a member added on the 16th or later would not generate a capitation payment for that month even though they would be considered eligible for services.

Retroactive Term

A member retroactively terminated between the first and 15th of the month would generate a capitation recoupment entry for the capitation previously paid for the entire month. However, a member retroactively terminated on the 16th or later would not generate a capitation recoupment entry for the capitation previously paid for the entire month.

Capitation Payments

We make monthly capitation payments to the medical group/IPAs and capitated facilities for providing and arranging covered services to our members.

We deliver capitation payments through check or electronic funds transfer on the date listed in the Agreement. If the due date falls on a non-banking day, we deliver the capitation payment the next banking day.

Electronic Funds Transfer (EFT)

To receive capitation payments through EFT, we require a signed EFT Payments form detailing the bank account and bank routing information. It takes three weeks for the EFT initial setup, or a change in banking information, to take effect.

We deposit capitation payments through EFT by the end of the banking/business day on the date specified in the Agreement.

Note: Most financial institutions charge a per transaction fee on EFTs.

Use Link to access and submit Authorization Agreement Payments forms.

For detailed instructions on EFT enrollment, click here.

Additional information and requirements for claims payment options can be found in *Chapter 9: Our Claims Process*.

Capitation Calculation Methods (Commercial)

Capitation calculation methods are detailed in your Agreement. For commercial products, we use four capitation calculation methods:

Flat Rate Calculation: A flat rate (PMPM) capitation calculated by applying the flat rate for each member to yield the standard services capitation amount. The flat rate is detailed in your Agreement. Both the flat file and the image reports display each member-level transaction.

Fixed Rate Age/Gender Adjusted Calculation: Fixed rate age/gender adjusted capitation uses age/gender factors to modify the flat base rate up or down to align standard services capitation with age-weighted risk. The flat base rate multiplied by the age/gender factor yields the standard services capitation amount.

Age/gender factors work to weight for age/gender risk consideration with respect to the demographic population. UnitedHealthcare actuarially develops age/gender factors. The age/gender factors may vary between medical groups/IPAs and are included in the Agreement.

We report the age/gender factors and standard services capitation amount at the member level on the flat file. Only the standard services capitation amount is reported on the image reports.

Fixed Rate Age/Gender/Benefit Adjusted Calculation: Fixed rate age/gender/benefit adjusted capitation contains three components: flat base rate, age/gender factor and benefit factor.

Fixed Rate Age/Gender/Copayment Adjusted Calculation: Copayment adjustment works to evaluate the member's copayment made directly to the care provider. We actuarially derive the copayment adjustment for each copayment level.

- We add or subtract the copayment adjustment from the flat base rate. The sum of flat base rate +/- copayment adjustment multiplied by, the age/gender factor to yield the standard services capitation amount. We report the flat base rate, age/gender factor, copayment adjustment and standard services capitation amounts at the member level on the flat file. The image reports only show the standard services capitation amount.

Commercial Capitation Contracts with Multiple Rates

The capitation source system can administer a single commercial contract with multiple rates, if the contract requires a different rate for members enrolled in a specific plan or in-network. These contracts are identified by the Primary Care Provider Network Indicator (PCPNI). The four capitation calculation methods described in the Capitation Calculation Methods section apply. This option is available for commercial contracts. It allows you to manage your capitation under one medical group/IPA number.

Capitation transactions reports can be summarized or detailed. All individual transactions are summarized by PNI code and reported on several capitations image reports. There are also detailed care provider PNI transactions reports on both the flat file (CP7810, column U, field 21) and image reports (CP7210, CP7230). Member PNI is reported on the flat file (CP7810, column AP, field 42).

Capitation Calculation for Medicare Advantage

For MA products, we use three capitation calculation methods:

1. **Flat rate** — A rate is paid PMPM. We calculate the flat rate capitation by applying the flat rate for each member to give us the standard services capitation amount. The Agreement details the flat rate. Both the flat file and image reports display each member level transaction.
2. **Percent of premium** — The percent of CMS premium calculation begins with the premium identified from the CMS Monthly Membership Report (MMR), less any premium adjustments, and multiplied by the contracted percentage.

   The net of all adjustments is the CMS premium. The flat file (1 R record type), shows the CMS premium at the member level with the field name Cap_Premium_Gross_Cap.

   Medical groups/IPAs and capitated facilities with a percentage-of-premium contract receive their contracted percentage rate of this cap premium gross cap amount as the standard services capitation amount for each member.

   The flat file (1 R record type) shows the standard services capitation amount at the member level by summing the fields Group_ Capitation_Amt plus Facility_Capitation_Amt. Image reports also show the standard services capitation amount at the member level.
3. **Risk adjusted fixed rate** —We calculate capitation using the base rate detailed in the Agreement, multiplied by various factors.

It contains three components:

1. Base rate — as detailed in the Agreement.
2. Risk Adjusted Factor (RAF) — the score for each MA plan member taken directly from CMS' Monthly Membership Report (MMR). This factor is reported on the flat file and image reports.
3. Health status variables are the base rate adjusted for members categorized as ESRD or Hospice by CMS on the MMR. For details on the ESRD and Hospice adjustments, please see your Agreement.

The risk-adjusted fixed rate capitation amount will vary monthly resulting in changes in the risk adjustment factor and demographic factors for Medicare Advantage plan members for that month. Both the flat file and image reports show each member-level transaction. The risk-adjusted fixed rate capitation has the standard six-month system retro window. Payments made by CMS outside the six-month retroactivity window are not included.

CMS Premiums and Adjustments

CMS Premium

We use the premium reported on the MMR from CMS as the first step in development of the premium used for the percent of premium calculation. The algorithm, methodology-blend percentage and rates/factors are posted on the CMS website at **cms.gov** for all periods.

Unpaid CMS Premium

If we do not receive payment from CMS for a particular member, we do not pay capitation for that member. Typically unpaid CMS premiums occur in the first month of eligibility. The payment is usually received within 60 calendar days.

If the medical group/IPA has unpaid premiums, it must continue to arrange for the member's medical care and pay for services accordingly.

If CMS does not retroactively pay the premium within 120 calendar days, the medical group/IPA should notify its provider advocate with specific information for that member. That way, the non-payment can be pursued with CMS.

Out-of-Area Premium

We receive premium from CMS based, in part, on the member's State and County Code (SCC) as reported by CMS. We use the premium CMS reports as a basis for percent of premium capitation.

CMS may report a member in a different state than the state their assigned medical group/IPA is located. As an example, CMS may report a member's SCC as Washington, yet their assigned medical group/IPA is in Oregon.

Once the CMS system updates SCC, CMS pays the correct SCC going forward. Typically, CMS does not retroactively adjust premium for changes in SCC.

End Stage Renal Disease (ESRD) Premium

ESRD premiums are paid using a risk-adjusted model. The model provides a three-tier approach: dialysis status, receiving a transplant, and functioning graft status. CMS communicates these tiers using the Customer's Risk-Adjusted Factor Type Code.

In addition to the ESRD flag, the flat file reports the member-level risk-adjusted factor type code to help the medical group/IPA identify their ESRD patient who is our member. The risk-adjusted factor type code is not reported on the image reports. Find more information on CMS.gov.

Working Aged Premium Adjustment

The working aged adjustment shows as a member-specific adjustment in the premium payment we receive from CMS. CMS calculates the working aged adjustment based on a yearly Medicare Secondary Payer (MSP) factor CMS determines. We show this adjustment at the member level on the flat file (1 R record type for adjustments within the six-month retro window and the 3M record type for adjustments beyond the six-month retro window). Find specifics on the CMS Working Aged Program on cms.gov.

CMS User Fee Premium Adjustment

CMS deducts a user fee from all MA plans to fund various education programs for Medicare-eligible persons. The user fee adjustment shows as a non-member specific adjustment in our payments from CMS. Every member is allocated the user fee adjustment. CMS might modify the rate monthly, however, typically the percentage changes three times per year. We show this adjustment at the member level on the flat file, 1 R record type, with the field name CMS_User_Fee.

Sequestration Premium Adjustment

UnitedHealthcare's MA plans reduce care provider capitation payments for MA membership by 2%.The 2% sequestration reduction is reported at the member level on the flat file, 1 R record type, with the field name called the MSBP.

This is a result of the CMS-announced sequestration reductions of Medicare payments to care providers, facilities and other health care professionals and impacts care provider, facility, ancillary care provider and other professional payments in our MA plans, including Medicare Advantage Dual Special Needs Plans (DSNP).

Sample Member Capitation Assessment

Capitation reports reflect the "cap premium gross cap" amount. A medical group/IPA and/or capitated facility with a percent of premium contract can request a sample member capitation assessment.

For MA plans, the review reflects the premium received from CMS. It also shows the transactions outlined in the preceding CMS premium sections to calculate the standard services capitation payment.

You may request a sample member capitation assessment no more than once a year.

A medical group/IPA or capitated facility may request one member capitation assessment, covering one month within the last 12-month period, for no more than six members per contract year.

Confidentiality

Sample member capitation review results include confidential and proprietary information. The medical group/IPA or capitated facility must sign a confidentiality agreement before receiving a sample member capitation assessment. We only present this information in one of our offices. The confidentiality agreement states that assessment results may not be removed from the premises.

Capitation Reconciliation

UnitedHealthcare produces capitation using two separate systems:

- Core transaction processing system — Information from this system reflected in the capitation flat file and on the image reports. The summary reports, CP7030 or CP7010, go to the payment summary.
- Payment system — Information from this system reflects the sum of the core transaction system, system transaction plus any non-system manual adjustments.

We provide a capitation payment summary to each medical/IPA care provider group to allow the medical group to reconcile the monthly capitation payment. The payment amount is the sum of the amount from the core transaction processing system, plus any non-system adjustments.

Capitation Adjustment Codes

We use capitation adjustments in a variety of circumstances. Each adjustment consists of a three-character Capitation Adjustment Code. Each adjustment code has a corresponding description. We use adjustment codes to administer a specific system-generated payment or carve-out per your Agreement. We also use a code for a non-system adjustment.

The flat file contains only the capitation adjustment code. However, the CP7020 image report contains both the capitation adjustment code and corresponding description.

We give care providers documentation, as specified in this guide, in support of each capitation payment.

Non-System Manual Adjustments

An electronic format of non-system manual adjustments and corresponding backup documentation is available on UHCprovider.com. Each adjustment is reported as a separate line item on the payment summary. To force these adjustments through the system, we reverse them in the next processing-period, processed as a system adjustment and reported on the flat file and image reports.

Provider Remittance Advice (PRA)

The invoice number on the PRA is an indication of the source system from which the transaction originated. Each transaction originated from either the core transaction processing system (NICE) or payment system as a non-system manual adjustment (ORACLE). Each of the source systems follows an invoice numbering convention as follows:

- Core transaction: YYMMPPNNNNSSDD (Example: 1701CO 00013301). This amount will foot to the CP7030 or CP701 0 [image reports]:
  - YY — last two [four] digits of the year (06)[(2006)]
  - MM — month (06) PP — product type (CO) Commercial [(SH) Medicare]
  - NNNN — computer generated sequential number (0001)
  - SS — UnitedHealthcare State code (33)
  - DD — UnitedHealthcare division code (01)
- Non-system manual adjustment: YYM M PPAAACTN N N N N N I IOSSDD (Example: 0606COALG 1101 [SHQMB] 2345JSC [ZZC] 3301). This amount will not be included in the Capitation Reporting:
  - YY — last two digits of the year (06) MM — month (06)
  - PP — product type (CO) Commercial [(SH) Medicare]
  - AAA — adjustment code (Example MBR would be for a member adjustment.)
  - C — transaction count (1)
  - T — contract type (1) values include; 1-Primary Care, 2-Facility, 3-Subcap, 4-Third Party
  - NNNNNN — care provider number (01 2345)
  - II — internal document tracker (JS) [(ZZ)]
  - ORACLE system indicator (C)
  - SS — UnitedHealthcare State code (33)
  - DD — UnitedHealthcare division code (01)

Retroactive Term

The MA capitation process uses the member's date of birth (DOB), as reported by CMS, as a basis for capitation calculations driven by member age.

Extended Retro Process (MA)

CMS sends MA premium payment adjustments to UnitedHealthcare that may span over a 72-month time frame on the Monthly Membership Report (MMR). Our capitation processing engine can only process retroactivity up to 48 months, regardless of contractual or eligibility limitations on retroactive changes. We apply the premium

capitation calculation methodology. These extended retro process adjustments appear on the capitation flat file, 3M record type with the following adjustment codes:

- MMR — Standard retroactive premium payment adjustments.
- MME — Adjustments represent transactions outside of the six-month retro window that error out during the processing of the MMR.
- MMX — Adjustments represent transactions for members that could not be identified during the processing of capitation or are beyond the 48-month system limitation.
- The MME and MMX adjustments processed in subsequent months after they occur, due to the research involved to complete these transactions.

Delegate Performance Management Program

We conduct an analysis of clinical, quality and health outcomes to identify potential variations in care delivery to support the best quality care and outcomes for our members. By comparing data, that is risk-adjusted when appropriate, identifying variations from peer benchmarks and sharing that information with you, we can work collaboratively to improve value for our members.

Together we get a clearer picture of measures that may provide opportunities for improving quality and care experiences for our members. We account for standards of care, evidence-based guidelines and **Choosing Wisely® recommendations** from the American Board of Internal Medicine Foundation, supported through partnerships with more than 70 national medical specialty societies. Any changes to care programs not previously communicated to the Delegation Oversight Committee should be raised during annual review.

Performance Domains
Performance measurement supports practice improvement and provides delegates with access to information regarding how their group compares to peer benchmarks for specific measures. This information provides a starting point for an ongoing dialog regarding how we may best support your efforts to provide high-quality, cost-effective care to our members.

Delegate performance domains include:

- Clinical UM.
- Clinical quality including STARS, HEDIS and member satisfaction.
- Encounter data performance management.
- Credentialing performance management.
- Financial performance management.
- Compliance with UnitedHealthcare, federal and state requirements.

Performance domains are evaluated regularly, compared to peer benchmarks, and communicated to the delegate in performance reports.

Improvement Action Plans
We may require the delegate to develop an improvement action plan designed to bring the delegate into compliance with performance standards.

Delegates who do not achieve compliance within the established time frames may require continued oversight until they achieve compliance.

Continued non-compliance or failure to perform may result in removing the delegate from the services.

Notification of Platform Transitions or Migrations
During our initial review of a delegate's operational capabilities, we also review the delegate's information systems or transaction platforms to validate their ability to comply with our operational and regulatory requirements and connectivity standards. Therefore, we request the delegate provide at least 120 days advance written notice to their UnitedHealthcare delegation oversight representative and their UnitedHealthcare contract administrator or provider advocate of the intent to either:

1. Change administrative platform(s) for impacted delegated function(s), including migrations, version upgrades, or conversions, or
2. Make material changes in existing administrative platforms that might impact delegated functions.

If you are unsure of what a material change is, please contact your delegation oversight representative.

Please note, some changes may require pre-cutover evaluation and testing by the UnitedHealthcare delegation oversight team(s) to ensure continued compliance with all regulatory compliance and data sharing capabilities.

Appeals and Grievances

Care Provider, Member Appeals and Grievance Complaints

Members have the right to appeal the determination of any denied services or claim by filing an appeal with us. Time frames for filing an appeal vary depending on applicable state or federal requirements.

We maintain a system of logging, tracking and analyzing issues received from members and care providers. We use the information to measure and improve member and care provider satisfaction.

This system helps us fulfill the requirements and expectations of our members and our network care providers. In addition, it supports compliance with CMS,

the NCQA, The Joint Commission, and other accrediting and/or regulatory requirements.

We acknowledge and enter all written complaints into the complaint database. If we identify a potential quality of care issue within the complaint (using pre-established triggers), we forward the case to the Quality of Care Department to investigate. If the complaint involves an imminent and serious threat to the member's health, the case is referred on to the Quality Intervention Services for immediate action. We identify and request relevant medical records and information needed to resolve quality of care investigations. We use the results to assign severity levels and data collection codes. This helps us objectively and systemically monitor, evaluate and improve the quality and safety of clinical care and quality of service provided to our members.

We track and trend care provider complaints and use the information during their recredentialing. We conduct an annual analysis of the complaint data to look for opportunities for improvement. Care provider and member complaints are important to the recredentialing process because they help us attract and retain care providers, employer groups and members.

Member Grievance and Appeals

Network care providers are required to:

- Immediately, within one hour of receipt, forward all member grievances and appeals (complaints, appeal, quality of care/service concern, whether oral or written) to us for processing to:
  UnitedHealthcare
  P.O. Box 6106
  Mail Stop CA 124-0157
  Cypress, CA 90630
- Respond to our requests for information about the member's appeal or grievance within the designated time frame. For expedited appeals, submit the requested information within two hours. For standard appeals, submit within 24 hours (no exceptions or delays due to weekend or holidays). Time frames apply to every calendar day of the year.
- Comply with our final determinations regarding member appeals and grievances.
- Cooperate with us and the external independent medical review organization. This means promptly forwarding copies of all medical records and information relevant to the disputed health care service in your possession to the external review organization, and/or any newly discovered relevant medical records or any information in the your possession, requested by an external review organization. Respond to our requests for proof of claim payment or a copy of the pre-service authorization of overturned appeals: expedited appeals, within two hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Time frames apply to every calendar day of the year.
- Provide us with proof of claim payment or a copy of the pre-service authorization within the stipulated time frames on reversals of adverse determinations. Respond to requests for proof overturned appeals were resolved: expedited appeals, within two hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Time frames apply to every calendar day of the year.

UnitedHealthcare West Member Grievances

CA Commercial

Members may use a UnitedHealthcare West Grievance Form to file their grievance. We do not delegate authority or responsibility for processing member grievances, appeals or complaints to our network care providers. However, we do require our network care providers help resolve grievances, appeals or complaints.

For more information regarding disputes and grievance processes for UnitedHealthcare West members (AZ, CA, CO, NV, OK, OR, TX, WA), please refer to the *UnitedHealthcare West Supplement*.

Leased Networks

This may apply to care providers in AK, HI, KY, PR, and the USVI. Refer to your Agreement.

Applicability of this Supplement

The Leased Network Supplement applies to physicians, health care professionals, facilities and ancillary providers who participate through a leased network for certain products accessed by UnitedHealthcare in an area where we do not have a direct network.

These participating care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For topics not referenced in this supplement, refer to main guide.

Leased Supplement

Any mention of a care provider's "Agreement with us" refers to your Agreement with the entity operating the leased network (your "Master Contract Holder").

For the processes listed below, follow your Master Contract Holder Agreement to:

- Update demographic information.
- Submit National Provider Identification information.
- Credential/re-credential.

Medica HealthCare Supplement

About Medica HealthCare

Medica HealthCare Inc., a wholly owned subsidiary of UnitedHealthcare, is a Medicare Advantage (MA) health plan. We offer MA plans in two Florida counties: Broward and Miami-Dade.

Medica participating care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For protocols, policies and procedures not referenced in this supplement, please refer to the appropriate chapter in the main guide.

Mission Statement

We work to improve the health of our members by providing:

- Access to health care services
- Choices for their health care needs
- Simplification of the health care delivery system

We streamline authorization and referral processes. We build care provider networks around the needs of our members. This provides the best experience for our members and care providers. We commit to give direct access to expert customer service representatives who understand member needs and may help them make informed choices.

How to Contact Us

Questions or Comments

Questions or comments about this manual should be emailed to Network Management Services (NMS) at pcp-NetworkManagementServices@uhcsouthflorida.com, or submitted by mail to:

Medica HealthCare
Network Management Services
9100 South Dadeland Blvd.
Suite 1250
Miami, FL 33156-6420

Contact Us Table

Resources	Where to Go	What you can do there
Authorizations and Notifications	**Online:** UHCprovider.com/paan **Phone:** 866-273-9444 Monday through Friday, 9 a.m. to 5 p.m. **After Hours Phone:** 305-421-1220 Monday through Friday, 5 p.m. to 11 p.m. Saturdays, Sundays, Holidays 8 a.m. to 5 p.m.	• Initiate requests for notifications and authorizations electronically • Submit notifications, prior authorizations, referrals, admissions, and discharge planning • Submit after-hours or weekend emergencies, notifications or hospital admissions
Eligibility and Benefits Verification	**Online:** UHCprovider.com/eligibilitylink **Phone:** 800-348-5548 **Fax:** 305-670-2308	• Verify eligibility and benefits of enrolled members
Claims	**Online:** UHCprovider.com/claims **Phone:** 800-348-5548 Monday through Friday, 8 a.m. to 5 p.m. ET **Fax:** 866-725-9337	• Submit or review claims, encounters, inquiries, status, or review requests • Check claims, eligibility, benefits

Resources	Where to Go	What you can do there
Claims (WellMed)	**Online:** eprg.wellmed.net **Phone:** 800-550-7691 **Mail:** WellMed Claims P.O. Box 400066 San Antonio, TX 78229	• Use payer ID #WELM2.
Technical Support for Change Healthcare claims submission network	**Phone:** 800-845-6592	• Obtain assistance with password or technical support issues
Audit and Recovery	**Phone:** 877-842-3210 **Online:** Connect.werally.com	• Ask questions related to overpayments
Chiropractic, Physical Therapy, Occupational Therapy and Speech Therapy Providers	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. **Fax:** 888-659-0619 **Email:** pcp-NetworkManagementServices@uhcsouthflorida.com	• Access list of participating Physical Therapist providers in our directory
Credentialing	**Phone:** 800-963-6495 Monday through Friday, 9 a.m. to 5 p.m. **Fax:** 844-897-6352	• Update or complete credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility
DME and Infusion (MedCare)	**Phone:** 800-819-0751	• Register for these services • On call 24 hours a day • You may also call Utilization Management or Network Management
Electronic Remittance (Facilitated by Change Healthcare)	**Phone:** 800-845-6592 **Online:** changehealthcare.com	• Information and registration for electronic payment services
Fraud, Waste, and Abuse (FWA) Hotline	**Online:** medicaplans.com **Phone:** 800-455-4521, Monday through Friday, 9 a.m. to 5 p.m. **Fax:** 888-659-0617 **Email**: ReportFraud@UHCsouthflorida.com **Mail:** Medica HealthCare Special Investigations Unit P.O. Box 56-6596 Miami FL 33256-6596	• Report concerns related to fraud, waste or abuse
Grievances & Appeals	**Phone:** Call the provider number listed on the back of the member's identification card. **Mail:** Medica HealthCare Grievances & Appeals Department P.O. Box 30997 Salt Lake City, UT 84130	• Obtain information about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms
Home Health (MedCare)	**Phone:** 305-883-2940	• Arrange for services • On-call 24 hours a day • You may also call Utilization Management or Network Management
Member Services	**Phone:** 800-407-9069 Everyday, 8 a.m. to 8 p.m. ET **TTY:** 711 **Fax:** 800-517-6924	• Assist our members with questions, help locate specialists, and perform other related functions • Also printed on the member's Plan ID card

Resources	Where to Go	What you can do there
Network Management Services—Medica Provider Relations and Contracting	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. **Fax:** 888-659-0619 **Email:** pcp-NetworkManagementServices@uhcsouthflorida.com	• Ask questions regarding your Agreement, in-servicing and follow-up and outreaches • Report demographic changes such as TIN changes, care provider terminations and additions • Submit informal complaints • Find or request forms or other materials • Panel status
Pharmacy (OptumRx)	**Phone:** 800-711-4555	• Verify pharmacy benefits and eligibility, adjudications, or authorizations
Risk Management	**Phone:** 877-504-1179 **Email:** risk.management@uhc.com	• Report incidents involving all privacy issues (potential breaches of PHI or PII) immediately to our Risk Manager
24-Hour Nurse Hotline **Optum Nurse Line** Only available under certain plans	**Phone:** 855-575-0293	• Speak to a nurse to triage to emergency or urgent care, or to refer members to their primary care physician
United Behavioral Health	**Online:** providerexpress.com Licensed clinicians available 24 hours. Member Services – 24 hours. **Phone:** 800-985-2596 No DSNP 800-496-5841 DSNP & iSNP	• Obtain information about behavioral health and substance use services for all members • Access a list of behavioral health practitioners and care providers in the provider directory
Dental (Solstice)	**Online:** SolsticeBenefits.com **Phone:** 855-351-8163	• Access a list of Solstice dental providers in the provider directory
Fitness (Renew Active)	**Online:** Medica.myrenewactive.com **Phone:** 800-407-9069	
Hearing (Hear-X/HearUSA)	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m.	
Laboratory **LabCorp**	**Online:** labcorp.com **Phone:** 855-277-8669 Automated Line **Phone:** 800-877-7831 Live Scheduling	• Find information on locations, to make an appointment, and to order lab tests and view results
QUEST	**Online:** Questdiagnostics.com/home/patients.html **Phone:** 866-697-8378	
Mail Order Pharmacy (OptumRx)	**Online:** optumrx.com **Phone:** 877-889-6358	• Obtain mail-order medications
Podiatry - Network Mgmt Services (Foot and Ankle Network)	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m.	• Access a list of podiatrists in our provider directory
Transportation (Member Services)	**Phone:** 888-774-7772 Monday through Friday, 9 a.m. to 5 p.m.	• Request services
Vision - Network Mgmt Services (iCare)	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m.	• Access a list of vision providers in our provider directory

WellMed Medical Management, Inc. (WellMed)

For members who belong to a Primary Care Physician (PCP) in the Medica HealthCare Network, their utilization management (UM) and claim services are handled through WellMed. To identify these members, refer to the member ID card. The payer ID is listed as WELM2 and "WellMed" is listed in the lower right corner of the card.

Claims Processing for WellMed Members

Submit claims electronically to payer ID WELM2. If mailing, send to:

WellMed Claims
P.O. Box 400066
San Antonio, TX 78229.

Confidentiality of Protected Health Information (PHI)

All employees, contracting care providers and delegates of Medica HealthCare are required to maintain the confidentiality of all PHI. We keep all Utilization Management information confidential, following federal and state laws and regulations. We limit PHI access to the minimum necessary.

You must report all privacy issues immediately to Risk Management at 877-504-1179.

Examples of privacy incidents include:

- Reports and correspondence containing PHI or Personally Identifiable Information (PII) sent to the wrong recipient
- Member or provider correspondence that includes an incorrect member's information
- Complaint received indicating PHI or PII may have been misused
- Concern about compliance with a privacy or security policy
- PHI or PII sent unencrypted outside of your office
- Lost or theft of laptops, PDAs, CDs, DVDs, flash/USB drives and other electronic devices
- Caller mentions they are a regulator (i.e., person is calling from the Office for Civil Rights, Office of E-Health Standards & Services, State Insurance Departments, Attorney General's Office, Department of Justice), or threatens legal action or contacting the media in relation to a privacy issue
- Caller advises your office of a privacy risk

Physician Extender Responsibilities

Physician extenders are state licensed health care professionals who are employed or contracted by physicians to examine and treat Medicare members. These are Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA). When a physician extender provides care, they must:

- Be supervised by a physician. The physician must be on the premises at all times when the physician extender is seeing patients.
- Ensure the member is made aware of their credentials. The member should be aware they might not see a medical doctor.
- Get the sponsoring physician's signature on all progress notes.
- Provide services as defined and approved by the sponsoring physician.

Referrals

Medica HealthCare's Simple Referral Process helps Primary Care Physicians coordinate patient care.

Referrals are needed for most participating specialists.* Requests for non-participating care providers need additional authorization.

- You may request a referral for one or multiple visits.
- The referral is good for the number of visits approved, valid for six months from the date issued.
- No supporting documentation is needed for referrals to specialists.
- Submit all requests for referrals through our online provider portal on **UHCprovider.com/referral**.
- Upon submitting a referral request, the system automatically generates the referral number.
- For member convenience, you may also provide members with a copy of the referral confirmation.
- Specialists have the ability to view referral via UnitedHealthcare portal.
- For additional questions call us at 877-670-8432 or email us at **pcp-NetworkManagementServices@uhcsouthflorida.com**.

Prior Authorizations

Medica does not require prior authorization for certain services. Please use the Enterprise Prior Authorization List (EPAL) to see what services do require authorization on **UHCprovider.com/priorauth** > Plan Requirements for Advance Notification/Prior Authorization > under Plan Requirements and Procedure Codes > Medica HealthCare and Preferred Care Partners Prior Authorization Requirements.

WellMed and Utilization Management

Prior authorization requests for Medica members assigned to a PCP belonging to Preferred Care Partners Medical Group (PCPMG) can be done online at **eprg.wellmed.net** or by fax at 866-322-7276.

* Contact Network Management Services for a complete list of specialty types that need referrals.

Authorization Requirements

- You are responsible for getting prior authorization for all services requiring authorization before the services are scheduled or rendered.
- Submit prior authorization for outpatient services or planned inpatient admissions, including Skilled Nursing Facilities (SNF), Acute Inpatient Rehab (AIR) and Long Term Acute Care Hospital (LTACH) admissions, as far in advance of the planned service as possible to allow for review. You are required to submit prior authorizations at least seven calendar days prior to the planned date of service.
- Prior authorizations for home health and home infusion services, durable medical equipment, and medical supply items should be submitted to MedCare Home Health is 305-883-2940 and Infusion/DME at 800-819-0751.

Note: Request an expedited (72 hours) review if waiting for a standard (14 calendar days) review could place the member's life, health, or ability to regain maximum function in serious jeopardy. If the situation meets this definition, request a prior authorization be expedited by placing 'STAT' or 'urgent' on the Prior Authorization Form.

- Prior authorizations are required for referrals to out-of-network care providers when the member requires a necessary service that is not within the Medica network. The referring physician must submit a completed Prior Authorization Form for approval.
- It is important you and the member are fully aware of coverage decisions before you render services.
- If you provide the service before a coverage decision is rendered, and we determine the service was not a covered benefit, we may deny the claim and you must not bill the member. Without a coverage determination, a member does not have the information needed to make an informed decision about receiving and paying for services.

Notification Requirements

Prior to doing an inpatient or ambulatory outpatient service requiring prior authorization, the facility must confirm the coverage approval is on file. This promotes conversations between the facility and the member about the cost for the procedure.

- Facilities are responsible for admission notification for inpatient services even if the coverage approval is on file.
- If a member is admitted through the emergency room, notification is required no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.
- If a member receives urgent care services, you must notify us within 48 hours of the services being rendered.

Admission Notification Requirements

Facilities are responsible for admission notification for the following inpatient admissions, even if advance notification was provided by the physician and coverage approval is on file:

- Planned elective admissions for acute care
- Unplanned admissions for acute care
- Admissions following observation
- Admissions following outpatient surgery
- Skilled Nursing Facility (SNF) admissions
- Long Term Acute Care Hospital (LTACH)
- Acute Inpatient Rehab (AIR)
- Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission (or by 5 p.m. ET on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For after-hour, weekend and federal holiday admissions, please call the Utilization Management Department at 866-273-9444 for assistance.
- Even if the physician gave us the admission notification, the facility still needs to submit one.
- Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services depends on:
  - The member's coverage
  - The facility being eligible for payment
  - Claim processing requirements
  - The facility's Agreement with us
- Admission notifications must contain:
  - Member name and member health care ID number
  - Facility name
  - Admitting/attending physician name
  - Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
  - Actual admission date
  - Admission orders written by a physician
- For emergency admissions when a member is unstable and not capable of providing coverage information,the facility should notify us as soon as the information is known and communicate the extenuating circumstances. We will not apply any notification- related reimbursement deductions.

If the requirements described are not followed, the services may be denied. The member may not be billed.

A notification or prior authorization approval does not ensure or authorize payment, subject to state rules and MA policies. Payment depends on the member's coverage,

the care provider's eligibility and Agreement and claim requirements.

How to Request Prior Authorization

- **Link:** UHCprovider.com/paan.
- **Phone:** If you do not have electronic access, call the number on the back of the members' health care ID card.

Required Information for Prior Authorizations:

- Member information: Name, date of birth (DOB), and membership ID number
- Requesting care provider information: Name, specialty, designate par or non-par, address and phone and fax numbers
- Primary care physician information, if different from the requesting care provider: Name, phone and fax numbers
- Referral information: Name of referral care provider, designate par or non-par, address, phone and fax numbers
- Diagnosis or symptoms: Include the diagnosis description and the corresponding ICD-10 code for each diagnosis to the highest specificity
- Service(s) Requested:
  - Identify each procedure, and its corresponding CPT code,
  - Document any pertinent clinical summary information which would be helpful to that specialist or for the UM determination in the additional comments field, and
  - Enter the date of service and number of visits requested, and sign where indicated.

Where a clinical coverage review is required in the member's benefit plan, we may request additional information.

- We may not cover certain services within an individual member's benefit plan, regardless of whether prior authorization is required.
- In the event of a conflict or inconsistency between applicable regulations and the Advance Notification Requirements in this manual, we follow the notification process in accordance with applicable regulations.

Time frames for Processing Prior Authorization Requests

We will make a determination within 14 calendar days of receipt, or within 72 hours for an expedited review.

It is important we have all necessary documentation at the time of your request to help with the decision.

Clinical Coverage Review

Certain services require prior authorization, which results in:

1. A request for clinical information,
2. A clinical coverage review based on medical necessity, and
3. A coverage determination.

You must cooperate with our requests for information, documents or discussions for purposes of a clinical coverage review including, providing pertinent medical records, imaging studies and reports and appropriate assessments for determining degree of pain or functional impairment.

As a network care provider, you must return calls from our UM staff or Medical Director. You must provide complete clinical information as required within the time frame specified on the outreach form.

In addition:

- We may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.
- For MA members, we use CMS coverage determinations, the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) to determine clinical criteria for Medicare members. There is a hierarchy used in applying clinical criteria.

Clinical Coverage Review Criteria

We use scientifically based clinical evidence to identify safe and effective health services for members for inpatient and outpatient services. For Inpatient Care Management (ICM's), we use evidence based MCG Care Guidelines. Clinical coverage decisions are based on:

- The member's eligibility
- State and federal mandates
- The member's certificate of coverage, evidence of coverage or summary plan description
- UnitedHealthcare medical policies and medical technology assessment information
- CMS NCDs and LCDs, and other clinical based literature (for Medicare and Retirement)

Coverage Determination Decisions

We base coverage determinations for health care services upon the member's benefit documents and applicable federal requirements. Our UM Staff, its delegates, and the physicians making these coverage decisions are not compensated or otherwise rewarded for issuing adverse non-coverage determinations.

Medica HealthCare and its delegates do not offer incentives to physicians to encourage underutilization of

services or to encourage barriers to receiving the care and services needed.

Coverage decisions are made based on the definition of "reasonable and necessary" within Medicare coverage regulations and guidelines. We do not hire, promote or terminate physicians or other individuals based upon the likelihood or the perceived likelihood the individual will support or tend to support the denial of benefits.

Prior Authorization Denials

We may deny a prior authorization request for several reasons:

- Member is not eligible;
- Service requested is not a covered benefit;
- Member's benefit has been exhausted; or
- Service requested is identified as not medically necessary (based upon clinical criteria guidelines).

We must notify you and the member in writing of any adverse decision (partial or complete) within applicable time frames. The notice must state the specific reasons for the decision, and reference to the benefit provision and clinical review criteria used in the decision making process. We provide the clinical criteria used in the review process for making a coverage determination along with the notification of denial.

Peer-to-Peer (P2P) Clinical Review

For Inpatient Care Management Cases, P2P requests may come in through the P2P Support team by calling 800-955-7615.

P2P discussions may occur at different points during case activity in accordance with time frames, once a medical director has rendered an Adverse Determination. A P2P reconsideration request may only occur before you file a formal appeal.

UnitedHealthcare physicians conducting clinical review determinations are available, by telephone, to discuss medical necessity review determinations with the member's physician requesting the service. We offer pre-denial P2P review. A clinician will contact you to initiate the P2P call. Please follow time line provided by the nurse during the call.

Additional UM Information

External Agency Services for Members

Some members may require medical, psychological, social services or other external agencies outside the scope of their benefits (for example, from Health and Human Services or Social Services). If you encounter a member in this situation, you should either contact Network Management Services, or have the member contact our Member Services Department at 800-407-9069 for assistance with, and referral to, appropriate external agencies.

Technology Assessment Coverage Determination

We use the technology assessment process to evaluate new technologies and new applications of existing technologies. Technology categories include medical procedures, drugs, pharmaceuticals, or devices. This information allows us to support decisions about treatments which best improve member's health outcomes, efficiently manage utilization of health care resources, and make changes in benefit coverage to keep pace with technology changes and to help ensure members have equitable access to safe and effective care. If you have any questions regarding whether a new technology or a new application of existing technologies are a covered benefit for our members, please contact Utilization Management at 866-273-9444.

Hospitalist Program for Inpatient Hospital Admissions

The Hospitalist Program is a voluntary program for members. Hospitalists are physicians who specialize in the care of members in an acute inpatient setting (acute care hospitals and skilled nursing facilities). A hospitalist oversees the member's inpatient admission and coordinates all inpatient care. The hospitalist is required to communicate with the member's selected physician by providing records and information such as the discharge summary, upon the member's discharge from the hospital or facility.

Discharge Planning

Discharge planning is a collaborative effort between the Inpatient Care Managers, the hospital/facility case manager, the member, and the admitting physician to ensure coordination and quality of medical services through the post-discharge phase of care.

Although not required to do so, we may assist in identifying health care resources, which may be available in the member's community following an inpatient stay.

Utilization Case Management nurses conduct telephone reviews to support discharge planning, with a focus on coordinating health care services prior to the discharge.

The facility or physician is required to contact us and provide clinical information to support discharge decisions under the following circumstances:

- An extension of the approval is needed. Contact must be made prior to the expiration of the approved days.
- The member's discharge plan indicates transfer to an alternative level of care is appropriate.
- The member has a complex plan of treatment that includes home health services, home infusion therapy, total parenteral nutrition, or multiple or specialized durable medical equipment identified prior to discharge.
- Addressing lifestyle-related health issues and referring to programs for weight management, nutrition, smoking cessation, exercise, diabetes education and stress management, as appropriate.

- Helping members understand and manage their condition and its implications.
- Education for reducing risk factors, maintaining a healthy lifestyle, and adhering to treatment plans and medication regimens.

Appeal and Reconsideration Processes

Medicare Advantage Hospital Discharge Appeal Rights Protocol

Medicare Advantage members have the statutory right to appeal their hospital discharge to a Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO) for immediate review. The BFCC-QIO for Florida is KEPRO.

The BFCC-QIO notifies the facility and Medica of an appeal and:

- Medica facility onsite Concurrent Review Staff completes the Detailed Notice of Discharge (DNOD), and delivers it to the member, or their representative as soon as possible but no later than 12 p.m. ET of the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO; or
- When there are not any Medica facility onsite staff, the facility completes the DNOD, and delivers the DNOD to the member or their representative as soon as possible but no later than 12 p.m. ET of the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO and Medica.

Facility (SNF, HHA, CORF) Notice of Medicare Non-Coverage (NOMNC) Protocol

CMS requires Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Comprehensive Outpatient Rehabilitation Facilities (CORFs) to deliver the NOMNC notice to members at least two calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member's services are expected to be fewer than two calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non- institutional setting. In a non-institutional setting, if the span of time between services exceeds two calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or member's authorized representative if the member is incompetent. You must use the most current version of the standard CMS approved notice entitled, Notice of Medicare Non-Coverage (NOMNC) form. The standardized form and instructions regarding the NOMNC are on the CMS website or contact KEPRO the BFCC-QIO for Florida at: **keproqio.com**. The NOMNC notification text may not be modified.

Clinical Appeals: Standard and Expedited

To appeal an adverse decision (a decision to deny authorization of a service or procedure because the service is determined not to be medically necessary or appropriate), on behalf of a member, you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter you received provides you with filing deadlines and the address to submit the appeal. In the event a member designates a health care professional to appeal the decision on the members' behalf a copy of the member's written consent is required and must be submitted with the appeal.

When we make the final decision, we notify you via mail. If the decision is to overturn the original determination, we will authorize the service. If the decision is to uphold the original denial determination, there will be no further action for you to undertake.

Benefit Summaries

For Information on benefit plans visit medicaplans.com > **Plans and Services**.

Member Rights and Responsibilities

The Member Rights and Responsibilities Statement is published each year in the Evidence of Coverage (EOC) available on the Medica website at **medicaplans.com**. You may get a copy of the Member Rights and Responsibilities Statement by contacting Network Management Services at 877-670-8432. If your patient has questions about their rights as a MA member, please refer them to the Member Services phone number on the back of their ID Card.

Member Participation in Treatment Options

Members have the right to freely communicate with their physician and participate in the decision making process regarding their health care, regardless of their benefit coverage. Physicians should encourage and provide active member communication and participation in their treatment planning and course of care. This includes the member's right to withhold resuscitative services or to forgo or withdraw life-sustaining treatment in compliance with federal and state laws.

Each member has the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law, as applicable. Physicians must communication information, regarding the risks, benefits, and consequences of treatment or non-treatment, at a level the member may understand to decide among the treatment options.

Competent members have the right to refuse a recommended treatment, counsel or procedure. The physician may regard such refusal as incompatible with the continuance of the physician/patient relationship and provision of proper medical care. If this occurs, and the physician believes that no professionally acceptable alternatives exist, the physician must so inform the member in writing, by certified mail. The physician must give the member 30 calendar days to find another care provider.

During this time, the physician is responsible for providing continuity of care to the member.

Advance Directives

For information on advance directives, refer to *Chapter 15: Member Rights and Responsibilities*.

Documentation and Confidentiality of Medical Records

You are required to maintain records, correspondence and discussions regarding the member in the strictest of confidence and protection.

You must keep a medical records system that:

- Follows professional standards
- Allows quick access of information
- Provides legible information, accurately documented and available to appropriate health care providers
- Maintains confidentiality

Our member should sign a Medical Record Release Form as a part of their medical record. Call Network Management Services (877-670-8432) to request a copy of this form.

The following guidelines are applicable:

- Records that contain medical/clinical, social, financial or other data on a patient is treated as confidential and is protected against loss, tampering, alteration, destruction, or inadvertent disclosure;
- Release of information from your office requires you have the patient sign a Medical Record Release Form. Retain it in the medical record;
- Release of records is in accordance with state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Records containing information on mental health services, substance use, or potential chronic medical conditions that may affect the member's plan benefits are subject to additional specific waivers for release and confidentiality.

Exemption from Release Requirements

HIPAA regulations allow us to give PHI to government programs without member permission. We give this when it is necessary to determine member eligibility.

Medical Records Requirements

You must ensure your medical records meet our standards. The following are expanded descriptions of some of these requirements.

Patient Identifiers: Should consist of the patient name and a second unique identifier, and should appear on each page of the medical record.

Advance Directives: It is your responsibility to provide the member with advance directive information, and to encourage the member to retain a copy for their personal records.

Biographical Information: Each record should contain the patient's name, date of birth, address, home and work phone numbers, marital status, sex, primary language spoken, name and phone number of emergency contact, appropriate consent forms and guardianship information if relevant.

Signatures: For paper medical records, have all entries dated and signed or initialed by the author. Author identification may be a handwritten signature or initials followed by the title (MD, DO, PA, ARNP, RN, LPN, MA or OM). There must be a written policy requiring, and evidence of, physician co-signature for entries made by those other than a licensed practitioner (MD, DO). Electronic signatures are acceptable for electronic medical records.

Family History: Document the family history no later than the first visit.

Past Medical History: Documentation should include a detailed medical, surgical and social history.

Immunizations: Documentation of immunizations performed by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. At a minimum, you must have their vaccination history.

Medication List: List the member's current medications, with start and end dates, if applicable. Reconcile within 30 days post inpatient admissions.

Referral Documentation: If a referral was made to a specialist, the consultation report should be filed in the medical record. There should be documentation the physician has discussed abnormal results with the patient, along with recommendations.

Chart Organization: You should maintain a uniform medical record system of clinical recording and reporting with respect to services, which includes separate sections for progress notes and the results of diagnostic tests.

Preventive Screenings: You need to promote the appropriate use of age/gender specific preventive health services for members to achieve a positive impact on the member's health and better medical outcomes.

Required Encounter Documentation: For every visit, document:

- The date;
- Chief complaint or purpose;
- Objective findings;
- Diagnosis or medical impression;
- Studies ordered (lab, x-ray, etc.);
- Therapies administered or ordered;
- Education provided;
- Disposition, recommendations, instructions to the member and evidence of whether there was follow-up; and
- Outcome of services.

You must document you have a written policy in place regarding follow- up care and written procedures for recording results of studies and therapies and appropriate follow-up.

As a part of their medical record, members should sign a Medical Record Release Form. They should sign a Refusal Form when declining a preventative screening referral.

We recommend medical records include copies of care plans whenever you provide home health or skilled nursing services.

Case Management and Disease Management Program Information

Optum provides Case Management (CM) and Disease Management (DM) services for Medica HealthCare.

Here are the criteria for referrals to Optum CM and DM Programs:

- Complex Case Management — (Special Needs Plan (SNP) members only)
- Three or more unplanned admissions and/or Emergency Room (ER) visits in the last six months or
- Multiple, complex co-morbid conditions and/or
- Coordination of multiple community resources/financial supports to cover basic services
- Heart Failure (HF) Disease Management Program
- Diagnosis of HF and
- Has CHF on an inpatient claim or
- HF admission in last three months
- Diabetes Disease Management Program
- Diabetic with A1C 9% or greater or
- An inpatient admission related to diabetes in the past 12 months or
- Two or more ER visits related to diabetes
- Advanced Illness Case Management — Primary goal is to facilitate and support end of life wishes and services
- Life expectancy of 12 - 18 months
- Chronic, irreversible disease or conditions and declining health
- Reduce disease and symptom burden
- Transplant Case Management and Network Services Bone marrow/stem cell including chimeric antigen receptor T-cell (CAR-T) therapy for certain hematologic malignancies, kidney and kidney/pancreas, heart, liver, intestinal, multi-organs and lung transplants
- Case management for one year post-transplant
- End Stage Renal Disease Case Management — The member is diagnosed with end stage renal disease and is undergoing outpatient dialysis including in-center or home hemodialysis, home peritoneal dialysis, etc.

If the member does not qualify for one of the above programs, they do have 24/7, 365 days a year access to speak with a nurse by calling the Optum NurseLine number on the back of their ID card.

NOTE: South Florida Medica no longer provides Social Worker evaluations without skilled services. Please direct your patient to their local social services department or The Florida State Department of Elder Affairs Help Line at 800-963-5337.

To request CM or DM services for one of our members, select only one program that your member meets the criteria for, and email the CM/DM referral form, available on medicaplans.com > Physicians and Providers > **Provider Forms**, to **southfl@optum.com**.

When appropriate, we provide referrals to other internal programs such as disease management, complex condition management, mental health, employee assistance and disability. Case management services are voluntary and a member may opt out at any time.

Optum Behavioral Health

We work with Optum Behavioral Health to provide behavioral health care services for our members. For more information on how to access the Behavioral Healthcare programs, you or our members may contact a representative through the phone number listed on the back of their health care ID card.

Special Needs Plans (SNP)

SNP Model of Care (MOC)

The MOC is the framework for care management processes and systems to help enable coordinated care for SNP members. The MOC contains specific elements

that delineate implementation, analysis and improvement of care.

These elements include description of SNP population (including health conditions), Care Coordination, Provider Network and Quality Measurement and Performance Improvement.

The MOC is a quality improvement tool and MOC helps ensure the unique needs of our SNP members are identified and addressed through care management practices. MOC goals are evaluated annually to determine effectiveness. To learn more, contact us via email at: snp_moc_providertraining@uhc.com.

The Centers for Medicare and Medicaid (CMS) requires annual SNP MOC training for all care providers who treat SNP members. The Annual SNP MOC Provider Training is available at UHCprovider.com. Reminders about training requirements are communicated annually through the Network Bulletin described in *Chapter 17*.

Risk Management

Risk management addresses liability, both proactively and reactively. Proactive is avoiding or preventing risk. Reactive is minimizing loss or damage after an adverse or bad event. Risk management in health care considers patient safety, quality assurance and patients' rights. The potential for risk is present in all aspects of health care, including medical mistakes, electronic record keeping, provider organizations and facility management.

An adverse event is defined as an event over which health care personnel could exercise control rather than as a result of the member's condition. Identifying something as an adverse event does not imply "error," "negligence," or poor quality care. It simply indicates an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process. Examples of adverse events in health care include unexpected death, failure to diagnose or treat disease, or surgical mistakes or accidents. Adverse events interfere with a care provider's delivery of medical care and may result in litigation.

Agency for Healthcare Administration (AHCA)

The Florida Agency for Healthcare Administration (AHCA), as directed under F.S. 641 Parts I, II, III and other applicable state laws, provides oversight and monitoring of health plans operating in the State of Florida as an HMO and their compliance to applicable regulations. This includes implementation of a Risk Management Program (RMP) with the purpose of identifying, investigating, analyzing and evaluating actual or potential risk exposures by a state licensed risk manager. The RMP also corrects, reduces and eliminates identifiable risks through instruction and training to staff and care providers.

Examples of adverse and serious incidents as defined by AHCA include:

- Death of a patient;
- Severe brain or spinal damage to a patient;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong site surgical procedure; or
- Performance of a wrong surgical procedure.

For more information, go to the AHCA website at ahca.myflorida.com.

Provider Reporting Responsibilities

You are required to report all adverse events identified above, whether actual or potential. To report such incidents, call 877-504-1179.

You must report incidents to AHCA within 24 hours of it happening. You must report all serious incidents, such as those listed below, immediately. This allows us to quickly assess the risk and address liability. Examples of serious incidents include:

- Death or serious injury;
- Brain or spinal damage;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong site surgical procedure;
- Performance of a wrong surgical procedure;
- Medically unnecessary surgical procedure;
- Surgical repair of damage from a planned surgical procedure; or
- Removal of unplanned foreign object remaining from a surgical procedure.

Our provider contracts include the obligation to participate in Quality Management inquiries upon request from the Clinical Quality Analyst.

What are the Responsibilities of Physicians and Providers?

You must report the ICD-10-CM diagnosis codes to the highest level of specificity and accurately. This requires accurate and complete medical record documentation. You are required to alert the MA organization of wrong information submitted. You must follow the MA organization's procedures for correcting information.

Finally, you must report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

Links to resources for the latest ICD guidelines and MRA resources are available online at medicaplans.com.

CPT and HCPCS Codes

The American Medical Association (AMA) and the CMS update procedure codes quarterly, with the largest volume effective January 1 of each year. CPT and HCPCS codes may be added, deleted, or revised to reflect changes in health care and medical practices.

If you submit your claim with an invalid or deleted procedure code, we will deny or return it. A valid procedure code is required for claims processing.

We encourage you to access CPT, HCPCS and ICD-10 coding resources and materials at the AMA's website at **ama-assn.org**, or from another vendor.

Mid-Atlantic Regional Supplement

Applicability of This Supplement

This Mid-Atlantic Regional Supplement applies to services provided to members enrolled in:

- MD-Individual Practice Association, Inc. ("M.D. IPA") and M.D. IPA Preferred, or
- Optimum Choice, Inc. ("Optimum Choice"), and Optimum Choice Preferred, and Optimum Choice Small Business Health Options Program (SHOP).

It may apply to care providers in DE, DC, MD, PA, VA, WV; reference your Agreement for applicability.

Care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For protocols, policies and procedures not referenced in this supplement refer to appropriate chapter in the main guide.

A complete list of Mid-Atlantic Healthplan Protocols pertaining to M.D. IPA, M.D. IPA Preferred, Optimum Choice, and Optimum Choice Preferred may be located on **UHCprovider.com/plans** > Choose Your State.

The term "prior authorization" referenced in this supplement is also referred to as "preauthorization". We use both terms in this supplement. They mean the same.

Product Summary

This table provides information about M.D. IPA and Optimum Choice products for the Mid-Atlantic Region.

Attributes	M.D. IPA and Optimum Choice	M.D. IPA Preferred and Optimum Choice Preferred
How do members access physician and health care professionals?	Members choose a PCP who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care.	**Network benefits:** Members choose a PCP who arranges or coordinates care, with the exception of emergency services, network OB/GYN and routine eye refraction care. **Out-of-network benefits:** Members are not required to have care arranged or coordinated by a PCP.
Does a PCP have to write a referral to a specialist?	**Yes;** except for visits to a network OB/GYN, routine eye refraction care, or emergency services.	**Network benefits:** Yes, except for visits to a network OB/GYN, routine eye refraction care, or for emergency services. **Out-of-network benefits:** No referral needed.
Is the treating physician required to obtain prior authorization for procedures or services?	**Yes**; please view the section on *Prior Authorizations* process located within this supplement. Find a complete list of codes requiring prior authorization on UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > **UnitedHealthcare Mid-Atlantic Plan Notification/ Prior Authorization Requirements**.	**Yes**; please view the section on *Prior Authorizations* process located within this supplement. Find a complete list of codes requiring prior authorization on **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources > **UnitedHealthcare Mid-Atlantic Plan Notification/Prior Authorization Requirements**.

UnitedHealthcare Optimum Choice Small Business Health Options Program (SHOP)

For information refer to *Chapter 3: Commercial Products*, Health Insurance Marketplace (Exchanges).

Key Points	Optimum Choice Small Business Health Options Program (SHOP) Exchange
Product Name	Optimum Choice, Inc.
How do members access physicians and health care professionals?	For each covered family member, members choose a network PCP, or are assigned a PCP, to manage the member's care and generate referrals to network specialists when required.
Is a special referral required?	**Yes,** on selected procedures. See guidelines in the referral requirements section of Mid-Atlantic Supplement.
Are treating physicians and/or facilities required to request prior authorization when providing certain services?	**Yes,** on selected procedures. See guidelines in the Prior Authorization List located on **UHCprovider.com/priorauth**.

UnitedHealthcare Optimum Choice Health Savings Account (HSA) Plan

The Optimum Choice and Optimum Choice Preferred HSA benefit plans are high-deductible medical benefit plans that combine our traditional gated HMO benefit plans with an HSA option. Expenses under this benefit plan are the member's responsibility until their deductible is reached. HSA benefit plans require reimbursement for services provided to members are based on a fee-for-service reimbursement methodology.

Key Points	Optimum Choice, Inc. Health Savings Account
PCP Requirement	The Optimum Choice HSA product requires each UnitedHealthcare member to choose a PCP.
PCP Referrals to Network Specialists	The member's PCP generates referrals for specialty care and facility care.
Reimbursement	Services for members enrolled in Optimum Choice HSA are excluded from your capitation payment and are paid on a fee-for-service (FFS) basis per the All Payer Payment Appendix included in the UnitedHealthcare physician Agreement.
Optimum Choice HSA Member Health Care ID Card	The Optimum Choice HSA product name and member's PCP are indicated on the member's health care ID card. Specialist referral requirements are on the back of the health care ID card. When confirming eligibility, please use **eligibilityLink**.

Provider Responsibilities

For detailed information and instructions on verifying eligibility, the choice and role of the PCP and other care provider requirements, refer to *Chapter 2: Provider Responsibilities and Standards*.

Eligibility and Health Care ID Cards

ID card information may vary by health benefit plan. For example, some members may have health care ID cards which indicate M.D. IPA Preferred or Optimum Choice Preferred benefits. You can see an image of the ID card specific to the member when you verify the member's eligibility. For more information on ID cards and to see a sample health care ID card, refer to the *Health Care Identification (ID) Cards* section of Chapter 2: Provider Responsibilities and Standards.

Please check the member's health care ID card during each member visit, and keep a copy of both sides of the health care ID card for your records. Possession of a health care ID card is not proof of eligibility. Before seeing a member, it is important you verify their eligibility and benefits, as well as the member's PCP selection, to avoid payment issues. Go to **UHCprovider.com/eligibility**.

The following unique features are located on M.D. IPA and Optimum Choice health care ID cards:

1. Laboratory provider information is located on the front of the cards; please see the *Laboratory Requirements* section of this supplement.
2. Radiology county information is located on the front of the cards; please see the *Radiology Services* section of this supplement.
3. Information regarding the necessity of referral and prior authorization requirements is now listed on the back of the cards.

Laboratory Requirements

M.D. IPA and Optimum Choice members must use the medical laboratory noted on their health care ID card for medical laboratory services. Any specimens collected in the office MUST be sent to the laboratory indicated on the member's health care ID card. Depending on where the member lives, the health care ID card shows:

- LAB = LABCORP (Laboratory Corporation of America).
- LAB = PAR (may use any participating outpatient commercial medical laboratory). Our online directory of health care professionals is available on **UHCprovider.com/findprovider**.

Refer to **UHCprovider.com/plans** > Choose Your State.

Radiology Services

M.D. IPA and Optimum Choice members must use the radiology county noted on the health care ID card. Depending upon the member's Primary Care Provider's office location, the health care ID card shows:

- RAD = PAR (may use any office based participating provider) A complete list of these providers may be found on **UHCprovider.com/findprovider**.
- RAD = County (the name of a county, i.e., "MONT [Montgomery County]" is listed on the card)

A complete list of county specific radiology vendors is found on **UHCprovider.com/plans** > (Choose Your State) > Commercial > Radiology Vendors.

Copays

Please verify the member's copayments when verifying their eligibility.

Member PCP Requirements

A PCP is defined as a physician specializing in family practice, internal medicine, pediatrics, or general practice. Other care providers will be included as primary physicians as required by state mandates. Members are required to see their PCP or a covering physician at the address location that shares the same TIN listed on the Patient Eligibility screen. Some PCPs have multiple TINs but may not participate under each of those TINs for the member's benefit plan. Before scheduling an appointment, it is important to verify the member's assigned PCP and the

TIN listed on the Patient Eligibility screen is the same TIN for the address location where the member will be seen. Please submit your address corrections through the My Practice Profile Link, or call the phone number on the back of the member's health care ID card before seeing the member.

UnitedHealthcare of the Mid-Atlantic region may close a PCP panel if a member complains about access, or if UnitedHealthcare of the Mid-Atlantic region identifies a quality-related issue.

For requests about panel status (i.e., Open/Closed to New/Existing Patients), please contact your Network Account Representative 30 calendar days before any action. To find your Network Account Representative, go to UHCprovider.com > (scroll down) > **Contact Us** > Find a Network Contact > Select your state. Members are required to select a network PCP, or a PCP is auto-assigned.

Direct Access Services

Female members may receive obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN, family practice physician, or surgeon identified by the medical group/IPA or UnitedHealthcare as providing OB/GYN physician services. This means the member may receive these services without prior authorization or a referral from her PCP. In all cases, the physician must be affiliated with the member's assigned medical group/IPA and participating with UnitedHealthcare.

Referrals

For referral process information, check the Mid-Atlantic Health Plan Referral Protocol located on **UHCprovider.com/plans** > Choose Your State > Commercial Plans > Mid-Atlantic Health Plan > Referral Protocol for M.D.IPA, M.D.IPA Preferred, Optimum Choice, and Optimum Choice Preferred for:

- Referral submission requirements
- Maximum number of referral visits
- Exceptions for specific specialists or treatments

Referrals are not required when M.D. IPA or Optimum Choice is the secondary carrier.

Find forms and specific referral processes for some treatments on **UHCprovider.com/plans** > Choose Your State > Commercial Plans > Mid-Atlantic Health Plan.The referral form is hyperlinked within the protocol titled "Referral Protocol for M.D.IPA, M.D.IPA Preferred, Optimum Choice and Optimum Choice Preferred".

Prior Authorizations

How to Submit

There are multiple ways to submit prior authorization requests to UnitedHealthcare, including electronic options. To avoid duplication, once a prior authorization is submitted and confirmation is received, please do not resubmit.

- **Online:** **UHCprovider.com/priorauth** (for information and prior authorization lists)
- **Link:** use the Prior Authorization and Notification tool at **UHCprovider.com/paan**.
  - For medical benefit injectable specialty medications that require prior authorization, use the Specialty Pharmacy Transactions tile on your Link dashboard at **UHCprovider.com/paan**.
- **Phone:** 877-842-3210. Clinical Services staff are available during the business hours of 8 a.m. to 8 p.m. ET.

Find the forms referenced below on the UHCprovider.com/priorauth > **Advance Notification and Plan Requirement Resources** webpage.

Radiology Prior Authorization Requests and Prior Authorization List

Prior authorization requests for radiology may be submitted electronically using our online prior authorization tool. M.D. IPA and Optimum Choice are not part of the UnitedHealthcare Radiology Prior Authorization Program. Refer to the **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources > UnitedHealthcare Mid-Atlantic Health Plan Notification/ Prior Authorization Requirements.

Outpatient Rehabilitation (Physical, Occupational, and Speech Therapy) Prior Authorization Request

Prior authorization requests for physical, occupational, speech, and other therapy-related service may not be submitted electronically. Fax these prior authorization requests to the Clinical Care Coordination Department at 888-831-5080 using the Rehabilitation Services Extension Request Form found at **UHCprovider.com/plans** > Choose Your State.

Chiropractic Services Prior Authorization Request

Prior authorization requests for chiropractic services may not be submitted electronically. Fax these prior authorization requests to the Clinical Care Coordination Department at 888-831-5080 using the Chiropractic Services Extension Form, found on **UHCprovider.com/plans** > Commercial Plans > Mid-Atlantic Health Plan, along with a copy of the current Consultant Treatment Plan (PCP Referral).

Please allow two business days for extension request decisions. Missing information may result in a delayed

response. Decisions are based on the member's plan benefits, progress with the current treatment program, and submitted documentation.

Exception Requests

All exceptions to our policies and procedures must be preauthorized by submitting a request online at UHCprovider.com/paan or by phone at 877-842-3210. The most common exception requests are:

- Immunizations (outside the scope of health benefit plan guidelines), and
- Referral of an HMO member out-of-network to a non-participating physician, health care practitioner or facility.

Prior authorization is required for elective outpatient services. It is the physician's responsibility to obtain any relevant prior authorization. But the facility should verify prior authorization is obtained before providing the service. If the facility does not get the required prior authorization, we may deny payment. Final coverage and payment decisions are based on member eligibility, benefits and applicable state law.

If you have a question about a pre-service appeal, please see the section on *Pre-Service Appeals* under *Chapter 6: Medical Management*.

Inpatient Admission Notification

It is the facility's responsibility to notify UnitedHealthcare within 24 hours after weekday admission (or by 5 p.m. ET the next business day if 24-hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5 p.m. ET the next business day.

For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us as soon as they know the information and explain the extenuating circumstances. Facilities are responsible for providing admission notification for inpatient admissions, even if advance notification was provided by the physician and coverage approval is on file.

Prior authorization is required for all elective inpatient admissions for all M.D. IPA and Optimum Choice members. It is the admitting physician's responsibility to obtain the relevant prior authorization. But the facility should verify that prior authorization is obtained before the admission. Payment may be denied to the facility and attending physician for services provided in the absence of prior authorization. Prior authorization doesn't guarantee coverage or payment. All final coverage and payment decisions are based on member eligibility, benefits and applicable state law.

Skilled Nursing Facility (SNF) placements do not require prior authorization. You must verify available benefit and notify us within one business day of SNF admission.

Maryland Facility Variations from the Standard Notification Requirements for Facilities

For information specific to members in Maryland, please refer to UHCprovider.com/priorauth > Prior Authorization and Notification Program Summary > and scroll down.

Admission Notification Requirements

Phone: 800-962-2174 or Fax: 844-831-5077.

Once we receive your notification, we begin a case review. If notification isn't provided in a timely manner, we may still review the case and request other medical information. We may retroactively deny one or more days based upon the case review. If a member receiving outpatient services needs an inpatient admission, you must notify us as noted above. Emergency room services resulting in a covered admission are payable as part of the inpatient stay as long as you have notified us of the admission as described.

Delay in Service

Facilities that provide inpatient services must maintain appropriate staff resources and equipment to help ensure covered services are provided to members in a timely manner. A delay in service is defined as any delay in medical decision-making, test, procedure, transfer, or discharge not caused by the member's clinical condition. Services should be scheduled the same day as the physician's order. However, procedures in the operating room, or another department requiring coordination with another physician, such as anesthesia, may be performed the next day unless emergent treatment was required. A service delay may result in sanctions of the facility and non-reimbursement for the delay days, if permissible under state law.

A clinical delay in service is assessed for any of these reasons:

- Failure to execute a physician order in a timely manner, resulting in a longer length of stay.
- Equipment needed to fulfill a physician's order is not available.
- Staff needed to fulfill a physician's order is not available.
- A facility resource needed to fulfill a physician's order is not available.
- Facility doesn't discharge the member on the day the physician's discharge order is written.

Concurrent Review

Review is conducted onsite at the facility or by phone for each day of the stay using criteria. Your cooperation is required when we request information, documents or discussions such as clinical information on member status and discharge planning. If criteria aren't met, the case is referred to a medical director for assessment. We deny payment for facility days that don't have a documented need for acute care services. We require physicians' progress notes be charted for each day of the stay. Failure to document will result in denial of payment to the facility and the physician.

Facility Post-Discharge Review
A post-discharge review is conducted when a member has been discharged before notification to UnitedHealthcare occurs or before information is available for certification of all the days. A UnitedHealthcare representative will request the member's records from the Medical Records Department or assess a review by phone and review each non-certified day.

Inpatient days that don't meet acuity criteria are referred to a medical director for determination and may be retrospectively denied. Delays in service or days that don't meet criteria for level of care may be denied for payment.

Facility-to-Facility Transfers
The facility must notify us of a facility-to-facility transfer request. In general, transfers are approved when:

- There is a service available at the receiving facility that isn't available at the sending facility,
- The member would receive a medically appropriate level of care change at the receiving facility, or
- The receiving facility is a network facility and has appropriate services for the member.

If any of the above conditions aren't met, transfer coverage is denied. Services at the receiving facility will be approved if:

- Medical necessity criteria for admission were met at the receiving facility, and
- There were no delays in providing services at the receiving facility.

Injectable Medications

Drugs requiring both prior authorization and use of a specific vendor: this protocol applies when you obtain specialty medications, including prescription ordering and purchase. You must use a participating specialty pharmacy in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare. The specialty pharmacy bills us for the medication. You only need to bill us for administration of the medication and not for the medication itself.

The specialty pharmacy will advise the member of any medication cost-share responsibility and arrange for collection of payment (if applicable) before dispensing the medication to the physician's office. For more information, please refer these resources:

- The Preauthorization Code List located in the Mid-Atlantic Healthplan Protocols.
- A listing of specialty drug codes that require procurement through a designated specialty pharmacy.
- UHCprovider.com/priorauth > Prior Authorization and Notification Resources > **Clinical Pharmacy and Specialty Drugs**. **Note:** you may be required to include the member's specific diagnosis for payment.
- Information on our medical evidence-based policies is available on: UHCprovider.com/policies > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans**.

You can submit prior authorization requests by phone or use the Specialty Pharmacy Transactions tile on your Link dashboard at **UHCprovider.com/paan**.

Please include clinical notes, if prompted to do so. List the specialty pharmacy vendor as the servicing provider in the case. We will call you within three business days if the conditions aren't met for prior authorization of the drug. If authorized, we will provide a written confirmation.

Specialty pharmaceutical vendor information is available on **UHCprovider.com/specialtyrx**.

Clinical Appeals

To appeal an adverse decision (a decision by us to not prior authorize a service or procedure, or a payment denial because the service wasn't medically necessary or appropriate), you must submit a formal letter that includes your intent to appeal, justification for the appeal and supporting documentation. The denial letter will provide you with the filing deadlines and the address to submit the appeal.

Urgent Appeal Submissions:

Medical fax: 801-994-1083

Pharmacy fax: 801-994-1058

Claims Process

Please refer to *Chapter 9: Our Claims Process* for detailed information about our claims process.

All claims that can be submitted electronically must be submitted to payer ID 87726.

Reconsideration and Appeals Processes

For claim reconsiderations for M.D. IPA and Optimum Choice, please submit your request online using **claimsLink**.

Capitation

Capitation payment will be paid to the practice for covered services per member per month (PMPM). The PCP receives separate capitation payments for members of M.D. IPA and Optimum Choice monthly, on the fifth day of each month.

The PMPM is calculated by multiplying the fixed monthly rates (detailed in the Capitation Rate Schedule contained in your Agreement) by the number of members who have selected or been assigned to a PCP within the practice.

Payment Rules

The capitation payment for a given month is calculated based on the 15/30 rule. This rule is used to determine whether a capitation payment is made for the full month or not at all. If the effective date of member change falls between the first and 15th of the month, the change is effective for the current month. If the effective date of the member change falls on or after the 16th of the month, the capitation adjustment is reflected on the first of the following month. As such, retroactive adjustments to capitation payments may be made based on the member's eligibility on the 15th of the month.

15/30 Rule	For purposes of capitation payments, members are added on the first day of the month or terminated on the last day of the month, with the exception of newborns, which are added on the date of their birth(s). Capitation is paid for full months, and conversely recouped for full months if appropriate. For example: **Retroactive Add:** A member added retroactively on the 14th of the month would generate a capitation payment for the entire month. However, a member added on the 16th or later would not generate a capitation payment, even though the member would be considered eligible for services. To help you identify these members, the member's standard services capitation is reported as $0.
	Retroactive Term: A member retroactively terminated between the first and 14th of the month would generate a capitation recoup entry for the capitation previously paid for the entire month. However, a member retroactively terminated on the 16th or later would not generate a capitation recoup entry for the capitation previously paid for the entire month.

UnitedHealthcare of the Mid-Atlantic region provides Capitation Reports to PCPs, as described below:

ECap Report Name	ECap Report Purpose
7030-A01: Capitation Analysis Summary – Provider Medical Group Report	High-level capitation information by current and retro periods for each care provider.
7010-A01: Capitation Paid ECap – Provider Medical Group Report – Summary	A contract-level report that summarizes the capitation paid by current and retro periods. The three sections of the report include amounts for: 1. Standard services 2. Supplemental benefits and capitated adjustments 3. Non-capitated adjustments and withholds
7010-A02: Capitation Paid ECap – Primary Care Provider Report - Detail	A PCP-level report that summarizes the capitation paid by current and retro periods. The three sections of the report include amounts for: 1. Standard services 2. Supplemental benefits and capitated adjustments 3. Non-capitated adjustments and withholds
7210-A01: Capitation Details – Primary Care Provider Report for Standard Services-(PMG)	Detailed capitation information for each current member assigned to a PCP.
7240-A01: Member Changes Capitation Details – Primary Care Provider Report for Standard Services-(PMG)	Detailed retroactive change information on added, changed and terminated members. The three sections of the report include information on: 1. Member adds 2. Member demographic changes 3. Member terms
7290-A01: Capitation Adjustment Details – Primary Care Provider Report- (PMG)	Capitation adjustment details for member and provider-level guide adjustments. The two sections of the report include information on: 1. Current period 2. Retro period

The PCP practice should reconcile the capitation payment and report upon receipt. Requests for an adjustment or reconciliation of the capitation payment must be made within 60 calendar days of receipt. If the PCP/medical group (practice) does not request reconsideration of the capitation payment within 60 days, the capitation payment provided is accepted as payment in full (as per contract). You may obtain copies of the reports above by calling Provider Services at 877-842-3210.

Bill Above

In addition to the capitation payments, certain covered services are eligible for reimbursement. To obtain a copy of this information, please contact your Network Representative. To locate your Network Representative, please go to UHCprovider.com > Support and Privacy > Contact Us > **Find a Network Contact** > select your state.

Neighborhood Health Partnership Supplement

Applicability of This Supplement

The Neighborhood Health Partnership (NHP) Supplement applies to covered services provided to members enrolled in NHP benefit plans when you fit into these two categories:

1. Your Agreement with UnitedHealthcare includes a reference to the NHP protocols or guides, or you have directly contracted with NHP to participate in networks maintained for NHP members.
2. You are located in the NHP service area, which is expanding.

NHP Flex Benefit Plans: This supplement does not apply to care providers located outside the NHP service area.

NHP participating care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For protocols, policies and procedures not referenced in this supplement, please refer to appropriate chapter in the main guide.

The term "prior authorization" referenced in this supplement is also referred to as "pre-certification". We use both terms in this supplement.

How to Contact NHP

Resource	Where to go	
Provider Website	Link and UHCprovider.com • Policies: UHCprovider.com/policies > Commercial Policies • Provider news and updates, such as the Network Bulletin **Note:** You must register to access some of the features available to you. Go to UHCprovider.com/newuser.	
Provider Services Advance Notifications, Prior Authorizations, Admission Notifications	**Phone:** 877-842-3210 **EDI:** See EDI transactions and code sets on UHCprovider.com/edi. We accept EDI 278 submissions directly to UnitedHealthcare or through a clearinghouse. Be sure to include the CPT codes for your request. **Online:** UHCprovider.com/priorauth **Phone:** United Voice Portal, 877-842-3210 **Fax:** Only Admission Notifications to 844-831-5077. Submit Advance Notifications and Prior Authorizations online or by calling 877-842-3210. See member's health care ID card for specific service contact information.	
Appeals		
Urgent Appeals	**Urgent Appeals Fax** Medical: 801-994-1083 Pharmacy: 801-994-1058	
Standard Preservice Appeals	**Standard Appeals Address:** UnitedHealthCare PO Box 30559 Salt Lake City, UT 84130 **Standard Appeals Fax:** Medical: 801-938-2100 Pharmacy: 801-994-1345	
Breast Pumps	Lincare: 855-236-8277 Byram Medical: 877-902-9726 Edgepark Medical: 888-394-5375	lincare.com byramhealthcare.com edgepark.com

Resource	Where to go
Cardiology: Prior authorization of cardiology services as described in the *Outpatient Cardiology Notification/Prior Authorization Protocol* section of this guide.	**Online:** UHCprovider.com/cardiology **Phone:** 888-397-8129
Chiropractic Services Information	Quality Managed Healthcare, Inc. **Phone:** 954-236-3143 **Fax:** 954-236-3254
Claims	**EDI:** UHCprovider.com/edi., Payer ID: 87726 The ERA payer ID number is also changing to 87726. If you would like to receive 835 ERA files for NHP, or if you currently receive 835 ERA files for NHP under payer ID 95123 or 96107, please contact your vendor to enroll under payer ID 87726. The health care ID card for members who have transitioned indicates payer ID 87726. **Link:** UHCprovider.com/claimslink **Online:** UHCprovider.com/claims (policies, instructions and tips) **Phone:** 877-842-3210 (Follow the prompts for status information.)
Claims (Paper)	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800
Durable Medical Equipment/ Respiratory & Commodity Services (Oxygen, CPAP, hospital beds, standard wheelchairs)	Apria: 855-613-8303 apria.com Lincare 855-236-8277 lincare.com Rotech: 877-623-5272 rotech.com
EDI Support	**Online:** UHCprovider.com/edi **Phone:** 866-509-1593
Eligibility Verification • Verify primary care physician • Verify eligibility and benefits • Check claim(s) status • Obtain status of referrals • Office visit copay • Inpatient copay • Prescription drug copay (if applicable)	**EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse **Online:** Using eligibilityLink **Phone:** 877-842-3210
Home Health Services	Lincare: 855-236-8277 lincare.com Byram Medical: 877-902-9726 byramhealthcare.com Edgepark Medical: 888-394-5375 edgepark.com
Home Infusion Services (including enteral)	Orsini Health: 800-240-9572 orsinihealthcare.com ExpressScripts: 855-315-3590 accredo.com OptionCare (Walgreens) Infusion: 800-683-5252 walgreenshealth.com
Insulin Pumps and Supplies National Vendors	Minimed Distribution Group (Medtronic): 800-933-3322 minimed.com
Intensity Modulated Radiation Therapy (IMRT)	**Link:** Use the Prior Authorization and Advance Notification tool at UHCprovider.com/paan. **Online:** UHCprovider.com/oncology > Commercial Intensity Modulated Radiation Therapy Program (program information) **Phone:** 877-842-3210

Resource	Where to go
Medical Supply Providers (Disposable supplies, ostomy, urological, incontinence supplies)	Byram Medical: 877-902-9726 byramhealthcare.com Edgepark Medical: 888-394-5375 edgepark.com Liberty Medical: 800-615-0714 libertymedical.com Medline: 800-633-5463 medline.com McKesson: 855-404-6727 mckesson.com/providers/home-care/mckesson-patient-care-solutions/
Mental Health Services Prior Authorization Optum Behavioral Health	**Phone:** 800-817-4705
Outpatient Injectable Chemotherapy and Related Cancer Therapies	**Online:** UHCprovider.com/oncology **Phone:** 888-397-8129
Pharmacy (OptumRx)	**Online:** professionals.optumrx.com > Prior Authorizations **Prior Authorization:** 800-711-4555 **Specialty Pharmacy Customer Service:** 888-739-5820
Physical, Occupational and Speech Therapy (OptumHealth)	**Phone:** 800-873-4575 **Fax:** 248-733-6070
Podiatry Foot and Ankle Network (FAN) Prior Authorization and Advance Notification	**Phone:** 305-363-5160 **Fax:** 305-557-3810 **EDI:** Transactions (278A) and (278N). **Online:** UHCprovider.com/priorauth **Link:** UHCprovider.com/paan **Phone:** 877-842-3210 (if you do not have access to electronic services)
Radiology/Advanced Outpatient Imaging Procedures: Prior authorization of radiology services as described in the *Outpatient Radiology Notification/Prior Authorization Protocol* section of this guide	**Online:** UHCprovider.com/radiology **Phone:** 866-889-8054
Substance Use Services	United Behavioral Health (UBH), operating under the brand Optum **Phone:** 800-817-4705
Case Management	• Congenital Heart Disease: 877-842-3210 • Kidney Resource Services: 877-842-3210 • Ventricular Assist Devices: 877-842-3210 or fax 855-282-8929 • Transplant Resource Services: 877-842-3210 or fax 855-250-8157

Discharge of a Member from Participating Provider's Care

Please refer to the section *Member Dismissals Initiated by a PCP*, Chapter 2: Provider Responsibilities, for more information.

Laboratory Services

Direct all NHP members to LabCorp, Inc. service centers for outpatient laboratory (lab) procedures. If a participating care provider draws the specimen in the office, send the specimen to LabCorp, Inc.

Home health care agencies are responsible for delivery of drawn specimens to one of the LabCorp, Inc. service centers.

We pay lab services according to your Agreement. They must be performed by a participating care provider that is a facility for:

- Emergency room services;
- Chemotherapy;
- Ambulatory surgery;
- Transfusions; or
- Hemodialysis.

LabCorp, Inc. must process clinical laboratory specimens drawn at a skilled nursing facility.

Use of Non-Participating Laboratory Services

This applies to all participating care providers. It also applies to laboratory services, clinical and anatomic, ordered by any practitioner.

You are required to refer laboratory services to participating laboratories, except as otherwise authorized by NHP. To get more information on participating laboratories:

- Go to **LabCorp.com** or call 800-833-3984, option #3 to determine how to conveniently access their services.
- Call Provider Services at 877-842-3210.

In the unusual circumstance you require a specific laboratory test for which you find no participating laboratory is available, please contact NHP UM at 877-842-3210.

LabCorp requires this information to make sure accurate testing and billing:

- Member's NHP health care ID number
- LabCorp requisition forms with all required fields completed
- Specific test orders using test codes
- Diagnosis codes

Referrals

The PCP is responsible for determining when the member needs a referral. Only the PCP may make an initial referral. These must be made to participating care providers. We deny claims for services rendered without a proper referral. You may not bill the member for those services unless, prior to receiving the service, the member agrees in writing:

1. That the referral is not in place or the service is not a covered service, and
2. To be financially responsible for the cost of the service.

Referrals to a specialist may be necessary:

- When a member fails to respond to current medical treatment.
- To confirm or establish a member's diagnosis and/or treatment modality.
- To provide diagnostic studies, treatments or procedures that range beyond the scope of the PCP. PCPs may make referrals to a specialist according to the Specialty Referral Guidelines section.

These specialty services do not require referral:

- Chiropractic (subject to benefit limitations)
- Dermatology (five visits per calendar year)
- Gynecology
- Podiatry*
- Substance use treatment*
- Mental health*

Out-of-Network Referrals

Out-of-network referrals are only approved when the services are not available from a participating care provider. Request out-of-network referrals by calling NHP at 877-842-3210. Once we receive the referral, the data will be reviewed and, if approved, entered into the system to help ensure payment of the specialist claims.

Specialty Referral Guidelines

- Once the specialty services have been properly authorized, the member or PCP may schedule an appointment with the specialist.
- Please submit specialist referrals online using **referralLink**.
- We mail an authorization letter to the specialist for the member's medical record.
- We do not pay specialist claims without a referral.
- The specialist should re-verify the member's eligibility at the time of visit by calling Provider Services 877-842-3210. Please refer to the back of the member's health care ID card to help ensure the appropriate Provider Services department is contacted.

* See the prior authorization section of this supplement.

Call 800-817-4705 for behavioral health service requests.

All NHP HMO members require a referral before scheduling appointments for specialty services.

Obstetrics

A member may self-refer to an NHP obstetrician who is a participating care provider for routine obstetrical (OB) care. If the member is referred to a non-participating specialist, the specialist must notify us through **UHCprovider.com** or by calling 877-842-3210 to make sure accurate claims payment for ante- and postpartum care.

- Plain film radiography performed by an NHP participating care provider or in the obstetrician's office during an authorized visit, does not require prior authorization.
- Routine labs performed in the obstetrician's office, or that are provided by a participating care provider in support of an authorized visit, do not require prior authorization.
- Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician's office that do not require prior authorization may be performed.

Utilization Management (UM)

Submit your request electronically using one of the methods outlined in the *How to Contact NHP* section.

Be sure to include the place of service and CPT codes in your request.

If you do not have electronic access, you may submit prior authorization requests by phone.

Prior Authorization Requirements

All NHP members require prior authorization for the services listed on the Prior Authorization List located on UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > **Neighborhood Health Partnership Advance Notification Guide**.

Except as otherwise provided, NHP requires prior authorization prior to these admissions:

- All hospital admissions*
- Inpatient rehabilitation facility
- Skilled nursing facility
- Long term acute care facility
- Special care unit

You must provide clinical information to support the medical necessity of the admission and/or observation stay, by the next business day following the admission. Final determinations are made by a medical director, as appropriate.

* Admissions from the emergency room, to the ICU/CCU, or admission for emergency surgery must be Post-certified by the next business day following admission.

Drug Prior Authorization

To promote appropriate utilization, NHP requires prior authorization for certain medications dispensed through the pharmacy (prescription drug benefit) and/or incident to a physician's service (medical benefit). If the medication is to be dispensed by a participating pharmacy or to NHP UM if the medication is to be provided incidental to a physician's service, the care provider must provide clinical information to OptumRx. Prior authorization does not guarantee coverage.

For a full description of our clinical programs on medications dispensed through the outpatient pharmacy benefit, please refer to **UHCprovider.com**. To determine medications available through the pharmacy benefit, go to **UHCprovider.com/priorauth** > Clinical Pharmacy and Specialty Drugs.

Chemotherapeutic agents administered through the medical benefit require prior authorization. For the most current and complete list, go to **UHCprovider.com/priorauth/oncology**.

Pharmacy Drug PA Requests

OptumRx
Online: **professionals.optumrx.com**

Phone: 800-711-4555

NHP Medical Drug PA Requests

Online: Use the Specialty Pharmacy Transactions tile on your Link dashboard at **UHCprovider.com/paan**.

Phone: 877-488-5576

Concurrent Review

The continued stay for all inpatient admissions must be certified through the concurrent review process. Upon request, you must submit to NHP or its delegated entities, by phone, or fax, sufficient clinical information to:

- Certify the continued stay,
- Allow the review of the member's medical status during an inpatient stay,
- Extend the member's stay,
- Coordinate the discharge plan,
- Determine medical necessity at an appropriate level of care, and
- Perform quality assurance screening.

All discharge planning and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management. This includes OB care. If the diagnosis or treatment of a member is delayed secondary to the inability of the facility to provide a needed service, payment for these days is denied, including but not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in

obtaining requested consultations, and late rounding by the admitting physician.

Reimbursement for continued stay that does not meet NHP medical necessity criteria is denied. The member may not be billed for these services unless they have signed a waiver of liability or the services are denied as non-covered services. The member is held harmless in these proceedings.

Claims Reconsiderations and Appeals

Claim Reconsideration

Please refer to *Claim Reconsideration and Appeals Process* section located in Chapter 9: Our Claims Process for detailed information about the reconsideration process.

Your documentation should clearly explain the nature of the review request.

If you are unable to use the online reconsideration and appeals process outlined in Chapter 9: Our Claims Process, mail or fax appeal forms to:

UnitedHealthcare Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432
Fax: 801-938-2100

You have one year from the date of occurrence to file an appeal with the NHP. You will receive a decision in writing within 60 calendar days from the date we receive your appeal.

If you have a question about a pre-service appeal, please see the section on *Pre-Service Appeals* section in Chapter 6: Medical Management.

Capitated Health Care Providers

Electronic Payments and Statements (EPS) is not available to care providers who participate under a capitated arrangement. However, you may enroll in Electronic Funds Transfer (EFT). To enroll, please contact your Physician Advocate to request an EFT enrollment form.

You may access and download a capitation detail file. To learn how to access the report and view instructions for using it, go to **UHCprovider.com/reports**.

OneNet PPO Supplement

Applicability of This Supplement

OneNet PPO, LLC (OneNet) is a wholly owned subsidiary of UnitedHealthcare Insurance Company, a part of UnitedHealth Group, Incorporated. The OneNet supplement is a supplement to this UnitedHealthcare Guide, both of which OneNet health care providers must follow. This supplement may be referred to as the OneNet Physician, Health Care Practitioner, Hospital and Facility Guide or the "OneNet Guide".

This supplement lists operational procedures and information that apply to services provided to injured workers whose employer, workers' compensation carrier, administrator or other entity has contractually based authority to access the OneNet PPO Workers' Compensation Network for themselves or for their clients. It also applies to claimant services as a result of injuries sustained in an auto-liability claim. You are subject to both the main guide and this supplement. Because OneNet is a network only and not a payer, certain provisions of the main guide will apply to OneNet with some variation. This supplement identifies these principal variations. This supplement controls if information conflicts with the main guide. For protocols, policies and procedures not referenced in this supplement, please refer to the appropriate chapter in the main guide.

Terms Used in the Supplement

Adjuster: An Adjuster works for an insurance company, third party administrators (TPA) or directly for a self-insured employer. This person coordinates with all parties on a workers' compensation case or auto liability claim. They are responsible for the wage replacement and return-to-work coordination, as well as all management of the funding for medical services.

Clean Bill/Claim: "Bill" refers to the submitted UB or CMS1500 form. "Claim" represents the entire workers' compensation accident, including all submitted "Bills".

Bill/Claim Pricing or Repricing: The process of applying the OneNet contracted rates to bills including the application of clinical edits, reimbursement policies and standard coding practices. It may include the application of state or federal Workers' Compensation fee schedule rates, UCR or prevailing rate as defined by the state, or other government-authorized pricing methodology or schedule. The terms "claim/bill pricing" and "repricing" are used interchangeably. The process of applying contracted rates to bills from network providers includes the application of the lesser of the billed charges, contracted rate, state/federal schedule, UCR or other authorized fee schedule.

OneNet Client (Direct or Indirect Payer): Clients include insurance carriers, TPA and other entities with contractually based authority to access OneNet for themselves or their clients. OneNet clients may be a OneNet Payer or any entity that provides administrative services to a OneNet Payer (e.g., a TPA). Direct or indirect payers may use the services of a TPA or other entity to provide administrative services, including verifying eligibility and adjudicating and issuing bill payment. References in the health care provider Agreement to "Participating Entity", "Payer" or "Alternate Payer" also apply to OneNet clients (direct or indirect payers). OneNet, Procura, and UnitedHealthcare and its affiliates are not OneNet Payers.

OneNet Customer, Injured Worker, Insured, Claimant, Primary Participant or Participant: A person authorized by OneNet PPO, LLC to access OneNet participating health care providers under the terms of their Agreement. The term "OneNet Customer" means the same as "customer" or "member" in this guide. OneNet Customers, Primary Participants or Participants include the qualifying injured worker, subscriber, employee, insured, claimant policyholder or other person who, through their direct or indirect Agreement with OneNet, is eligible to access network health care providers.

Property and Casualty Benefit Plans: Workers' Compensation Benefit Programs and Auto Liability services as defined by a federal or state entity.

Utilization Review: Utilization management or utilization review is the use of managed care techniques such as prior authorization that allow payers, to address clinical appropriateness using evidenced-based criteria or guidelines as defined by each state. Procura may or may not provide utilization management services for their clients.

UCR/Prevailing Rate: The usual and customary or reasonable rate (also known as prevailing rate) determined by the state or other governmental entity or a database referenced by a state or governmental agency such as FAIR Health. The database is created using rates typically charged by providers in a geographic area.

OneNet PPO Product Overview

Health care providers are physicians, health care practitioners, hospitals and facilities whose Agreement with UnitedHealthcare includes participation in the Property and Casualty Benefit Plan known as OneNet. This may include health care providers within the OneNet service area, as well as health care providers in other areas such as states adjacent to the OneNet service area, and/or any future OneNet network expansion areas. As of the published date, the OneNet service area includes Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Pennsylvania, Tennessee, Virginia, Washington DC, and West Virginia.

Access to the OneNet PPO

Workers' Compensation and Auto Liability Networks, also referred to as a Property and Casualty Benefit Plan, is limited to employers and administrators contracted with Procura Management, Inc. (Procura), an Optum company.

OneNet is a network of physicians, health care practitioners, hospitals and ancillary facilities used for work-related illness and injury and/or medical services related to an auto liability claim. It serves workers' compensation programs and auto liability insurers administered by employers and third party administrators.

Procura Management, Inc. contracts directly or indirectly with employers, carriers and/or administrators to provide access to participating care providers at negotiated rates. Some of the advantages you may see as a participating care provider include the following:

- Increased patient volume by referrals generated through published directories, workplace postings and online provider look-up tools
- Efficient and consistent payment and adjudication of bills defined by your contract terms
- Hands-on Provider Relations staff

Who to Contact

Resource	Where to go
OneNet/Procura Clients (Direct or Indirect Payer) Responsible for the administration and payment of workers' compensation and auto liability programs accessing the OneNet PPO Network. Responsibilities include: • determining bill eligibility, • processing bills, • providing explanation of benefit (EOB) statements or remittance advices, • and may also include case management and utilization review services.	For questions related to these services, please contact the payer identified on the EOR or the payer provided by the patient. Procura and OneNet names will appear on the EOR/EOB/remittance advice when the OneNet PPO Workers' Compensation or Auto Network is being accessed.
Procura	For OneNet PPO in-network referrals, OneNet contracted rate pricing inquiries/appeals, or how to contact our clients. **Phone:** 877-461-3750 **Fax:** 484-804-6034 **Email:** proppo@procura-inc.com
Contract Questions	Contact your UnitedHealthcare Network Management representative. If you require assistance determining who your representative is, or how to reach them, visit UHCprovider.com > Contact Us > Find a Network Contact.
Appeals	If you are disputing state pricing or services deemed not part of the workers' compensation/auto illness or injury, contact the client at the number identified on the EOR. For all network-related concerns, contact Procura: **Phone:** 877-461-3750 **Fax:** 484-804-6034 **Email:** proppo@procura-inc.com Some states have formal dispute resolution or appeals processes. You must submit your appeal to Procura before using these appeals processes for both workers' compensation and auto bills.
Auto Precertification	Use the pre-certification numbers provided to you or contact Procura: **Phone:** 877-461-3750 **Fax:** 484-804-6034 **Email:** proppo@procura-inc.com
Auto Appeals, Denial information, Medical Management	Our Injury Management department will assist you in resolving your concerns: **For non-Allstate NJ customers and clients only:** 800-275-9485 **For Allstate NJ customers and clients only:** 877-722-8037

Resource	Where to go
To Request a copy of the Decision Point Review (DPR) Plan	Contact the payer identified on the EOR. DPR Plan provides specific requirements for submitting an appeal for medical reconsideration of an auto liability claim, but they are not required in all states.
Website	OneNet pricing sheets are available on **UHCprovider.com** > Link > UnitedHealthcare OneNet PPO Pricing. Final payment determination is the responsibility of our clients.
News, Information and Updates	For information on policies, protocols, products, new initiatives, website enhancements and tools for you, visit: **UHCprovider.com/news**.

Patient Eligibility

Contact the injured worker's employer, workers' compensation carrier, auto liability insurer or administrator to verify acceptance of an injury for purposes of coverage. ID cards are not usually issued or used for workers' compensation and auto liability programs. Injured workers and claimants accessing you through the OneNet PPO Network will not present an ID card. Insurers, administrators and employers are instructed to advise you of network access, if known, when you call to verify the injury and coverage. You may wish to ask if the employer, carrier or administrator is contracted with Procura to provide workers' compensation or auto liability network access.

Bill Process

Bill Submission

All bills, whether submitted electronically or by paper, should be sent directly to the applicable employer, worker's compensation carrier, auto liability insurer or third party administrator (TPA). Do not submit bills directly to OneNet or Procura, except for pricing appeals.

When submitting a bill, it is important to submit complete bills and to accurately code all diagnoses and services in accordance with national coding guidelines.

Additional information may be required for particular types of services, or based on particular circumstances or state requirements.

Clean bills must be submitted within the time frame identified in your contract, or within 12 months of the date services are provided, and in accordance with any applicable laws. Failure to submit bills correctly will result in the rejection and return of bills. You will receive a notice from the carrier or administrator in the event your bills are being withheld from bill pricing and payment while compensability is being determined.

If you have questions about submitting claims to us, please call the injured workers' employer, workers' compensation carrier, auto liability insurer or TPA for instructions on how to submit a bill.

Complete Bill Requirements

Your bills may not be processed if you omit:

- Items identified under the *Claims and Encounter Data Submissions* section of the UnitedHealthcare Guide
- Taxonomy code

Additional requirements:

- Items identified under the *Additional Information Needed for a Complete UB-04/CMS-1450 Form* section of the UnitedHealthcare Guide.
- When billing late charges, indicate bill type 115 or 117 (inpatient), or 135 or 137 (outpatient), in form locator 4 of the CMS-1450/UB-04.
- Bill all outpatient surgeries with the appropriate revenue and CPT codes if reimbursed according to ambulatory surgery groupings.

Submit all bills for professional services or facility services on a CMS 1500 or UB-04 claim form or their electronic equivalents and include all standard code sets that apply.

Bill Review Procedures

Our bill review procedures identify coding errors and coding irregularities. This helps provide better consistency during our claims pricing.

Tips to Expedite Bill Processing:

- Submit bills on a red CMS 1500 or a UB-04 form, using 11 or 12 point font size and black laser jet ink.
- Do not use a highlighter on the claim form or any attachments.
- Line up forms to print in the appropriate boxes.
- Submit bills on original forms, not photocopies.
- Complete all required fields on standard forms.
- Make sure attachments are complete and legible.
- Make sure information such as the care provider's name, telephone number, NPI, and other information is accurate.
- Remember to sign and date all necessary forms; an electronic signature is acceptable.

Pricing of Bills

OneNet pricing includes bill completeness and accuracy review, and pricing per your contracted rate.

Payment for covered services is the least of:

- The Property & Casualty Benefit Plan payment rate per your Agreement
- Your billed charges
- The state's workers' compensation fee schedule
- The federal workers' compensation fee schedule
- UCR or prevailing rate as determined by the state, or
- Other state, federal, or government authorized fee schedule

Application of this reimbursement comparison is generally at the claim line (service code) level, unless state or federal regulations applicable to the job-related injury specify comparisons must be done at claim-level aggregate values.

Payment for covered services of an auto liability bill is the least of:

- The Property & Casualty Benefit Plan Auto Liability payment rate per your agreement
- Your billed charges
- UCR or prevailing rate as determined by the state, or
- Any state, federal or mandated rates applicable to auto

Bills Subject to Bill Edits

For bills that are subject to code edits or line bundling and unbundling, the bill pricing resulting from these edits is allocated back to the original submitted bill lines and codes (refer to the OneNet pricing sheet). Priced bills do not display the lines or codes added or deleted by these bill edits. This is intended to assist physicians and OneNet's clients in bill reconciliation by having priced bills match the originally submitted bills.

Allocation of Global Pricing to the Bill Line Level

Certain bills are subject to global pricing, including case rates, flat rates and per diems. In these cases, a fixed percentage of the overall global rate may be allocated to the applicable lines of the bill.

Example of Global Pricing Distributed Across Lines
Health care provider has billed lines totaling $100 that are subject to a state fee maximum of $90 and a contracted global rate of $80. A portion of the global rate is allocated to each line as a percentage of the state fee charges.

	Billed Charges	State Fee	Allowed Amount
Line 1	$50.00	$45.00	$40.00
Line 2	$30.00	$27.00	$24.00
Line 3	$20.00	$18.00	$16.00
Total	**$100.00**	**$90.00**	**$80.00**

Whenever such allocations occur, OneNet clients are instructed that individual lines where global pricing has been distributed may not be processed separately. This means if the payer finds a service line to be non-compensable, and a portion of a global rate has been allocated to that line, that portion must still be considered when determining payment. Remark codes on the pricing sheet show when we cannot process individual lines of a bill-level rate separately.

Bill Inquiries

OneNet can verify our receipt, the OneNet contracted pricing and the date returned to our client. We cannot verify payment status nor any questions related to anything outside of the network contract.

Bill inquires related to the status of payments and non-OneNet related pricing should be directed to the applicable injured worker's employer, workers' compensation carrier, auto liability insurer or TPA.

The fastest way to to locate a OneNet PPO pricing sheet is to access UHCprovider.com > Link > UnitedHealthcare OneNet PPO pricing. Pricing sheets show the allowed amount of your bills after the application of OneNet bill pricing. They do not show the final bill adjudication by the payer, which could include pricing for charges that the payer identifies as non-payable, ineligible or the patient's responsibility. The EOB or remit created by the employer, carrier, insurer or administrator will identify charges deemed not payable for workers' compensation or auto liability.

If you do not have internet access, or if you cannot find the information for the Procura client you need on our website, please call 877-461-3750.

Bill Payment

OneNet and Procura do not pay bills and do not have an obligation to pay for services rendered to an injured worker or claimant authorized to access a OneNet PPO Network care provider. We send the priced bill to the appropriate payer for adjudication and payment determination. You are required to accept the OneNet contracted amount as payment in full for covered services.

For compensable workers' compensation-related services, the injured worker may not be billed, and there are no copayments, deductibles, or coinsurances. Balance billing is prohibited for all services covered by a workers'

compensation benefit plan. A health care provider may not bill participants for non-professional services including charges for overhead, administration fees, malpractice surcharges, membership fees, fees for referrals, or fees for completing bill forms or submitting additional information. If OneNet rejects or denies a bill because a health care provider failed to follow policies and procedures, the patient may not be billed.

For compensable auto claims, the claimant may have deductibles according to their policy. The claimant is responsible for those deductibles. An auto liability policy may also contain limited benefits. Once those benefits are exhausted, the claimant is responsible for all remaining charges or the services can be billed through their health insurance carrier if there are additional benefits for the claimant to utilize.

OneNet clients are required to adjudicate and pay clean bills within 30 days of bill pricing, or within applicable state or federal guidelines. If the OneNet workers' compensation or auto liability client fails to adjudicate and pay a bill within this time period, the care provider may, at their discretion, request the least of the full charges, or in the case of workers compensation, the applicable state or federal maximums that apply. In these instances, the OneNet payer will pay the bill as it was priced by OneNet. After receiving payment, the care provider must notify the OneNet payer that payment of full charges or applicable state or federal maximums are requested due to late bill payment. Exceptions to the right to request full billed charges for failing to offer timely payment is as follows:

- OneNet, Procura or the payer will notify the care provider after receipt of the bill, but before the expiration of the bill payment's time limit, if the bill is denied, missing required information, is deficient in some way or being held to determine auto or workers' compensation compensability.

The OneNet client must send you an EOB or remittance advice indicating that the OneNet PPO Network was accessed and the reimbursement amount for those services. The EOB shows:

- The billed charges for services,
- The OneNet contracted amount,
- The reimbursement amount,
- The amount adjusted based on the contract/benefit plan,
- Services found to be non-payable

Submit bills with non-payable services to the injured worker or claimant's health plan. Do not assume that UnitedHealthcare is the worker's health insurer. You can get this information by calling their employer or from the claimant directly.

Non-Covered Services and other Participant Protocols

Follow UnitedHealthcare's protocols on compensation for care provided to OneNet participants with the following exceptions:

- Workers' compensation and auto liability lines of business - When you perform a service that may not be covered under the workers' compensation/auto claim or the patient's health insurance, you may balance bill the injured worker or claimant only if the following conditions are met:
  - › Notify the participant at the time of service that the charge may not be compensable under their workers' compensation/auto injury or illness.
  - › Injured worker or claimant agrees at the time of service to be responsible for the charge.
  - › You have written consent from the patient to perform the service.
  - › Bill is submitted to the workers' compensation/ auto and health insurance, and the service is not compensable.
- The injured workers' employer, workers' compensation carrier, auto liability insurer or TPA determines compensability.
- You cannot use the online claim estimator on UHCprovider.com to estimate bills.
- You cannot submit OneNet bills for real-time processing on UHCprovider.com.

For hospital audit services, OneNet or OneNet clients may conduct their own audits of hospital bills. They may follow their own procedures, subject to mutual agreement of the OneNet client and the audited facility. These procedures vary from those of UnitedHealthcare's Hospital Audit Service Department. OneNet or Procura may request copies of medical records to comply with audits required by external accreditation agencies, the state, OneNet clients or for cause. OneNet clients may conduct independent hospital or facility bill audits and may also request copies of medical records as part of the process of ensuring quality care. You must provide medical records when requested by OneNet or OneNet clients at no cost to OneNet, the OneNet client, or the participant. UnitedHealthcare's hospital bill audit protocol does not apply to such audits or requests for medical records.

Bill Appeals (Post Service)

OneNet appeals cannot be submitted for reconsideration using the Bill Reconsideration tool on **UHCprovider.com/claims**.

Email direct pricing appeals for Procura bills to **proppo@procura-inc.com**, or call 877-461-3750. Questions about a state rate allowance should be directed to the client identified on the EOR.

Submit bill pricing appeals within 12 months of the bill process date, or within applicable state and federal time frames.

Follow the procedure below for payment appeals related to OneNet PPO:

- Email your payment appeals to Procura at: proppo@procura-inc.com.
- When resubmitting information, include all applicable documentation, including any additional information requested.
- Include the UB/HCFA bill and EOB.

If you have any concerns about the appeal process or specific concerns about a Procura/OneNet payer, please contact Procura at proppo@procura-inc.com or call 877-461-3750.

Overpayments

Direct all questions or refunds of overpayments to the applicable payer using the phone number listed on the injured worker's EOB or remittance advice.

If you find a bill where you were overpaid or if we inform you of an overpaid bill that you do not dispute, you must send the overpayment within 30 calendar days (or as required by law or your Agreement) from the date of your identification or our request.

Please include appropriate documentation that outlines the overpayment, including the patient's name, ID number, date of service, and amount paid. If possible, please also include a copy of the EOB that corresponds with the payment.

If you disagree with a request for an overpayment refund, notify the payer in writing as to why you do not believe overpayment occurred and why you dispute the refund.

If the payer still believes a refund should be provided, the payer forwards the information to Procura and OneNet for further review. Procura and OneNet will work with you and the payer to resolve the issue.

Bill Pricing Adjustments of $5.00 or Less

We strive to accurately re-price all bills and make adjustments when an incorrectly priced bill results in significant underpayment or overpayment for services.

Bill pricing resulting in either an overpayment or underpayment of $5.00 or less is not adjusted.

Appeals, Grievances or Complaints

OneNet injured workers and claimants direct appeals or grievances to their payer or administrator. They do not use the Appeals and Grievance Form used by UnitedHealthcare members. You are required to support the payer's appeals process by providing records as requested and complying with final determinations. In the case of complaints or grievances related to a participating care provider, the payer or administrator refers the information to UnitedHealthcare and OneNet. If you, as the care provider, are disputing the state or services deemed not part of the workers' compensation/auto illness or injury, please contact the client at the number identified on the EOR. For all network-related concerns, please contact Procura at 877-461-3750. Some states have formal dispute resolution or appeals processes. You must submit your appeal to Procura before using these appeals processes for both workers' compensation and auto bills.

Online Services

Care providers can view pricing sheets by using the UHCprovider.com > Link > UnitedHealthcare OneNet PPO Pricing. Pricing sheets show the allowed amount of your bill after the application of OneNet pricing. Pricing sheets do not show the final bill adjudication by the payer. It may include billed charges and pricing for charges that are not payable as identified on the EOB or remittance advice.

Because workers' compensation and auto liability information is not stored on any UnitedHealthcare member system, you may not use many of the web tools on UHCprovider.com.

Some unavailable tools include:

- Eligibility or benefits
- View patient personal health records
- Submit advance notifications
- View your OneNet fee schedule
- Claim Estimator
- Claim submission
- Reprint EOBs
- Electronic Payments and Statements
- Authorizations and referral information, submission and status.

Similar limitations exist for other UnitedHealthcare systems designed to use or verify benefits and eligibility information, such as the United Voice Portal.

Referrals

UnitedHealthcare's requirements for care provider referrals do not apply to the OneNet PPO Network. Do not use the Referral Submission system online. However, in some states, the injured worker or claimant may be required to use certain care providers to receive benefits. Please contact the injured worker or claimant's adjuster for guidance. Use your best efforts to recommend another participating care provider, if requested. For assistance identifying participating care providers, please call Procura at 877-461-3750.

Air Ambulance, Fixed-Wing Non-Emergency Transport

UnitedHealthcare's requirement to refer non-emergency fixed-wing air ambulance to a participating care provider does not apply. The injured worker or claimant may not receive benefits, depending on the state, unless an authorized care provider is used. If an in-network care provider is not available, please contact the adjuster to determine where to refer the injured worker or claimant for authorized care.

Laboratory Services

UnitedHealthcare's requirement that participating laboratory providers must be used does not apply. The injured worker or claimant may not receive benefits unless an authorized laboratory is used. Please contact the adjuster for guidance. Use your best efforts to refer to a laboratory based on the information provided by the adjuster. The OneNet PPO Network includes national, regional and local care providers of laboratory services. The self-referral and anti-kickback provisions of UnitedHealthcare's laboratory services protocols apply to OneNet care providers.

Pharmacy Services

The OneNet PPO workers' compensation and auto liability networks do not include a pharmacy network. Contact the adjuster to determine where to refer the patient for care.

Specialty Pharmacy and Home Infusion

UnitedHealthcare's requirements on Designated Specialty Pharmacy or Home Infusion Providers for Specialty Medications, and Specialty Pharmacy Requirements for Certain Specialty Medications do not apply to, and are not supported by, the OneNet PPO Network. Please contact the adjuster for the name of a specialty pharmacy provider, as the injured worker or claimant may be required to use certain care providers to receive benefits.

Provider Responsibilities and Workflows

OneNet care providers follow Chapter 2: Provider Responsibilities and Standards with the noted exceptions:

- As part of transitions under continuity of customer care, participating care providers should notify current patients accessing them through the OneNet Network of an effective date of termination of their Agreement at least 30 calendar days prior, or as required under applicable laws. OneNet does not maintain participant names and addresses and may not notify participants on your behalf.
- Additional exceptions related to benefits, eligibility, online tools and health care ID cards are in other parts of this supplement.

Behavioral Health Services

Contact the adjuster if you believe an injured worker or claimant would benefit from mental health/substance use services due to their job-related injury or auto accident. The network includes behavioral health care providers. Follow ODG guidelines and requirements or other evidence-based requirements as defined by each state.

Case Management

Procura clients may use their own internal case management services for injured workers or claimants. You are required to comply with the case management programs used by Procura and its clients. They will follow state-driven requirements or other evidenced-based guidelines. OneNet care providers must work with case managers and follow all applicable state laws, regulations and rules.

Medical Records Standards and Requirements

Standards and requirements described in *Chapter 11: Medical Records Standards and Requirements* extend to OneNet and OneNet clients. Adhere to any state requirements that exceed the requirements as outlined.

Quality Management and Health Management Programs

The following exceptions apply to the Health and Disease Management procedures in how they apply to OneNet and OneNet participants:

- UnitedHealthcare Case Management, Behavioral Health and Disease Management programs do not apply to OneNet workers' compensation or auto liability products.
- Do not report OneNet participant information to the UnitedHealthcare Cancer Registry.
- OneNet encourages the use of the Clinical and Preventive Health Guidelines when treating OneNet participants.
- While OneNet encourages the use of resources available on **UHCprovider.com** related to mental health/substance use, the processes described for behavioral health consults do not apply to the OneNet PPO Workers' Compensation or Auto Liability. Contact the case manager or adjuster for guidance if you believe a participant would benefit from mental health/substance use services due to their job-related injury or auto accident. You must follow ODG guidelines and requirements or other evidence-based requirements as defined by each state.

Participant Rights and Responsibilities

Get a copy of OneNet's Participant Rights and Responsibilities, which vary from UnitedHealthcare's Member Rights and Responsibilities, by calling Procura at 877-461-3750.

Advance Directives

Follow the advance directive requirements provided in the UnitedHealthcare guide for the OneNet Network, if applicable. OneNet does not produce benefit materials for injured workers or auto liability plans. We cannot inform OneNet participants of state laws on advance directives. This is the responsibility of the employer, workers' compensation carrier or other entities as defined by the employer.

Oxford Commercial Supplement

Oxford Commercial Product Overview

Oxford offers commercial gated or non-gated products.

Applicability of this Supplement

This supplement applies to all covered services you provide to members insured by or receiving administrative services from UnitedHealthcare Oxford. Oxford offers commercial products under the names of Freedom, Liberty, Metro, and Garden State, as follows:

- Freedom products are offered in Connecticut, New Jersey and New York.
- Liberty products are offered in Connecticut, New Jersey and New York.
- Metro Products are offered in New York and New Jersey.
- Garden State Products are offered in New York and New Jersey.

You are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, we will direct you to that location when applicable. For protocols, policies and procedures not referenced in this supplement, please refer to the appropriate chapter in the main guide.

Benefit Plans not Subject to the Requirements in this Protocol

- UnitedHealthcare Medicare Advantage plans offered under the AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic, and UnitedHealthcare Medicare Advantage brands on the Oxford health plan platform.
- UnitedHealthcare Oxford Navigate individual benefit plans underwritten by Oxford Health Insurance, Inc.

How to Contact Oxford Commercial

OxfordHealth.com > Providers > Tools and Resources offers instructions, quick reference guides, access to forms and policies, and other resources, without a requirement to be registered.

For step-by-step instructions to using our website transactions, go to OxfordHealth.com > Providers (or Facilities) > Tools & Resources > Administrative Tools & Information. UHCprovider.com is a care provider gateway to many other tools, training and resources. For members with nine-digit ID numbers, please go to OxfordHealth.com. For members with 11-digit ID numbers, please go to UHCprovider.com.

Download this Quick Reference Guide for more information and images of sample ID cards for each membership type.

Voice Portal: 800-666-1353

In most cases, to use the Voice Portal, you are required to enter your care provider's or facility's TIN or NPI number. A Voice Portal quick reference guide is located on OxfordHealth.com > Providers or Facilities > Tools & Resources > Administrative Tools & Information > Voice Portal Quick Reference.

Other Contact Information and Resources

Commercial Products

RESOURCE	WHERE TO GO
Appeals, Administrative (Claims)	**Mail:** UnitedHealthcare Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903
Appeals, Clinical & Medical Necessity	**Fax:** 877-220-7537 **Mail:** Oxford Clinical Appeals Department P.O. Box 29139 Hot Springs, AR 71903
Behavioral Health Appeals	Behavioral Health Appeals P.O. Box 30512 Salt Lake City, UT 84130-0512 Phone: 800-999-9585 **Fax:** 855-312-1470
Appeals (Members) **Second Level Member Appeals**	OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > **Forms** • Claims Review Request Form • Member Authorization for a Designated Representative **Mail:** UnitedHealthcare Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903
Internal Appeals: **Claims Payment Disputes**	Forms: OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > **Forms** • Claims Review Request (1-19 claims) • Claims Research Project (20 or more claims) • New Jersey Provider Claim Appeal Form
Appeals: Pharmacy (urgent)	**Fax:** 801-994-1058
Behavioral Health Department	**Phone:** 800-201-6991
Cardiology Utilization Review/Medical Necessity Review Cardiac Catheterization Prior Authorization Echocardiogram and Stress Echocardiogram	**Online:** **UHCprovider.com/priorauth** > Cardiology (available 24 hours a day) **Online Policies:** Refer to the back of the member's health care ID card for the applicable website. • **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** OR • **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies** **Phone (eviCore):** 877-PREAUTH / 877-773-2884 (Monday through Friday, 7 a.m. – 7 p.m. ET)
Chiropractic Services: **OptumHealth**	Provider Services/Claims **Online:** **myoptumhealthphysicalhealth.com** **Phone:** 800-985-3293

Commercial Products	
RESOURCE	**WHERE TO GO**
Claim Submission	**EDI:** Commercial Claims Payer ID: 06111 More information about EDI: **OxfordHealth.com** > Providers or Facilities > **Transactions** > Electronic Payments & Statements Learn more on **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Administrative Tools & Information > **Electronic Data Interchange (EDI)** You may also visit **PNTdata.com** > Customers > Providers to learn about a free submission tool that doesn't require practice management software. **Online:** **UHCprovider.com/claims** **Mail (paper claims):** UnitedHealthcare Attn: Claims Department P.O. Box 29130 Hot Springs, AR 71903
Claim Corrections and Reconsiderations	**EDI:** Submit facility claim corrections electronically. **Online:** claimsLink **UHCprovider.com** > Service Links > **Link Self-Service Tools** **Paper:** **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Network Information > Forms • Claim Review Request (1-19 claims) • Claim Research Project (20 or more claims) • New Jersey Provider Claim Appeal Form
Claim Status	**EDI:** 276/277 Claim Status Inquiry and Response transactions are available through your vendor or clearinghouse. **Online:** **OxfordHealth.com** > Providers or Facilities > **Transactions** > Check > Claims **Phone:** 800-666-1353 and say "Claims" when prompted. You may speak with a representative Monday through Friday, 8 a.m. - 6 p.m. ET.
Clinical, Administrative and Reimbursement Policies	**Online:** Refer to the back of the member's health care ID card for the applicable website. • **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** OR • **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**
Clinical Services Department	**Phone:** 800-666-1353 (Monday through Friday, 8 a.m. – 6 p.m. ET)
Credentialing and Recredentialing Member of the Council for Affordable Quality Healthcare (CAQH)	**Online:** **UHCprovider.com** > UnitedHealthcare's Credentialing & Recredentialing Plan **Phone:** United Voice Portal at 877-842-3210 **New Jersey only** **Online:** State of New Jersey Department of Health: **nj.gov/health** or **CAQH.org**. **Phone:** Provider Services at 800-666-1353 or CAQH Support at 888-599-1771
Electronic Payments and Statements (EPS) Information and Enrollment	**Online:** • **OxfordHealth.com** > Provider or Facilities > Tools & Resources > Administrative Tools & Information > **Electronic Payments & Statements (EPS)** or • **Optumbank.com** > View your account > Log in **Helpdesk:** 877-620-6194

Commercial Products	
RESOURCE	**WHERE TO GO**
Electronic Data Interchange (EDI) Check status of referrals, precertifications, and claims; member eligibility and benefits	Payer ID: 06111 EDI Support: **Online:** UHCprovider.com/edi OxfordHealth.com > Providers or Facilities > Tools & Resources > Administrative Tools & Information > Electronic Data Interchange **Phone:** 800-842-1109, Monday through Friday, 8:30 a.m. – 5 p.m. ET
Eligibility and Benefits	**EDI:** 270/271 Eligibility and Benefits Inquiry and Response transactions are available through your vendor or clearinghouse. **Online:** OxfordHealth.com > Providers or Facilities > Transactions > Check > Eligibility and Benefits **Voice Portal and Provider Services:** 800-666-1353 (Say "Benefits and Eligibility" when prompted.) You may speak with a representative Monday through Friday, 8 a.m.-6 p.m. ET.
Forms	**Online:** OxfordHealth.com > Provider or Facilities > Tools & Resources > Network Information > Forms
Fraud Hotline	**Phone:** 866-242-7727
HIPAA Compliance and Security	**Online:** uhc.com/privacy For additional information on granting remote access to your EMR system: emrcdsa@uhc.com.
Infertility Services: Optum	**Phone:** 877-512-9340 **Fax:** 855-536-0491
Inpatient Admission	**EDI:** Use your clearinghouse. **Online:** OxfordHealth.com > Providers or Facilities > Transactions > Submit > Precert Requests **Phone:** 800-666-1353 **Fax:** 800-303-9902
Inpatient and Outpatient: Clinical Services	**Phone:** 800-666-1353
Intensity Modulated Radiation Therapy (IMRT)	**Online:** evicore.com (24 hours per day) OxfordHealth.com > Providers or facilities > Tools & Resources > Medical Information > Radiology and Radiation Therapy Information **Fax:** 888-242-9058 **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265 **Phone:** 877-PREAUTH (877-773-2884) (Monday through Friday, 7 a.m.-7 p.m. ET)
Laboratory Services: LabCorp (Laboratory Corporation of America) Client Services	Locate participating laboratories by: **Online:** OxfordHealth.com > Providers or Facilities > Search > Laboratories **Phone:** Patient service center locator number for customers 888-LABCORP (522-2677) North New Jersey: 800-223-0631 South New Jersey: 800-633-5221 New York: 800-223-0631 Connecticut: 800-631-5250
Outpatient Injectable Chemotherapy and Related Cancer Therapies	**Online:** UHCprovider.com/priorauth > Oncology **Phone:** 877-773-2884 (Monday through Friday, 7 a.m. – 7 p.m. ET)

Commercial Products	
RESOURCE	**WHERE TO GO**
Oxford On-Call® (urgent and non-urgent care)	**Phone:** 800-201-4911 • Available 24 hours per day • Staffed by registered nurses • Assistance for urgent and non-urgent medical problems, recommend an appropriate site of care
Pharmacy Customer Service	**Phone:** 800-788-4863 TTY/TDD: 800-498-5428 Available 24 hours per day
Pharmacy Prior Authorization	**Phone:** 800-711-4555 Available 24 hours per day
Physical and Occupational Therapy Claims Submission and Inquiry	Provider Services: 877-369-7564 **Online:** myoptumhealthphysicalhealth.com For claims submitted electronically: Payer ID 06111 **Phone:** 800-666-1353 **Mail (paper claims):** UnitedHealthcare Attn: Claims Department P.O. Box 29130 Hot Springs, AR 71903
Prescription Mail Order	OptumRx P.O. Box 2975 Mission, KS 66201
Prior Authorization Submission	**EDI:** Use your vendor or clearinghouse. **Online:** OxfordHealth.com > Providers or Facilities > Transactions > Submit > Precert Requests **Online:** UHCprovider.com/priorauth **Online:** UHCprovider.com/paan (use the Link Prior Authorization and Advance Notification tool) Find the form on OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > Forms. **Phone:** Provider Services 800-666-1353 (Monday through Friday, 8 a.m.- 6 p.m. ET)
Prior Authorization Verification	**EDI:** Use your vendor or clearinghouse. **Online:** OxfordHealth.com > Providers or Facilities > Transactions > Check > Precert Status **Phone:** Voice Portal: 800-666-1353 (Representatives are available Monday through Friday, 8 a.m.-6 p.m. ET.) Say "Precertification" when prompted.
Radiology and Radiation Therapy Prior Authorization Utilization Review, Medical Necessity Review	**Online:** UHCprovider.com/priorauth > Radiology (available 24 hours per day, seven days per week) Forms and policies: OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Radiology & Radiation Therapy Information **Phone (eviCore):** 877-PREAUTH (877-773-2884) (Monday through Friday, 7 a.m.-7 p.m. ET)
Referral Submission or Verification	**EDI:** Use your clearinghouse or vendor. **Online:** OxfordHealth.com > Providers > Transactions > Submit > Referrals or Transactions > Check > Referrals **Phone:** Voice Portal: 800-666-1353 (Monday through Friday, 8 a.m. - 6 p.m. ET) Say "referral" when prompted.
Search for Participating Care Providers, Other Health Care Professionals and Facilities	**Online:** OxfordHealth.com > Providers or Facilities > Search > (select the provider type) **Phone:** 800-666-1353

Commercial Products	
RESOURCE	**WHERE TO GO**
Termination Requests	**Phone:** 800-666-1353 **Mail:** Physicians and other health care professionals send by certified mail, return receipt requested to: UnitedHealthcare Network Contract Support Mail Route: TX023-1000 1311 W President George Bush Highway, Suite 100 Richardson, TX 75080-9870 **Behavioral health providers only:** **Phone:** 877-614-0484

Care Provider Responsibilities and Standards

Compliance with Quality Assurance and Utilization Review

Physicians and other health care professionals agree to fully comply with and abide by the rules, policies and procedures that we have or will establish. We provide written notice of any changes 30 days in advance, including, but not limited to:

- Quality assurance, such as onsite case management of members, incentivist programs and notification compliance measures.
- Utilization management, including prior authorization procedures, referral processes or protocols and reporting of clinical accounting data.
- Member, physician and other health care professional grievances.
- Timely provision of medical records when we or our contracted business associates request them.
- Cooperation with quality of care investigations, including timely response to queries and/or completion of improvement action plans.
- Care provider credentialing.
- Any similar programs developed by us.

Advising Members of Their Rights

Our members have the right to obtain complete, current information concerning diagnosis, treatment and prognosis in terms they may understand. When it is not advisable to give such information to the member, make the information available to an appropriate person acting on the member's behalf.

Our members also have the right to receive information as necessary to give informed consent before the start of any procedure or treatment. They may refuse treatment to the extent permitted by law. You must inform them of the medical consequences of that action.

Office and Access Standards

Your office must adhere to policies regarding:

- Confidentiality of member medical records and related member information.
- Patient-centered education.
- Informed consent, including telling a member before initiating services when a particular service is not covered and disclosing to them the amount they must pay for the service.
- Maintenance of advance directives.
- Handling of medical emergencies.
- Compliance with all federal, state and local requirements.
- Minimum standards for appointment and after-hours accessibility.
- Safety of the office environment.
- Use of physician extenders, such as physician assistants (PA), nurse practitioners (NP) and other allied health professionals, together with the relevant collaborative agreements.

As a participating care provider, you agree to certain access standards. You agree to arrange coverage for medical services, 24 hours a day, seven days a week, including:

1. **Telephone coverage after hours:** You must have either a constantly operating answering service or a telephone recording directing members to call a special number to reach a covering medical professional. Your message must tell the caller to go to the emergency room (ER) or call 911 if there is an emergency. The message should be in English and any other relevant languages if your panel consists of members with special language needs.
2. **Covering care providers:** You must provide coverage of your practice 24 hours a day, seven days a week. Your covering care provider must be a participating care provider unless there isn't one in your area. UnitedHealthcare must certify any non-participating health care professionals you use to provide coverage for your practice.

Americans with Disabilities Act (ADA) Guidelines

You must have practice policies showing you accept for treatment any patient in need of the health care you provide. Your organization and care providers must make public declarations (i.e., through posters or mission statements) of their commitment to non-discriminatory behavior in conducting business with all members. These documents should explain that this expectation applies to all personnel, clinical and non-clinical, in their dealings with each member.

In this regard, you are required to undertake new construction and renovations, as well as barrier reductions required to achieve program accessibility, following the established accessibility standards of the ADA guidelines. For complete details go to **ADA.gov** > Featured Topics > (scroll to) A Guide to Disability Rights Laws.

We May Request From a Care Provider's Office

We may request any of the following ADA-related descriptions of:

- Accessibility to your office or facility.
- The methods you or your staff uses to communicate with members who have visual or hearing impairments.
- The training your staff receives to learn and implement these guidelines.

Care for Members Who Are Hearing-Impaired

Refusing to provide either care or the help of an interpreter while caring for a person with a qualifying disability is an ADA violation. Members who are hearing-impaired have the right to use sign-language interpreters to help them at their doctor visits.

We will bear the reasonable cost of providing an interpreter. You must not bill the member for interpreter fees (**28 CFR* Sect. 36.301(c)****). The care provider/facility pays the interpreters for their services, then bills us for these services by submitting a claim form with Current Procedural Terminology (CPT) code 99199 with a description of the interpreter service.

Confirming Eligibility and Benefits

Checking the member's eligibility and benefits before rendering services helps ensure you submit the claim to the correct payer, collect correct copayments, determine if a referral is required and reduce denials for non-coverage. To check eligibility and benefits, use any of the following methods:

- **EDI:** 270/271 Eligibility and Benefit Inquiry and Response transactions are available through your vendor or clearinghouse.
- **Online:** **OxfordHealth.com** > Providers or Facilities > **Transactions** > Check > Eligibility and Benefits
- **Phone:** 800-666-1353, and say "benefits and eligibility" when prompted (Monday through Friday, 8 a.m. - 6 p.m. ET).

For additional help with web, Oxford Voice Portal and EDI solutions, please refer to **OxfordHealth.com** > Providers or Facilities > **Tools & Resources** > Administrative Tools & Information. You will find quick reference guides and instructions to assist you.

Member Health Care Identification (ID) Cards

We give each member a health care ID card for identification only. The member should present their card when requesting a covered health care service. We suggest that each time you check a member's health care ID card you also request photo identification to reduce the risk of an unauthorized use of the member's card.

Possession of a health care ID card is not proof of eligibility. You must verify eligibility and benefits before or at the point of service for each office visit.

You may see more detailed information on ID cards and a sample health care ID card, in the section titled *Commercial Health Care ID Card Legend* in Chapter 2: Provider Responsibilities and Standards. You may see a sample ID card image specific to the member when you verify eligibility using our eligibilityLink application.

Participating Hospitals, Ancillary Providers and Care Providers Agree to:

- Verify a member's status. We will not pay for services rendered to persons who are not our members.
- Obtain prior authorization from us or a delegated vendor for all hospital services requiring prior authorization before rendering services. Generally, all hospital services require our prior authorization.
- Notify us of all emergency/urgent admissions of members upon admission or on the day of admission. If the facility is unable to determine on the day of admission that the patient is our member, the facility must notify us as soon as possible after discovering that the patient has coverage with us.
- Notify us of an ambulatory surgery performed due to an ER or urgent care visit within 24-48 hours.
- Admit and treat our members the same way you treat all other facility patients (i.e., according to the severity of the medical need and the availability of covered services).
- Render services to members in a timely manner. The services provided must be consistent with the treatment protocols and practices used for any other facility patient.
- Work with the responsible PCP to help ensure continuity of care for our members.
- Maintain appropriate standards for your facility.
- Cooperate with our utilization review program and audit activities.

* 28 CFR Sect. 36.....303(c)
** 28 CFR Sect. 36.....303(b)(1)

- Receive compensation only from us and adhere to our balance billing policies.
- Complete appeals process in a timely manner, before proceeding to arbitration.

Standards of Practice

Services you perform for members must be consistent with the proper practice of medicine and be performed following the customary rules of ethics and conduct of the American Medical Association and other bodies, formal or informal, governmental or otherwise, from which you seek advice and guidance or to which they are subject to licensing and control.

PCP Selection

All HMO products require members to select a PCP to provide primary care services and coordinate their overall care. Female members may also select an obstetrician/gynecologist (OB/GYN) which they may see without a referral from their PCP. Members may only select a PCP within their network (e.g., a Liberty Plan member must select a Liberty Network participating PCP).

Role of the PCP

As a PCP, you must deliver medically necessary primary care services. You are the coordinator of our members' total health care needs. Your role is to provide all routine and preventive medical services and coordinate all other covered services, specialist care, and care at our participating facilities or at any other participating medical facility where our members might seek care (e.g., emergency care). You are responsible for seeing all members on your panel who need care, even if the member has never been in for an office visit. You may not discriminate on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, place of residence, health status, or source of payment. Some PCPs are also qualified to perform services ordinarily handled by a specialist. We will only pay claims submitted for specialist services by such a PCP if they are listed as a participating specialist in the particular specialty.

HIV Confidentiality

Per New York regulations, all care providers must develop and implement policies and procedures to maintain the confidentiality of HIV-related information. You must have the following procedures in place to comply with regulations specific to the confidentiality, maintenance and appropriate disclosure of HIV patient information.

Office staff will:

- Receive initial and annual in-service education regarding the legal prohibition of unauthorized disclosure.
- Maintain a list containing job titles and specified functions for employees authorized to access such information.
- Maintain and secure records, including records which are stored electronically, and ensure records are used for the purpose intended.
- Maintain procedures for handling requests by other parties for confidential HIV-related information.
- Maintain protocols prohibiting employees, agents and contractors from discriminating against persons having or suspected of having HIV infection.
- Perform an annual review of the following policies and procedures:
  - Perform HIV testing on all newborns.
  - Prenatal care providers should counsel expectant mothers regarding the required testing of newborns and the importance of the mother getting tested.
  - Advise expectant mothers of the counseling and services offered when results are positive. This includes psychosocial support, and case management for medical, social, and addictive services.

Only employees, contractors and medical nursing or health-related students who have received such education on HIV confidentiality shall have access to confidential HIV-related information while performing the authorized functions.

Specialists

As a participating specialist, you agree to:

- Provide referrals for specialty services.
- Provide results of medical evaluations, tests and treatments to the member's PCP.
- Pre-certify inpatient admission.
- Receive compensation only from us and adhere to our balance billing policies.
- Provide access to your records relating to services rendered to our members. If you believe consent is required from the specific member, you must obtain their consent.
- Follow our authorization guidelines for those services requiring prior authorization.

We only reimburse you for services if:

- We have a referral on file or the member has a non-gatekeeper benefit plan and the service is covered and medically necessary.
- A referral is not on file, and the member has an out-of-network benefit (i.e., a POS benefit plan), and if the service is covered and medically necessary, you are entitled to the contracted rate. However, the member is required to pay any deductible and/or coinsurance based on their out-of-network benefits.
- If the member is enrolled in a benefit plan without an out-of-network benefit (i.e., an HMO benefit plan), we are not responsible for payment (except in cases of emergency), nor may the member be balance billed.

Specialists as PCPs

We allow a member who has a life-threatening condition or a degenerative and disabling condition (i.e., complex medical condition) or disease, either of which requires specialized medical care over a prolonged period of time, to elect a network specialist as their PCP. We may grant a standing referral and the specialist PCP becomes responsible for providing and coordinating all of the member's primary care and specialty care. The PCP, specialist, and UnitedHealthcare must all be in agreement with the established treatment plan.

We may authorize a standing referral (See *Standing Referrals and Specialty Care Centers*) when the care provider is requesting more than 30 visits within a six-month period or covered services beyond a six-month period but within 12 months. Under a standing referral, a member may seek treatment with a designated specialist or facility without a separate PCP referral for each service.

If such an election appears to be appropriate, our Clinical Services department faxes the specialist a form to complete and return.

We cover such services without a referral only after you complete the form and we accept it. Otherwise, a referral is required for members with a gatekeeper benefit plan.

Transitional Care

Continuity and coordination of care helps ensure ongoing communication, monitoring and overview by the PCP across each member's health care continuum. Documentation of services provided by specialists such as podiatrists, ophthalmologists and mental health practitioners, as well as ancillary care providers including home care and rehabilitation facilities, help the PCP maintain a medical record supporting whole person care.

The NCQA and state departments in the tri-state area (New York, New Jersey and Connecticut) require elements of the chart to indicate continuity and coordination of care among care providers. We monitor the continuity and coordination of care that members receive through the following mechanisms:

- Medical record reviews
- Adverse outcomes that may develop as the result of disruptions in continuity or coordination of care
- Care provider termination

Newly Enrolled Members Who Need Transitional Care or Continuity of Care

When a new member enrolls with us, they may qualify for coverage of transitional care services rendered by their non-participating care providers. If the member has a life-threatening disease or condition, or a degenerative and disabling disease or condition, the transitional care period is 60 days.

For more information about transitional care, members may call UnitedHealthcare at 800-444-6222.

Reassignment of Members Who Are in an Ongoing Course of Care or Who Are Being Treated for Pregnancy

We adhere to the following guidelines when notifying members affected by a care provider termination:

- We notify all members who are patients of any terminated PCP's panel - internal medicine, family practice, pediatrics, OB/GYN - about our policy and what steps to follow, should the member require transitional care. We follow the same policy for members who regularly see a specialist who is terminated.
- We instruct members of a terminated PCP's panel to call Member Service if they choose to select a new PCP, or to request transitional care from their current care provider. We encourage them to request our Roster of Participating Physicians and Other Health Care Professionals to make their new selection.
- We instruct members of a terminated specialist to call Member Service if they need to request transitional care from their current specialist. We also direct members to call their current PCP for an alternate specialist referral.

Transitional Care When a Care Provider Leaves Our Network

We use the following rules when notifying members affected by a care provider termination:

- UnitedHealthcare members in New York qualify for transitional services on a network basis for up to 90 days from the date a care provider ceases to be in the UnitedHealthcare network.
- We tell all members who are patients of any terminated PCP, such as internal medicine, family practice, pediatrics and OB/GYN, about our policy and what steps to follow should they need transitional care. We follow the same policy for members being seen regularly by a specialist who is terminated.
- We instruct members with terminated PCPs to call Member Service whether they choose to select a new PCP, or to ask for transitional care from their current care provider. We encourage them to visit **OxfordHealth.com** to make their new selection.
- We tell our members who are patients of a terminated specialist to call Member Service if they need to request transitional care from their current specialist. Additionally, we tell them to call their current PCP to ask for a referral to a different network specialist.

If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period includes the provision of postpartum care directly related to the delivery. Our medical director must find the treatment by the non-participating care provider medically necessary. Transitional care is available only if the care provider agrees to:

- Accept as payment our negotiated fees for such services before transitional care.

- Adhere to our Quality Management procedures and provide medical information related to the member's care.
- Adhere to our policies and procedures regarding the delivery of covered services, including referrals and preauthorization policies, and a treatment plan approved by us.

Referrals

Submitting and Verifying Referrals

A PCP or OB/GYN may issue a referral to participating care providers using any of the methods outlined in the "How to Contact Oxford Commercial" section.

Once you enter the referral, the referring care provider may receive a reference number by fax. Provide the referral reference number to the member. The member may bring this reference number to the specialist who can directly confirm a referral is on file through **OxfordHealth.com** or by phone.

Find additional details regarding our Referrals policy at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. (Rrefer to the back of the member's health care ID card for the applicable website.)

Referral Policies and Guidelines

Our physician contracts require referrals be issued to participating physicians, hospitals, ancillaries and other health care professionals within the applicable network of care providers available to our members enrolled in gated health benefit plans. The only exceptions to this are:

1. Emergency cases, or
2. There are no participating care providers who can treat the member's condition.

If you would like to direct a member to non-participating care providers, you must request a network exception from our Clinical Services department and receive approval before the member receives service. If the member requests to see a specialist and is unable to reach their PCP or OB/GYN (after-hours, weekends or holidays), the PCP may issue a referral up to 72 hours after the member received services.

Precertification guidelines still apply to those covered services requiring precertification.

We must review and approve all referrals. A referral does not guarantee coverage of the services provided by the participating specialist. Covered services are subject to:

- Medical necessity, as determined by Oxford's Clinical Policies
- Member eligibility on the date(s) of service
- Member's benefits as defined in the conditions, terms and limitations of their Summary of Benefits/ Certificates/Contract

Participating specialists may only issue referrals within the applicable network of care providers available to the members enrolled in gated health benefit plans for certain covered services as outlined in the Referrals policy. You may not refer a member to a non-participating specialist. For more information, refer to the section on *Using Non-Participating Health Care Providers or Facilities*.

Automated Fax Notification

When you submit a referral, we send a fax to the referred-to care provider or other health care professional, usually within 24 hours. This fax serves as a confirmation notice of the referral.

You have the option to update your referral fax number or decline the auto-fax notification feature on our website in the My Account section.

Member Self-Referrals

We have programs to improve outcomes for members and help us better manage the use of medical services. You may refer members to these programs, or members may self-refer, to network specialists for the following services:

1. OB/GYN care, to include prenatal care, two routine visits per year and any follow-up care, or for care related to an acute gynecological condition
2. One mental health visit and one substance use visit with a participating care provider per year for evaluation
3. Vision services from a participating care provider
4. Diagnosis and treatment of tuberculosis by public health agency facilities
5. Family planning and reproductive health from participating or Medicaid care providers

Outpatient Radiology Self-Referral Procedures

We designed the Outpatient Imaging Self-Referral Policy to promote appropriate use of diagnostic imaging by network PCPs, specialty physicians and other health care professionals in the office and outpatient setting.

This policy does not apply to radiology services performed during an inpatient stay, ambulatory surgery, ER visit, or pre-operative/pre-admission testing. See the *How to Contact Oxford Commercial* section for contact information.

The outpatient imaging self-referral list is applicable to commercial benefit plans (excluding Oxford USA Plans). You may find more information in Oxford's Outpatient Imaging Self-Referral Clinical Policy at OxfordHealth.com > Providers (or Facilities) > Tools and Resources > Medical Information > **Radiology & Radiation Therapy Information** > Radiology & Radiation Therapy Information

or UHCprovider.com/policies > Commercial Policies > UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies. (Refer to the back of the member's health care ID card for the applicable website.)

Standing Referrals and Specialty Care Centers

You may request a standing referral to a participating specialist, ancillary provider, or specialty care center if a member requires ongoing specialist treatment, has a life-threatening condition or disease, or a degenerative and disabling condition or disease. This referral is available only if the condition or disease requires specialized medical care over a prolonged period. The participating specialist or ancillary provider must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the medically necessary care required for the treatment of the condition or disease. We cover the services provided only to the extent outlined in the member's Certificate of Coverage.

Utilization Management

Prior Authorization (Precertification)

We refer to the terms "prior authorization" and "precertification" in the supplement. You will notice both terms used throughout this supplement.

You may submit prior authorization requests using any of the methods outlined in the *How to Contact Oxford Commercial* section.

We urge you, facilities, ancillaries and other health care professionals to perform a prior authorization status check first to determine if there is already a prior authorization on file.

Submit prior authorization as far in advance of the planned service as possible to allow for review. We require prior authorization at least 14 business days before the planned service date unless otherwise specified within the Services Requiring Prior Authorization policy at OxfordHealth.com > Providers (or Facilities) > Tools & Resources > Medical Information > Medical and Administrative Policies or UHCprovider.com/policies > Commercial Policies > UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies. Refer to the back of the member's health care ID card for the applicable website.

- Submit authorization requests for obstetrical admissions for normal delivery as early as possible in the course of prenatal care, based on the expected date of delivery.
- Participating care providers and facilities are responsible for contacting us for:
  - Procedures requiring prior authorization. However, an active referral must also be on file for services to be covered as network benefits, depending on the member's health benefit plan referral requirements.
  - Any change of treating care provider, location, CPT codes or dates of service for the authorized service.
  - Member emergency admissions upon admission or on the day of admission. If the care provider/facility is unable to determine on the day of admission that the patient is our member, the care provider/facility must notify us as soon as possible after discovering that the patient has coverage with us.
- We notify participating care providers of all determinations involving New York members by phone and in writing. All participating care providers are responsible for calling the member the same day the care provider receives notification of our determination.
- Neither prior authorization nor referral is required for members to access a participating women's health specialist (i.e., gynecologists and/or certified nurse midwives) for routine and preventive health care services. Routine and preventive health care services include breast exams, mammograms and Pap tests.
- Members are responsible for notifying us of emergency facility admissions to a non-participating facility.
- We may require a member see a care provider, selected by us, for a second opinion. We reserve the right to seek a second opinion for any surgical procedure. There is no formal list of procedures requiring second opinions. Members may also seek a second opinion when appropriate.

Status of a Submitted Authorization Request

Verify the status of an authorization request by the following methods:

- Voice Portal: available 24 hours a day
- Online: available 24 hours a day
- Provider Services: speak to a service representative during business hours

Medically Necessary Services

Medically necessary services are services or supplies provided by a hospital, skilled nursing facility (SNF) or care provider which are required to identify or treat a member's illness or injury, as determined by our medical director. These services or supplies must be:

- Consistent with the symptoms or diagnosis and treatment of a member's condition.
- Appropriate regarding standards of good medical practice.
- Not solely for the member's convenience or that of any care provider.
- The most appropriate supply or level of service which may safely be provided.

- For inpatient services, it also means the member's condition may not safely be diagnosed or treated on an outpatient basis.

Prior Authorization List

1. You may log on to OxfordHealth.com > Provider or Facilities > Transactions to use the Precert Required Inquiry tool on the Transactions tab to check prior authorization requirements for up to 12 CPT codes at one time.
2. The Services Requiring Prior Authorization administrative policy is at OxfordHealth.com > Providers (or Facilities) > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical and Administrative Policies Index or UHCprovider.com/policies > Commercial Policies > UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies. Refer to the back of the member's health care ID card for the applicable website.
3. You may request a copy of the most current list by mail:
   Oxford Policy Requests and Information
   4 Research Drive
   Shelton, CT 06484

Changes to the policies related to services appearing on this list are announced in the Oxford Policy Update Bulletin available at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin or UHCprovider.com/policies > Commercial Policies > UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies > Policy Update Bulletins. Refer to the back of the member's health care ID card for the applicable website.

- A member's benefit plan may not cover certain services, regardless of whether we require advance notification.
- If there is conflict or inconsistency between applicable regulations and the supplement notification requirements, we follow applicable regulations.
- Prior authorization requirements may differ by individual care providers, ancillary providers and facilities. If additional prior authorization requirements apply, we notify you before applying prior authorization rules.

eviCore Healthcare Prior Authorizations Online

eviCore Healthcare (eviCore) provides a secure, interactive web- based program where prior authorization requests may be initiated and determined in real time. If the program finds the request is medically necessary, it issues an authorization number immediately. If the program cannot verify medical necessity through the online process, you may submit more information at the session conclusion and print a procedure request summary page. If an online request for authorization doesn't meet medical necessity criteria, eviCore forwards it for clinical review. They may request more information for medical necessity review with a medical director.

If the criteria have not been met, your office and the member are notified in writing of the denial. Use the Prior Authorization and Notification tool at UHCprovider.com/paan, where the automated system guides you through a series of prompts to collect routine demographic and clinical data. This eliminates the need to call eviCore and lets you enter multiple clinical certification requests at your convenience.

Prescription Medications Requiring Prior Authorization

Based on the member's benefit plan design, some high-risk or high-cost medications require advance notification to be eligible for coverage. This process is also known as prior authorization and requires you to submit a formal request and receive advanced approval for coverage of certain prescription medications.

The list of prescription medications (including generic equivalents, if available) that require prior authorization is available on OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Prescription Drug Information > Drugs Requiring Precertification.

Prior Authorization and Referral Guidelines When Coordinating Benefits

When we are the secondary or tertiary carrier, we modify normal requirements for prior authorization and referrals as follows:

- We defer to the requirements of the primary carrier and waive our referral and prior authorization guidelines. We do not waive other requirements (e.g., itemized bills, student verification, consent for exchange of mental health or substance use information).
- Exception: Referral and prior authorization guidelines apply:
  - If the primary carrier does not cover a service or applies an authorization penalty.
  - When a motor vehicle accident occurs or workers' compensation is involved.

Using Non-Participating Health Care Providers or Facilities

As a participating care provider, you must use participating care providers and facilities within the member's benefit plan network (i.e., Liberty Network). We have a compliance program to identify participating care providers who regularly use non-participating care providers and facilities. We take appropriate measures to enforce compliance.

If a member asks you for a recommendation to a non-participating care provider, you must tell the member you may not refer to a non-participating care provider.

The member must contact us to obtain the required prior authorization by calling 800-444-6222.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility for a member who has out-of-network benefits, we may authorize the procedure as out-of-network.

This means the reimbursement to the non-participating facility is subject to the member's out-of-network deductible and coinsurance obligations. The non-participating facility's charges are only eligible for coverage up to the reimbursement levels available under the member's benefit plan, using either a usual, customary and reasonable (UCR) fee schedule or a Medicare reimbursement system (called the Out-of-Network Reimbursement Amount for our New York members).

Members are responsible for paying their out-of-pocket cost and the difference between the UCR fee or other out-of-network reimbursement and the non-participating facility's billed charges. Remind the member their expenses may be significantly higher when using a non-participating care provider.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility on a member who does not have out-of-network benefits (HMO and EPO benefit plan members), we may deny the services based on the benefit plan.

If you ask for an exception, we may consider it only when our medical director determines in advance that:

1. Our network does not have an appropriate participating network care provider who can deliver the necessary care.
2. Medically necessary services are not available through our network care providers.

In such cases, we will approve the requested authorization. It must include a treatment plan approved by our medical director, the PCP and the non-participating care provider.

Exception Process for the Use Of Non-Participating Care Providers (New York and Connecticut)

For participating care providers, the use of participating care providers is required unless:

1. We approved an in-network exception.
2. The member explicitly agrees prior to the service (no more than 90 days before the scheduled date of the procedure) to receive services from a non-participating care provider by signing the applicable consent form and understands that the use of this care provider is:
    a. Out-of-Network: For members with out-of-network benefits, we pay non-care provider claims at the out-of-network benefit level. Out-of-network cost-shares and deductibles apply.
    b. Denied: For members without out-of-network benefits, we deny non-participating care provider claims as not covered because the member has no coverage for services provided by non-participating care providers. Members are therefore responsible for the entire cost of the service.

You can get more details and copies of the Non-Participating Provider Consent Form, at **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website. Specific policies include but are not limited to:

- Par Gastroenterologists Using Non-Par Anesthesiologists: In-Office & Ambulatory Surgery Centers (New York)
- In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy (Oxford Service Area)
- New York & Connecticut Participating Surgeons Using Non-Participating Providers for Intraoperative Neuro-Monitoring (IONM)
- Participating Provider Laboratory and Pathology Protocol (Connecticut and New York)

Hospital Services, Admissions and Inpatient and Outpatient Procedures

Facilities are responsible for providing admission notification for all of the following types of inpatient admissions, even if advance notification was provided by the physician and coverage approval is on file:

- Planned/elective admissions for acute care
- Unplanned admissions for acute care (admission notification only)
- SNF admissions
- Admissions following outpatient surgery and observation
- Newborns admitted to Neonatal Intensive Care Unit (NICU) and who remain hospitalized after the mother is discharged
- The facility must confirm a pre-service approval is on file for services requiring prior authorization

Care providers and ancillary providers are responsible for obtaining prior authorization for outpatient surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility.

Concurrent Review: Clinical Information

Upon admission, Clinical Services will accept concurrent review information provided by the admitting care provider or other health care professional and/or the hospital's Utilization Review department. The hospital must also provide us with the discharge plan on or before the discharge date. If a member requires an extended length

of stay or more consultations, call our Clinical Services department at 800-666-1353 for prior authorization instructions.

- For mental health/substance use, direct calls related to inpatient prior authorization to 800-201-6991.
- You must cooperate with all requests for information, documents or discussions for purposes of concurrent review and discharge. When available, provide clinical information using electronic medical records (EMR).
- You must cooperate with all requests from the interdisciplinary care coordination team and/or medical director to engage our members directly face-to-face or by phone.
- You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if you receive our request before 1 p.m. ET, or make best efforts to provide requested information within the same business day if you receive the request after 1 p.m. ET (but no later than 12 p.m. ET the next business day).
- Oxford uses MCG™ Care Guidelines, which are nationally recognized clinical guidelines, to help clinicians make informed decisions in many health care settings.

Inpatient Maternity Stay and Subsequent Home Nursing

Oxford follows federal mandates regarding the length of an inpatient maternity stay and the coverage of subsequent home nursing visits. Home nursing visit regulations vary by state as outlined below.

Inpatient Maternity Length of Stay

Oxford will cover inpatient maternity stays for both mother and newborn as follows:

- 48 hours following a vaginal delivery
- 96 hours following a cesarean delivery

Post-Discharge Home Nursing Visits

- Connecticut: Oxford will approve two home nursing visits if both mother and newborn are discharged before the mandated length of stay described above.
- New Jersey and New York Plans: Oxford will approve one home nursing visit if both mother and newborn are discharged before the mandated length of stay described above.

Newborn coverage varies by benefit plan and state. For more details, refer to **OxfordHealth.com** > Providers or Facilities > **Transactions** > Check Eligibility & Benefits.

Neonatal Intensive Care Unit (NICU) Level of Care

We base NICU bed levels on the intensity of services and identifiable interventions received by the neonate. NICU bed levels are linked to revenue codes defined by the National Uniform Billing Committee. Based on our medical necessity review, we assign a bed day level for those facilities contracted with more than one level of NICU. Claims are reimbursed based on what has been authorized per a medical necessity review of the NICU bed day per the facility contract.

Hospital Responsibilities

The hospital is required to notify us of:

- Newborns admitted to NICU and who remain hospitalized after the mother is discharged.
- Concurrent inpatient stays (notification before discharge).
- Any member who changes level of care. The member must be enrolled and effective with us on the date the services are rendered. But, if CMS or an employer or group retroactively disenrolls the member up to 90 days following the dates of service, we may deny or reverse the claim.

The hospital must also:

- Provide daily inpatient census log by 10 a.m. ET, including all admits and discharges through midnight the day prior.
- Provide notification of all admissions of our members at the time of, or before, admission. The hospital must notify us of all emergencies (upon admission or on the day of admission), and of “rollovers” (i.e., any member who is admitted immediately upon receiving a preauthorized outpatient service).
- Provide notification for any transfer admissions of members before the transfer unless the transfer is due to life-threatening medical emergency.
- Communicate necessary clinical information daily, or as requested by our case manager.

If the hospital does not provide the necessary clinical information, we may deny the day for medical necessity. We give reconsideration only if we receive clinical information within 48 hours (72 hours for New Jersey facilities).

If we conduct onsite utilization review, the hospital will provide our onsite utilization management personnel reasonable workspace and access to the hospital, including access to members and their medical records. All care providers must deliver letters of non-coverage to the member before discharge. This includes hospitals, acute rehabilitation, SNFs, and home care.

We consider appeals if the hospital can show that the necessary clinical information was provided within 48 hours, but we failed to respond in a timely manner.

Retrospective Review of Inpatient Stays (Notification of Admission After Discharge)

If we request it, the hospital will provide the necessary clinical information to perform a medical necessity review within 45 days of discharge. If the hospital does not provide the necessary clinical information, we may deny the day for medical necessity. We give reconsideration only if clinical

information is received within 48 hours (72 hours for New Jersey members).

Our Responsibilities for Inpatient Notifications

- We will maintain a system for verifying member eligibility/status and use reasonable efforts to transmit a decision regarding an emergency/urgent admission to the hospital.
- We will request any necessary clinical information. If we do not ask for such information, the day's services will be our liability.
- We agree to provide concurrent and prospective reviews for all services.
- We will assign a first day of review (FDOR) for all elective inpatient services, and we will certify all days up to and including the FDOR.
- We will notify the hospital and attending care provider or other health care professional verbally and in writing of all denied days.
- We will perform clinical review of days that fall on the weekends and holidays for which we or the facility is closed, and days upon which there are unforeseen interruptions in business on the following business day. Such reviews will be considered concurrent.
- We will not deny services retrospectively or reduce the level of payment for services that have been preauthorized or received concurrent review approval unless:
  - The member is retroactively disenrolled.
  - The certification or concurrent review approval was based on materially erroneous information.
  - The services are not provided in accordance with the proposed plan of care.
  - Hospital delays in providing an approved service to prolong the length of stay beyond what was approved.

Mental Health, Substance Use and Detoxification Treatment

Inpatient Care

All inpatient mental health/substance use treatment requires prior authorization.

Partial Hospitalization

Partial hospitalization always requires certification through the behavioral health department. If clinical criteria are met, the case manager facilitates certification and management at a contracted facility with a partial hospitalization program. The case manager continues to follow the member's treatment while they are in the program.

Prior Authorization Outpatient Mental Health Services (New York)

Covered services are those received on an outpatient basis from duly licensed psychiatrists or practicing psychologists, certified social workers, or a facility-issued operating certificate by the commissioner of mental health, a facility operated by the Office of Mental Health, a professional corporation or university faculty practice corporation. This includes:

- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Crisis intervention

We provide coverage to the maximum number of visits shown on the member's Summary of Benefits.

Inpatient Mental Health Services (New York)

Members receive covered services on an inpatient or partial hospitalization basis in a facility as defined by subdivision 10 of section 1.03 of the Mental Hygiene Law, as well as by any other network care provider we deem appropriate to provide the medically necessary care.

We cover a required inpatient stay as a semi-private room. If we authorize partial hospitalization, two partial hospitalization visits may be substituted for one inpatient day. We provide coverage for active treatment to the maximum number of days shown on the member's Summary of Benefits.

Visits for biologically based services will apply to this limit. Active treatment means treatment furnished together with inpatient confinement for mental, nervous or emotional disorders, or ailments that meet standards prescribed within the regulations of the commissioner of mental health.

Laboratory Policies and Procedures

Ancillary Services

Our network of laboratory service providers consists of an extensive selection of walk-in patient service centers; many regional and local laboratories; and a national provider of laboratory services, Laboratory Corporation of America (LabCorp).

Participating vs. Non-participating Laboratory Provider Referrals

Refer our members to participating service centers and laboratories to help them avoid unnecessary costs. Referrals are not required. Only a care provider's prescription or lab order form is required.

We review laboratory ordering information periodically. If our data shows a pattern of out-of-network utilization for your practice, we contact you to share this information and engage you to use the contracted network.

Participating Provider Laboratory & Pathology Protocol (New York)

You must follow specific guidelines when you are recommending the use of, making a referral to, or involving a non-participating laboratory or pathologist in a member's care.

For additional details and/or to obtain a copy of the Non-Participating Provider Consent Form, refer to the Participating Provider Laboratory and Pathology Protocol policy at **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website.

In-Office Laboratory Testing and Procedures List
The in-office laboratory testing and procedure list outlines the laboratory procedural/testing codes we reimburse to network care providers when performed in the office setting. For the most up-to-date list, refer to the In-Office Laboratory Testing and Procedures List at **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > **Medical and Administrative Policies** or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website. One of our network laboratories must perform laboratory procedures/tests not appearing on this list. See the *How to Contact Oxford Commercial* section for contact information.

Specimen Handling and Venipuncture
Your prescription or lab order form is required when using participating laboratories to process specimen. If you bill specimen handling and venipuncture codes along with a lab code on the In-Office Laboratory Testing and Procedures List, we only reimburse the lab and venipuncture codes.

If you bill specimen handling and venipuncture codes without a lab code on our In-Office Laboratory Testing and Procedures List or with other non-laboratory services, we reimburse the specimen handling and venipuncture codes per our fee schedule.

Radiology, Cardiology and Radiation Therapy Procedures

Oxford has engaged eviCore to perform initial reviews of pre-certification requests.

eviCore has established an infrastructure to support the review, development, and implementation of comprehensive outpatient imaging criteria. The radiology and cardiology evidence-based guidelines and management criteria are available on the eviCore website. In addition, eviCore established coding and billing guidelines to help ensure appropriate billing of radiation oncology codes.

eviCore handles all pre-certification requests. To pre-certify a radiology, cardiology or radiation therapy procedure, please contact eviCore at 877-PRE-AUTH (877-773-2884) or visit the Prior Authorization and Notification tool (PAAN/LINK).

Radiology Procedures

Oxford also requires a minimum care provider accreditation and certification requirements for MRI, PET, CT and nuclear medicine studies. Find more detailed information in the Radiology Procedures Requiring Precertification for eviCore Health Care Arrangement policy at **OxfordHealth.com** > Providers (or Facilities) > Tools and Resources > Medical Information > Radiology & Radiation Therapy Information or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. (Refer to the back of the member's health care ID card for the applicable website.)

- **Online:** Link, using the Prior Authorization and Notification app
- **Phone:** 877-PRE-AUTH (877-773-2884)

Imaging Requiring Prior Authorization

The referring care provider is responsible for contacting eviCore to request prior authorization and to provide sufficient history to verify the appropriateness of the requested services. Our policy does not permit prior authorization requests from persons or entities other than referring care providers.

Radiology Prior Authorization Policy for Urgent Cases

The imaging facility must confirm before providing service that eviCore issued an authorization number. In the case of urgent examinations, or cases in which, in the opinion of the attending care provider or other health care professional, a change is required from the authorized examination, and the eviCore offices are unavailable, you may perform the services and request a new or modified authorization number. You must make the request within two business days of the service date through the Imaging Care

Management department for Radiology. You should make the request immediately if the eviCore offices are available.

eviCore will review the clinical justification for the request using the same criteria as a routine request. See the *How to Contact Oxford Commercial* section for additional information.

Obtain prior authorizations for outpatient radiology, cardiology, and radiation therapy procedures on UHCprovider.com using the Link Advance Notification and Prior Authorization app.

UHCprovider.com/paan

877-PRE-AUTH (877-773-2884)

Cardiology Procedures

Oxford has engaged eviCore to perform initial reviews of requests for pre-certification of for echocardiogram, stress echocardiogram, cardiac nuclear medicine studies, cardiac CT, PET and MRI and cardiac catheterizations procedures. eviCore established correct coding and evidence-based criteria to determine medical necessity and appropriate billing of cardiology services. The cardiology evidence-based criteria and management criteria are available on the eviCore website at **evicore.com**. Oxford continues to be responsible for decisions to limit or deny coverage and for appeals.

The utilization review process involves matching the member's clinical history and diagnostic information with the approved criteria for each imaging procedure requested. Qualified health care providers make utilization review decisions for diagnostic procedures. eviCore may assign data collection for clinical certification of imaging services to non-medical personnel working under the direction of qualified health care providers. You receive communication of review determinations for non-urgent care by fax/telephone within two business days of receiving all the necessary information. For urgent requests, eviCore communicates their findings for medical necessity within 24 hours of receiving all required information.

For members, eviCore accepts requests for retrospective clinical certification review of medically urgent care up to two business days after care has been given for radiology and 15 days for cardiac catheterization, if the services are performed outside eviCore's hours of operation and rendered on an urgent basis. eviCore makes retrospective review decisions within 30 business days of receiving all necessary information. If your request is not authorized, they send a review determination in writing to the member and the requesting care provider within five business days of the decision. All authorization reference numbers are issued at the time of approval. eviCore uses the reference CPT code as the last five digits of the authorization number. We require the submission of clinical office notes for specific procedures. Clinical notes include the member's medical record and/or letters received from specialists.

For a list of procedures requiring pre-certification through eviCore, refer to the Cardiology Procedures Requiring Precertification for eviCore Health Care Arrangement policy at:

OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** or UHCprovider.com >Policies and Protocols > Commercial Policies > **UnitedHealthCare Oxford Clinical, Administrative and Reimbursement Policies**.

Radiation Therapy Procedures

Oxford has engaged eviCore to perform prior authorization and medical necessity reviews for all outpatient radiation therapy services. Oxford continues to be responsible for decisions to limit or deny coverage and for appeals.

For a list of procedures requiring pre-certification through eviCore, refer to the clinical policy titled "Radiation Therapy Procedures Requiring Precertification for eviCore Health Care Arrangement" at **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website.

Oxford Municipality and School Board Members

Radiology, Radiation Therapy, Cardiology, Cardiac Catheterization, Echocardiogram and Stress Echocardiogram Procedures

eviCore performs a medical necessity review before rendering services. To obtain prior authorization for a course of radiation therapy, or rendering a Diagnostic Radiology procedure, use the Prior Authorization and Notification app on Link. See **UHCprovider.com/priorauth** for more information.

We require the submission of clinical office notes for specific procedures if a medical necessity review and utilization review is not conducted before services are performed. Clinical notes include the member's medical record and/or letters received from specialists. Supporting clinical information provided by the ordering care provider must contain the ordering/referring care provider's name and signature, address, phone and fax numbers, specialty, and tax identification number. It must also include all of the following information:

- Reason for the procedure performed
- Member's signs and symptoms
- Treatment, including type and duration
- Previous studies for the specific medical issue
- Any other pertinent clinical information to determine medical necessity.

Note: eviCore policy does not permit prior authorization requests from persons or entities other than the following:

- Radiology services: The referring physician is responsible for providing medical documentation showing clinical necessity for the requested or rendered outpatient radiology procedure, for pre- and post-service review.
- Radiation therapy services: The rendering radiation therapist is required to request prior authorization. Follow the Physician Worksheets to provide the right information to determine the medical necessity of requested services.

Referrals
Certain Oxford products require referrals for radiology, cardiology or radiation therapy from the member's PCP. If your patient is enrolled in one of these benefit plans, they are required to obtain a referral before seeing you for an initial visit.

Claims Processing
We continue to process claims from participating care providers for radiation therapy services. You receive payment directly from us.

You may not balance bill the member if a claim is denied because medical necessity was not demonstrated. We will offer all appropriate appeal rights for any service that is not approved for payment.

Prior authorization is not required when cardiology procedures are provided in the ER, observation unit, urgent care facility, or during an inpatient stay.

See a list of Services Requiring Prior Authorization at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > **Medical & Administrative Policy Index** > Services Requiring Prior Authorization or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website.

The clinical criteria consistent with existing UnitedHealthcare and Oxford policies are available on **evicore.com**.

You can verify prior authorization requirements by:

1. Calling the number on the back of the member's health care ID card to check eligibility.
2. Visiting **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources.
3. Using the Prior Authorization and Notification app on Link.

Infertility Utilization Review Process
Oxford delegated Optum, a UnitedHealth Group company, to perform reviews for infertility services under their Managed Infertility Program (MIP) for all Oxford Commercial members with an infertility benefit. Optum uses MIP to promote both quality of care and continuity of service by supporting members through every aspect of the infertility process. Optum infertility nurse case managers provide support and help members make informed decisions about infertility treatment and care through treatment education, considerations in choosing where to obtain care, and assistance navigating the health care system.

For Oxford products, the rendering care provider is required to request prior authorization and/or notification of services. Make this request using the Managed Infertility Program Treatment form. Provide sufficient information to determine the medical necessity of the requested services.

Optum has been diligent in their research to help ensure the clinical policies and guidelines they use are consistent with best practices and state mandates.

Get the Managed Infertility Program (MIP) Prior Authorization template by either:

- Logging onto **myoptumhealthcomplexmedical.com**
- Calling OptumHealth at 877-512-9340
- Sending an email to **MIP@optum.com**

Physical and Occupational Therapy

Oxford delegated certain administrative services related to outpatient physical and occupational therapy services to OptumHealth Care Solutions. Hospital outpatient treatment facilities, outpatient facilities at or affiliated with rehabilitation hospitals are considered outpatient settings for physical and occupational therapy.

All physical and/or occupational therapy visits require utilization review and an authorization, including the initial evaluation. After registering on **myoptumhealthphysicalhealth.com**, click on the Forms link and locate the Patient Summary Form. The treating care provider or health care professional must submit a Patient Summary Form to OptumHealth. They may submit the completed form through the OptumHealth website **myoptumhealthphysicalhealth.com**. Send the forms within three days of initiating treatment. They must be received within 10 days from the initial date of service indicated on the form. OptumHealth adjusts the initial payable date when they receive the forms outside of the 10-day submission requirement.

The Patient Summary Form must include the initial visit. If OptumHealth Care Solutions does not receive the required form(s) within this time frame, they deny the claim. OptumHealth Care Solutions reviews the services requested for medical necessity. After the initial approved visits have occurred, if a member's care requires additional visits or more time than was approved, you must submit a new Patient Summary Form with updated clinical information.

Note: Prior authorization is not required for certain groups.

Musculoskeletal Services

OrthoNet, a musculoskeletal disease management company, is our network manager for most musculoskeletal services.

OrthoNet's orthopedic division performs utilization management review of requested services to help ensure they meet approved clinical guidelines for medical necessity.

OrthoNet conducts the review by determining medical necessity and medical appropriateness, and initiates discharge planning, as appropriate. OrthoNet will base the results on clinical information and some or all of the following criteria/tools:

- Member benefits
- Oxford medical and reimbursement policies
- MCG Care Guidelines

Services performed by the following specialties (participating and non-participating) are subject to utilization review by OrthoNet's orthopedic division regardless of the diagnosis:

- Orthopedic surgery
- Pediatric orthopedic surgery
- Podiatry
- Neurosurgery
- Hand surgery
- Physical medicine rehabilitation

OrthoNet's orthopedic division manages services provided by the facilities below (participating and non-participating) when billed together with certain ICD-10 codes:

- Acute care hospital
- Ambulatory surgery
- DME
- Other ancillary facility
- Home health care
- Physical rehabilitation hospital
- Physical rehabilitation facility
- SNF

For a complete list of orthopedic diagnosis codes, or for more information on Oxford's arrangement with OrthoNet, refer to the Orthopedic Services policy at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > **Medical & Administrative Policy Index** or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website.

Chiropractic Services

OptumHealth Care Solutions manages our chiropractic benefit. To receive standard chiropractic benefit coverage, members must obtain an electronic referral from their PCP. PCPs perform the customary initial comprehensive differential diagnosis with the necessary and appropriate workup.

You may request a chiropractic referral for a maximum of one visit within 180 days (six months). Participating chiropractors must complete and submit Patient Summary Forms to OptumHealth Care Solutions for services performed.

They may submit the Patient Summary Forms through the OptumHealth Care Solutions website at **myoptumhealthphysicalhealth.com**. They must submit the form within three business days and no later than 10 business days following the member's initial visit or recovery milestone. We must receive the patient summary form within 10 days from the initial date of service indicated on the form. OptumHealth adjusts the initial payable date when they receive the forms outside of the 10-day submission requirement.

Once they receive the forms, OptumHealth Care Solutions reviews the services requested for medical necessity and makes denial determinations.

If a member's care requires more visits or time than was approved, you must submit a new Patient Summary Form with updated clinical information after the initially approved visits have occurred.

According to your contract with Care Solutions, the member may not be balance billed for any covered service not reimbursed if you do not submit the Patient Summary Form, or for those services which do not meet medical necessity or coverage criteria. However, you may file an appeal.

Acupuncture Services

Only members who have the alternative medicine rider have coverage for acupuncture. If a member does not have the alternative medicine rider, we deny requests to cover acupuncture, even if a letter of medical necessity has been submitted. Acupuncture services must be rendered in-network and performed by one of the following care provider types:

- Participating licensed acupuncturist (LAC)
- Participating licensed naturopaths
- Participating care provider (MD or DO) who is credentialed as physician acupuncturist

Pharmacy Management Programs

The pharmacy benefit plan includes a dynamic medication list, referred to as the Prescription Drug List (PDL), and various clinical drug utilization management programs. We base these programs on FDA-approved indications and medical literature or guidelines.

The PDL contains medications in three tiers. Tier 1 is the lowest cost option, and Tier 3 is the highest cost option. Some groups have a 4-tier benefit design.

To help make medications more affordable, consider whether a Tier 1 or Tier 2 alternative is appropriate if the member is currently taking a Tier 3 medication. We perform ongoing reviews of the PDL and make updates at least twice per year. Medications requiring notification or prior authorization are noted with a "PA," medications that require step therapy are noted with "ST" and supply limits with "SL."

PDL Management Committee and the Pharmacy & Therapeutics Committee
The UnitedHealthcare PDL Management Committee, a group of senior care providers and business leaders, makes tier decisions and changes to the PDL based on a review of clinical, economic and pharmacoeconomic evidence.

The UnitedHealthcare National Pharmacy and Therapeutics (P&T) Committee is responsible for evaluating and providing clinical evidence to the PDL Management Committee to help assign medications to tiers on the PDL. The information provided by the P&T Committee includes evaluation of a medication's role in therapy, its relative safety and its relative efficacy.

The P&T Committee reviews and approves clinical criteria for prior authorization and step therapy programs, and supply limits. In addition to medications covered under the pharmacy benefit, the P&T Committee is responsible for evaluating clinical evidence for medications, which require administration or supervision by a qualified, licensed health care professional.

The P&T Committee is comprised of medical directors, network care providers, consultant physicians, clinical pharmacists and pharmacy directors.

For more information regarding Oxford's Pharmacy Management Program, go to **oxhp.com**.

Quality Management and Patient Safety Programs Drug Utilization Review (DUR)
We receive the majority of prescription claims electronically for payment. Within seconds, our systems record the member's claim and review past prescription history for potential medication-related problems. DUR helps review for potentially harmful medication interactions, inappropriate utilization and other adverse medication events to maximize therapy effectiveness within the appropriate medication usage parameters. There are two types of DUR programs: concurrent and retrospective.

Concurrent Drug Utilization Review (C-DUR)
The C-DUR program performs online, real-time DUR analysis at the point of prescription dispensing. This program screens every prescription before dispensing for a broad range of safety and utilization considerations. C-DUR uses a clinical database to compare the current prescription to the member's inferred diagnosis, demographic data and past prescription history. The C-DUR program uses criteria to identify potential inappropriate medication consumption, medical conflicts or dangerous interactions that may result if the prescription is dispensed.

If the C-DUR identifies a potential problem, it notifies the dispensing pharmacist by sending either a soft alert (warning message) or a hard alert (a warning message also requiring the pharmacist to enter an override). The dispensing pharmacist uses professional judgment to determine appropriate interventions, such as contacting the prescribing care provider or other health care professional, discussing concerns with the member and dispensing the medication.

Retrospective Drug Utilization Review (R-DUR)
The R-DUR program involves a daily review of prescription claims data to identify patterns in prescribing or medication utilization suggesting inappropriate or unnecessary medication use. The program uses a clinical database to review member profiles for potential over-or under-dosing as well as duration of therapy, potential drug interactions, drug-age considerations and therapy duplications.

You and other prescribers receive a member-specific report outlining opportunities for intervention and asking them to respond to specific issues and concerns.

Clinical Programs

Prescription Medications Requiring Prior Authorization (Subject to Plan Design)
Based on the member's benefit plan design, selecting high-risk or high-cost medications may require advance notification to be eligible for coverage. We may ask you to provide information explaining medical necessity and/or past therapeutic failures. A representative will collect pertinent clinical data for the service requested. If we do not approve the prior authorization, a pharmacist or medical director, in keeping with state regulations, makes the final coverage determination. We notify you and the member of the decision.

Step Therapy (Subject to Plan Design)
Certain medications may be subject to step therapy, also referred to as First Start for New Jersey members. The step therapy program requires a trial of a lower-cost, Step 1 medication before a higher-cost, Step 2 medication is eligible for coverage. When a member presents a Step 2 medication at the pharmacy, our systems may automatically check the claims history to see if a Step 1 medication is in the claims history. The medication may automatically process. If not, you may request a coverage review. If we do not approve the medication, a pharmacist or medical director, in keeping with state regulations, makes the final coverage determination. We notify you and the member of the decision.

Supply Limits (Subject to Plan Design)
Some medications are subject to supply limits. We base supply limits on FDA-approved dosing guidelines as

defined in the product package insert and the medical literature or guidelines and data supporting the use of higher or lower dosages than the FDA-recommended dosage. This program focuses on select medications or categories of medications that are high-cost and/or are frequently used outside of generally accepted clinical standards.

When a pharmacist submits an online prescription claim, the online claims processing system compares the quantity entered with the allowable limits.

If the prescription exceeds the established quantity limits, we reject the claim, and the pharmacist receives a message. The current supply limit for the medication is displayed in the message. For New York and New Jersey fully insured business, a subset of medications has coverage criteria available to obtain quantities beyond the established limit, if medically necessary.

Emergencies and Urgent Care

Urgent Care

Urgent care is medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not a medical emergency. It does not otherwise fall under the definition of emergency care.

Definition of a Medical Emergency

Connecticut: An "emergency condition" is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in placing the health of such person or others in serious jeopardy, or serious impairment to bodily functions; or serious dysfunction of a bodily organ or part; or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

New Jersey: An "emergency condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use, and the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to affect a safe transfer of the woman or unborn child to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child.

New York: "Emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Emergency Room Visits

We cover ER services for medical emergencies. The member is responsible for paying their copayment. Follow-up ER visits within our service areas are not covered. However, follow-up care, if appropriate, is coordinated through the member's PCP and is subject to the standard referral process.

- ER visits during which a member is treated and released without admission do not require notice to us.
- If an ambulatory surgery occurs because of an ER or urgent care visit, you must notify us within 24-48 hours of when the surgery is performed. Coordinate all follow-up needs related to such emergency services through the member's PCP. They are subject to the standard referral process.
- When a member is unstable and not capable of providing coverage information, the facility should submit the concurrent authorization as soon as they know the information and communicate the extenuating circumstances.

In-Area Emergency Services

You do not need to provide notification or obtain authorization for in-area ER treatment and subsequent release. However, all emergency inpatient admissions and emergency outpatient admissions (i.e., for emergent ambulatory surgery) require notification upon admission or on the day of admission (no later than 48 hours from the date of admission, or as soon as reasonably possible).

Out-of-Area Emergency Services

Out-of-area coverage for ER services are limited to care for accidental injury, unanticipated emergency illness or other emergency conditions when circumstances prevent a member from using ER services within our service area.

Emergency Admission Review

If the member is admitted to a hospital due to an emergency (as previously defined), we review the hospital admission for medical necessity and determine appropriate length of stay based on our approved criteria for concurrent review. Review begins when we become aware of the admission. You must notify us of all emergency inpatient admissions no later than 48 hours from the

date of admission, or as soon as reasonably possible. If the member is admitted to a contracted hospital, we use reasonable efforts to transmit a decision about the admission to the hospital (to the fax number and contact person designated by the hospital) within 24 hours of making the decision.

Non-Emergency Hospitalization
Any hospitalization service that does not meet the criteria for an emergency or for urgent care requires prior authorization and is subject to medical necessity review.

Coverage Outside of the United States

Oxford provides limited coverage for members outside of the United States, Mexico, Canada, or the U.S. Territories.

New York (NY) and Connecticut (CT) Products
The following applies to out-of-country care providers.

- Claims received for services performed outside of the United States do not require an authorization if the services are emergent in nature.
- We will not cover elective procedures outside of the United States, Mexico, Canada or the U.S. Territories for members who reside in the United States unless an authorization exists specifically indicating that out-of-country services were authorized. This includes prenatal care and delivery.
- All claims from out-of-country care providers must be translated and the amount billed and calculated in American dollars using the conversion rate as of the processing date.

New Jersey (NJ) Products
The following applies to out-of-country care providers.

- Claims received for services performed outside of the United States do not require an authorization if the services are emergent or urgent in nature.
- Claims will not be covered for elective procedures outside of the United States, Mexico, Canada or the U.S. Territories for members who reside in the United States unless an authorization exists specifically indicating that out-of-country services were authorized. This includes prenatal care and delivery.
- All claims from out-of-country care providers must be translated and the amount billed and calculated in American dollars using the conversion rate as of the processing date.

Out-of-Country Resident Members

NJ Small Group/PPO FP and Liberty
Services provided outside of the United States are excluded unless the covered member is outside of the United States for one of the following reasons:

- Travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, is for a period of six months or less.
- Business assignment, provided the covered member is temporarily outside of the United States for a period of six months or less.
- Eligibility for full-time student status (subject to pre-approval), provided the covered member is either enrolled and attending an accredited school in a foreign country or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States grants academic credit.

Note: We deny charges in connection with full-time student status in a foreign country that we have not pre-approved as non-covered charges.

Utilization Reviews

Our UM represents a combination of different disciplines, including utilization review with benefit and eligibility requirements, effective and appropriate delivery of medically necessary services, quality of care across the continuum, discharge planning, and case management.

Our Clinical Services department monitors services provided to members to identify potential areas of over and underutilization. UM decision-making is based only on appropriateness of care and service and the existence of coverage. We do not specifically reward or offer incentives to practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

Criteria and Clinical Guidelines

We have adopted the MCG™ Care Guidelines and criteria for inpatient and ambulatory care where no specific Oxford policy exists. We also develop specific policies related to covered services. Each policy describes the service and its appropriate utilization.

We employ several means to review the consistency and quality of clinical decision-making as directed through policies and adopted guidelines. The following processes are in addition to those required by regulatory agencies and NCQA:

- Inter-rater reliability tests developed in conjunction with an external consultant
- Monthly medical director consistency meetings and case discussions
- Monthly blind reviews done by all medical directors on a common set of clinical factors

We employ a process for adopting and updating clinical practice guidelines for use by network care providers and other health care professionals. Clinical practice guidelines help practitioners and members make decisions about health care in specific clinical situations. We develop

guidelines for preventive screening, acute and chronic care, and appropriate drug usage based on:

- Availability of accepted national guidelines
- Ability to monitor compliance
- Projected ability to make a significant impact upon important aspects of care

Clinical practice guidelines are available on **OxfordHealth.com** > Providers or Facilities > **Tools & Resources** > Medical Information > Clinical and Preventive Guidelines.

Clinical Review

Oxford may perform clinical reviews for various reasons, including but not limited to, medical necessity determinations, member eligibility, and to validate accuracy of coding for services or procedures requested or rendered by participating or non-participating care providers and other qualified health care professionals. We consider medically necessary services for reimbursement when rendered to eligible members, as reflected in the clinical information, provided the services are not fraudulent or abusive.

Oxford may review clinical information on an entire population of, or a subset of care providers, procedures or members, at our discretion. We may review this information prospectively, concurrently and/or retrospectively. We define clinical information as the member's clinical condition, which may include symptoms, treatments, dosage and duration of drugs, and dates for other therapies. Dates of prior imaging studies performed and other information the ordering care provider believes is useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports, should be provided.

Clinical information reviewed prospectively may be reviewed again concurrently or retrospectively to confirm the accuracy of the information available at the time of previous review. Oxford will retrospectively deny an approval only in circumstances indicated in the approval or in circumstances involving fraud, abuse or material misrepresentation.

The procedure and information required for review will depend on the circumstances of interest, as determined by Oxford.

The process of selecting services for review, requests for clinical information concerning such services, review of clinical information, and action based on clinical information complies with all relevant federal and state regulations, laws, and provisions in your contract with Oxford. We provide information on appeal rights for adverse determinations as required by law and regulation.

Utilization Review of Services Provided to New York Members

All adverse utilization review (UR) determinations (whether initial or on appeal) are made by a clinical peer reviewer. Appeals of adverse UR determinations will be reviewed by a different clinical peer reviewer than the clinical peer reviewer who rendered the initial adverse determination.

Initial Utilization Review Determination Time Periods
We make UR decisions by the following methods and in the following time frames:

Prior Authorization - We make UR decisions and provide notice to you and the member, by phone and in writing, within three business days of receipt of necessary information.

Concurrent review - We make UR decisions and provide notice to the member or their designee by phone and writing within one business day of receipt of necessary information

Retrospective - We will make UR decisions within 30 days of receipt of necessary information. We may reverse a preauthorized treatment, service or procedure on retrospective review whan all the following circumstances occur:

1. Relevant medical information presented to us or UR agent during retrospective review is materially different from the information presented during the preauthorization review.
2. The information existed at the time of the preauthorization review but was withheld or not made available.
3. UnitedHealthcare or the UR agent was not aware of the existence of the information at the time of the preauthorization review.
4. If we had been aware of the information, we would not have authorized the treatment, service or procedure requested.

If an initial adverse UR determination is rendered without attempting to discuss such matter with the member's care provider or other health care professional who specifically recommended the health care service, procedure or treatment under review, such care providers and other health care professionals have the opportunity to request reconsideration of the adverse determination. Except in cases of retrospective reviews, the medical director or other health care professional conducts the review as the clinical peer reviewer and make the determination within one business day of receipt of the request.

Failure to make an initial UR determination within the time periods described is deemed to be an adverse determination eligible for appeal.

Components of an Initial Adverse Determination
If the review results in an adverse determination, the initial adverse determination letter includes the following:

1. Reasons for the determination, including clinical rationale.
2. Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals.
3. Clinical review criteria relied upon to make our decision is provided upon request from the member or the member's designee.
4. Any other necessary information that must be provided to, or obtained by us, to render a decision on an appeal of our determination.

Appeal Requirements for Initial Adverse Utilization Review Determinations (New York Member Appeals)

Member appeals must be submitted to us or our delegate within 180 days from the receipt of the initial adverse UR determination. Standard (non-expedited) UR appeals may be filed by telephone or in writing by the member or their designee. Member appeals may be initiated in writing or by calling our Member Service department at the number on the member's health care ID card or at 800-444-6222. However, we strongly recommend the appeal be filed in writing. Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis. In the event that only a portion of such necessary information is received, we request the missing information, in writing, within five business days of receipt of partial information. If a determination is not made within 15 days of the filing of the appeal, we provide written acknowledgment to the appealing party within 15 days of the filing of a standard appeal.

Expedited UR Appeals

An expedited UR appeal may be filed for denials of:

- Continued or extended health care services, procedures or treatment.
- Additional services for member undergoing a course of continued treatment.
- Health care services for which the care provider or other health care professional believes an immediate appeal is warranted.

We make a decision on expedited UR appeals within two business days of receipt of the information necessary to conduct such appeal. If we require more information to conduct an expedited appeal, we immediately notify the member and their health care provider by telephone or fax to identify and request the necessary information, and follow up with a written notification. The appealing party may re-appeal an expedited appeal using the standard appeal process or through the external appeal process.

We allow you to submit an expedited member appeal without a member's written consent. All other appeals require the member's explicit written consent to appeal after our initial UR decision is made. A general assignment will not be accepted.

If we do not make a determination within 60 calendar days of receipt of the necessary information for a standard appeal or within two business days of receipt of necessary information for an expedited appeal, we consider the initial adverse UR determination to be reversed.

The law allows the member and UnitedHealthcare to jointly agree to waive the internal UR appeal process. Typically, we do not agree to this. In those rare situations where we are willing to waive the internal UR appeal, we inform the appeal requester and/or member verbally and/or in writing. If the member agrees to waive the internal UR appeal process, we provide them with a letter within 24 hours of the Agreement with information on filing an external appeal.

Internal Utilization Management Appeals Process

Retrospective Review Appeals (New York Provider Appeals)

A retrospective adverse determination is one where the initial medical necessity review is requested or initiated after the services have been rendered. This process does not apply to services where precertification or concurrent review is required. You may request an external appeal on your own behalf, by phone or in writing, when we have made a retrospective final adverse determination on the basis that the service or treatment is not medically necessary or is considered experimental or investigational (or is an approved clinical trial) to treat the member's life-threatening or disabling condition (as defined by the New York State Social Security Law).

All requests for such internal retrospective appeals must be made within 60 days of receipt of the initial retrospective medical necessity or experimental/investigational determination. If we require more information to conduct a standard internal appeal, we notify the member and their health care provider, in writing, within 15 days of receipt of the appeal, to identify and request necessary information.

Once we make a decision about the retrospective review appeal, we notify the member and their care provider in writing within two business days from the date we make the decision.

If the decision is adverse, and you continue to dispute our decision, you may be eligible for an external appeal through the New York external appeal process. Hospitals and other facilities may have alternate dispute mechanisms in place for review of these issues instead of external appeal. Please check your contract for more information.

Internal retrospective appeals submitted after the 60-day time frame is not handled through this process. If your appeal is still submitted within the contractual deadlines for an appeal, we automatically handle it through the contractual appeal process discussed in the next section.

Medical Necessity Internal Appeals Process for Care Providers Under Your Contract

If we make a decision that a requested service is not medically necessary, you may dispute our determination. Mail a written request, with supporting clinical documentation showing why we should reverse the denial of services, to:

Oxford Clinical Appeals Department
P.O. Box 29139
Hot Springs, AR 71903

The Clinical Appeals department makes a reasonable effort to render a decision within 60 calendar days of receiving the appeal and supporting documentation. If the contractual appeal decision is adverse, and you continue to dispute the decision, the dispute may be eligible for arbitration under your contract.

Note: There is a separate appeal process for internal member appeals and retrospective provider appeals under New York law. These processes do not apply to contractual appeals.

Appeals not submitted within the contractual time frames are denied.

Connecticut Members

Utilization Review Appeals

UR occurs whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. The UR appeals process should be used after you receive an initial adverse UR determination, and you do not agree with our decision. All appeals are subject to a review by us to evaluate the medical necessity of the services. You may use this process to appeal adverse determinations relating to all UR determinations, regardless of whether the services requested by you or your authorized representative have not yet been rendered (pre-service), are currently being rendered (concurrent) or have already been rendered (post-service).

Note: This UR appeals process should not be used for appeals relating to benefit, network or administrative issues.

UR appeals must be initiated within 180 days from receipt of an adverse determination (i.e., receipt of the determination notice). A decision may be rendered within the standard time frames or may be expedited as described in this section.

While a UR appeal may be filed by telephone or in writing, we strongly recommend you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send documentation/information already requested by us (if not previously submitted) and additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Unless we already issued a written determination, we use our best efforts to provide written acknowledgement of the receipt of your appeal within five business days but not later than 15 calendar days. Our decision to either uphold or reverse the adverse determination is made and communicated to you as follows:

- Request for service (pre-service): Within 30 calendar days of our receipt of the appeal. However, if additional information is requested, a determination is made within three business days of our receipt of the information, or the expiration of the period allowed to provide the information (i.e., 45 days).
- Concurrent services for a member in an ongoing course of treatment (concurrent): Within 30 calendar days of our receipt of the appeal. In this instance, treatment is continued without liability while your appeal is being reviewed. However, if additional information is requested, a determination is made within one business day of our receipt of the information, or the expiration of the period allowed to provide the information (i.e., 45 days).
- Coverage for services rendered (post-service): Within 60 calendar days of our receipt of the appeal. However, if additional information is requested, a determination is made within 15 days of our receipt of the information, or the expiration of the period allowed to provide the information (i.e., 45 days).

If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process. You may then file a request for an external review (see below), regardless of whether we can assert substantial compliance or de minimis error.

This will be our final adverse determination. If you are not satisfied with our decision, you have the option of filing an External Appeal (explained in the following section, “External Appeals”).

Expedited/Urgent Utilization Review (UR) Appeals

You can expedite your UR appeal when:

- You receive an adverse determination involving continued or extended health care services, procedures or treatments or additional services while you are undergoing a course of continued treatment (concurrent) prescribed by a health care provider; or
- The time frames of the non-expedited UR appeal process would seriously jeopardize your life, health or ability to regain maximum function; or
- In the opinion of a care provider with knowledge of the health condition, the time frames of the non-expedited UR appeal process would cause you severe pain that cannot be managed without care or treatment requested; or

- Your care provider believes an immediate appeal is necessary because the time frames of the non-expedited UR appeal process would significantly increase the risk to your health; or
- For a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.

You have two available options for expedited reviews. **These options are not available for health care services that have already been rendered (post-service).**

1. Internal Expedited UR Appeal: This process includes procedures to facilitate a timely resolution of the appeal including, but not limited to, the sharing of information between your care provider and us by telephone or fax. We provide reasonable access to our clinical peer reviewer within one business day of receiving notice of an expedited UR appeal.

A decision is rendered and communicated for an internal expedited UR appeal within the following time frames:

- 24 hours from our receipt of the appeal when the service being appealed is for substance use disorder or co-occurring mental disorder, and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder.
- 72 hours from our receipt of the appeal for all other types of services.

If you are not satisfied with the outcome of the expedited UR appeal, you may further appeal through the external appeal process. If we do not make a determination within 72 hours of receipt of the necessary information, the adverse determination is reversed.

The notice of an appeal determination includes reasons for the determination. If the adverse determination is upheld on appeal, the notice will include the specific reason(s) and clinical rationale used to render the determination, a reference to the specific health benefit plan provisions on which the decision is based, a statement you may receive from us (upon request and free of charge) reasonable access to and copies of all relevant documents. We also include a notice of your right to initiate an external appeal. A description of each process and associated time frames is included.

If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process. You may then file a request for an external review (see the following bullet), regardless of whether we can assert substantial compliance or de minimis error.

2. External Expedited Appeal: You have the option to seek review by an independent review organization in emergency or life-threatening circumstances. You may make a request to the Commissioner of Insurance for an expedited external appeal without first completing the internal appeals process if:

- The time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life-threatening situation; or
- For a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting; and
- The member or you, acting on their behalf with their consent, filed a request for expedited internal review.

If you choose this option, you must submit the appeal by contacting:

Connecticut Insurance Department
PO Box 816
Hartford, CT 06142-0816
Phone: 860-297-3910

For more information on how to file an expedited external appeal, refer to External UR Appeals below.

Final Adverse Determination Notice (FAD)

The contents of a FAD vary based on the state in which the member's certificate of coverage was issued. Each notice of FAD is in writing, dated and includes the following:

Connecticut:

1. Information sufficient to identify the benefit request or claim involved, including the date of service, the health care professional and the claim amount, if known.
2. The specific reason(s) for the adverse determination, including, upon request, a listing of relevant clinical review criteria including professional criteria and medical or scientific evidence used to reach the denial and a description of Oxford's standard, internal rule, guideline, protocol or other criterion, if applicable, used in reaching the denial.
3. Reference to the specific health benefit plan provisions we used to reach the denial.
4. A description of other material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim.
5. A description of Oxford's internal appeals process, which includes:
   i. Oxford's expedited review procedures,
   ii. Limits applicable to such process or procedures,
   iii. Contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and

iv. A statement the member or their authorized representative is entitled, following requirements of Oxford's internal grievance process, to receive from Oxford, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the request.

If the adverse determination is based on:

1. An internal rule, guideline, protocol or other similar criteria:
   i. The specific rule, guideline, protocol or other similar criteria; or
   ii. A statement that:
   - A specific rule, guideline, protocol or other similar criteria was relied upon to make the adverse determination and a copy of such rule, guideline, protocol or other similar criteria will be provided to the covered person free of charge upon request;
   - Provides instructions for requesting a copy; and
   - The links to such rule, guideline, protocol or other similar criteria on Oxford's website.
2. Medical necessity or an experimental/investigational treatment:
   i. A written statement of the scientific or clinical rationale used to render the decision that applies the terms of the benefit plan to the member's medical circumstance;
   ii. Notification of the member's right to receive, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence not previously provided regarding the adverse determination under review;
3. A statement explaining the right of the member to contact the Office of the Healthcare Advocate at any time for assistance or, upon completion of Oxford's internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include:
   i. The contact information for said offices; and
   ii. A statement if the member or their authorized representative chose to file a grievance that:
   - Appeals are sometimes successful;
   - The member may benefit from free assistance from the Office of the Healthcare Advocate, which may assist them with filing a grievance pursuant to 42 USC 300gg–93, as amended from time to time;
   - The member is entitled and encouraged to submit supporting documentation for Oxford's consideration during the review of an adverse determination, including narratives from the member or from their authorized representative and letters and treatment notes from the member's health care professional; and
   - The member has the right to ask their health care professional for such letters or treatment notes.
4. A health carrier may offer a member's health care professional the opportunity to confer with a clinical peer as long as a grievance has not already been filed prior to the conference. This conference between the physician and the health care professional peer will not be considered a grievance of the initial adverse determination.

New Jersey:

1. Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. Any request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to as soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal;
2. The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by Oxford in the denial;
3. Any new or additional rationale, which was relied upon, considered or used, or generated by Oxford, in connection with the adverse benefit determination; and
4. Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24-8.7(b).

New York:

1. The specific reason for denial, reduction or termination of services.
2. The specific health service that was denied, including the name of the facility/care provider and developer/manufacturer of service, as available.
3. A statement that the member may be eligible for an appeal, and a description of appeal procedures including a description of the urgent appeal process if the claim involves urgent care.
4. A clear statement, in bold, that the member has 45 days from the FAD to request an external appeal, and that choosing the second level internal appeal may exhaust the time limits required for filing an external appeal.
5. A description of the external appeals process.

If Oxford fails to adhere to these requirements for rendering decisions, the following rules apply to members enrolled in Connecticut and New Jersey products.

Connecticut: The member is deemed to have exhausted Oxford's internal appeals process and may file an external review, even if Oxford could prove substantial compliance or minor (de minimis) error.

New Jersey: Members are not obligated to complete the internal review process and may proceed directly to the external review process under the following circumstances:

- We fail to comply with any deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of non-compliance;
- We for any reason expressly waive our rights to an internal review of any appeal; or
- The member and/or their care provider applied for expedited external review at the same time as applying for an expedited internal review.

In such a case where Oxford asserts good cause for not meeting the deadlines of the appeals process, members or their designee and/or their care provider may request a written explanation of the violation. Oxford must provide the explanation within 10 days of the request and must include a specific description of the basis for which we determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with Oxford and rejects the request for immediate review, the member has the opportunity to resubmit their appeal.

Member's Rights to External Appeal

The member has a right to an external appeal of a FAD.

A FAD is a first-level appeal denial of an otherwise covered service where the basis for the decision is either a lack of medical necessity, appropriateness, health care setting, level of care or effectiveness or the experimental/investigational exclusion.

The care provider's certification must include a statement of the evidence relied upon by the care provider in certifying their recommendation, and an external appeal must be submitted within 45 days upon receipt of the FAD, whether a second-level appeal is requested or not. If a member chooses to request a second-level internal appeal, the time may expire for the member to request an external appeal.

An external appeal may also be filed:

1. When the member had coverage of a health care service denied on the basis that such service is experimental or investigational, **and**
2. The denial has been upheld on appeal or both UnitedHealthcare and the member have jointly agreed to waive any internal appeal, **and**
3. The member's attending care provider certified that the member has a life-threatening or disabling condition or disease:
   - › For which standard health services or procedures have been ineffective or would be medically inappropriate or
   - › For which there does not exist a more beneficial standard health service or procedure covered by their health care plan **or**
   - › For which there exists a clinical trial, **and**
4. The member's attending care provider, who must be a licensed, board-certified or board-eligible care provider qualified to practice in the area of practice appropriate to treat the member's life-threatening, or disabling condition or disease, must have recommended either:
   - › A health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B)), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; **or**
   - › A clinical trial for which the member is eligible. Any care provider certification provided under this section shall include a statement of the evidence relied upon by the care provider in certifying their recommendation, **and**
5. The specific health service or procedure recommended by the attending care provider that would otherwise be covered under the policy except for UnitedHealthcare's determination that the health service or procedure is experimental or investigational. The member is not required to exhaust the second level of internal appeal to be eligible for an external appeal.

External Appeal Process

If the Clinical Appeals department upholds all or part of such an adverse determination, the member or their designee has the right to request an external appeal. An external appeal may be filed when:

1. The member had coverage of a health care service denied on appeal, in whole or in part, on grounds that such health care service is not medically necessary but otherwise would have been a covered benefit, and
2. We made a final adverse determination regarding the requested service, or
3. UnitedHealthcare and the member both agreed to waive any internal appeal.

All external appeal requests may be sent to the following:

New York State Insurance Department
P.O. Box 7209
Albany, NY 12224-0209

Phone: 800-400-8882
Fax: 800-332-2729

Claims Process

Time Frame for Claims Submission

To be considered timely, care providers, other health care professionals and facilities are required to submit claims within the specified period from the date of service:

- Connecticut - 90 days
- New Jersey - 90 or 180 days if submitted by a New Jersey participating care provider for a New Jersey line of business member
- New York - 120 days

The claims filing deadline is based on the date of service on the claim. It is not based on the date the claim was sent or received. Claims submitted after the applicable filing deadline will not be reimbursed; the stated reason will be "filing deadline has passed" or "services submitted past the filing date" unless one of the following exceptions applies.

Exceptions:

- If an agreement currently exists between you and Oxford or UnitedHealthcare containing specific filing deadlines, the agreement will govern.
- If coordination of benefits caused a delay, you have 90 days from the date of the primary carrier explanation of benefits to submit the claim to us.
- If the member has a health benefit plan with a specific time frame regarding the submission of claims, the time frame in the member's certificate of coverage will govern. If a claim is submitted past the filing deadline due to an unusual occurrence (e.g., care provider illness, care provider's computer breakdown, fire, flood) and the care provider has a historic pattern of timely submissions of claims, the care provider may request reconsideration of the claim.

Clean and Unclean Claims, Required Information for all Claim Submissions

For complete details and required fields for claims processing, please refer back to *Chapter 9: Our Claims Process*.

Time Frame for Processing Claims

The state-mandated time frames for processing claims for our fully insured members are as follows. The time frames are applied based upon the site state of the member's product:

- Connecticut - 45 days (paper and electronic)
- New Jersey - 40 days (paper), 30 days (electronic)
- New York - 45 days (paper), 30 days (electronic)

We strive to process all complete claims within 30 days of receipt. If you have not received an explanation of benefits (EOB)/remittance advice within 45 days, and have not received a notice from us about your claim, please verify we received your claim.

Hospitals and Ancillary Facilities

A member must be enrolled and effective with us on the date the hospital and ancillary service(s) are rendered. Once the facility verifies a member's eligibility with us, (We maintain a system for verifying member status.) that determination will be final and binding on us, unless the member or group made a material misrepresentation to us or otherwise committed fraud in connection with the eligibility or enrollment.

If an employer or group retroactively disenrolls the member up to 90 days following the date of service, we may deny or reverse the claim. If there is a retroactive disenrollment for these reasons, the facility may bill and collect payment for those services from the member or another payer. A member must be referred by a participating care provider to a participating facility within their benefit plan's network. Network services require an electronic referral or prior authorization consistent with the member's benefits.

Requirements for Claim Submission with Coordination of Benefits (COB)

Under COB, the primary benefit plan pays its normal plan benefits without regard to the existence of any other coverage. The secondary benefit plan pays the difference between the allowable expense and the amount paid by the primary plan, if the difference does not exceed the normal plan benefits which would have been payable had no other coverage existed.

If Oxford is secondary to a commercial payer, bill the primary insurance company first. When you receive the primary carrier's explanation of benefits (EOB)/remittance advice, submit it to us along with the claim information. These claims must be submitted using a paper claim form with primary remittance advice attached. Oxford secondary claims may not be sent electronically.

We participate in Medicare Crossover for all our members who have Medicare as their primary benefit plan. This means Medicare will automatically pass the remittance advice to us electronically after the claim has been processed. We may process these claims as secondary without a claim form or remittance advice from your office.

Note: If Medicare is the secondary payer, you must continue to submit the claim to Medicare. We cannot crossover in reverse.

Determining the Primary Payer Among Commercial Plans

When a member has more than one commercial health insurance policy, primary coverage is determined based upon model regulations established by the National Association of Insurance Commissioners (NAIC).

1. **COB provision rule:** The benefit plan without a COB provision is primary.
2. **Dependent/non-dependent rule:** The benefit plan covering the individual as an employee, member or subscriber or retiree is primary over the benefit plan covering the individual as a dependent.
3. **Birthday rule:** The "birthday rule" applies to dependent children covered by parents who are not separated or divorced. The coverage of the parent whose birthday falls first in the calendar year is the primary carrier for the dependent(s).
4. **Custody/divorce decree rule:** If the parents are divorced or separated, the terms of a court decree determines which benefit plan is primary.
5. **Active or inactive coverage rule:** The benefit plan covering an individual as an employee (not laid off or retired), or as that employee's dependent, is primary over the benefit plan covering that same individual as a laid off or retired employee or as that employee's dependent.
6. **Longer/shorter length of coverage rule:** If the preceding rules do not determine the order of benefits, the benefit plan that has covered the person for the longer period of time is primary.

Coordinating with Medicare Benefit Plans

We coordinate benefits for members who are Medicare beneficiaries according to federal Medicare program guidelines.

We have primary responsibility if any of the following apply to the member:

- 65 years or older, actively working and their coverage is sponsored by an employer with 20 or more employees
- Disabled, actively working and their coverage is sponsored by an employer with 100 or more employees
- Eligible for Medicare due to end-stage renal disease (ESRD) and services are within 30 months of the first date of dialysis

Reimbursement Claim Components

Additional Copies of EOBs/remittance advice: Should you misplace a remittance advice, you may obtain a copy by performing a claims status inquiry on OxfordHealth.com > Providers or Facilities > Transactions > Check > Claims.

Ancillary facility reimbursement: We reimburse ancillary health care providers for services provided to members at rates established in the fee schedule or in attachment or schedule of the ancillary contract.

Fee schedules: Although our entire fee schedule is proprietary and may not be distributed, upon request, we provide our current fees for the top codes you bill. Provider Services may provide this information to answer questions regarding claims payment.

Global surgical package (GSP): A global period for surgical procedures GSP may be found in the Global Days policy at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > or UHCprovider.com/policies > Commercial Policies > UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies. Refer to the back of the member's health care ID card for the applicable website.

Hospital reimbursement: We reimburse hospitals for services provided to members at rates established in the attachment of the hospital contract.

Modifiers: Modified procedures are subject to review for appropriateness consistent with the guidelines outlined in our policies. For complete details regarding the reimbursement of recognized modifiers, refer to the Modifier Reference policy at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > Modifier Reference Policy or UHCprovider.com/policies > Commercial Policies > UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies. (Refer to the back of the member's health care ID card for the applicable website.)

PCP/Specialist reimbursement: All PCPs and specialists agree to accept our fee schedule and payment and processing policies associated with administration of these fee schedules.

Release of information: Under the terms of HIPAA, we have the right to release to, or obtain information from, another organization to perform certain transaction sets.

Requests for additional information: There are times when we request additional information to process a claim. Submit the requested information promptly as outlined in the request. If you don't submit it within 45 days, you must submit an appeal with the information.

Reimbursement address, phone or TIN changes: An accurate billing address is necessary for all claims logging, payment and mailings. Notify us of any changes. For instructions and forms on how to do so, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Forms > Provider Demographic Change Form.

New York Health Care Reform Act of 1996 (HCRA)

The enactment of the HCRA, in part, created an indigent care (bad debt and charity care) pool to support uncompensated care for individuals with no insurance or who lack the ability to pay. Therefore, the New York Bad Debt and Charity (NYBDC) surcharge is applied on a claim-by-claim basis. The NYBDC surcharge applies to most services of general facilities and most services of diagnostic and treatment centers in New York. Your obligation is to:

- Understand your eligibility as it relates to HCRA.
- Know what services are surchargable services, and bill such services accordingly.

For additional information on HCRA, reference the New York Department of Health's website: health.ny.gov > Laws and Regulations (on the right under Site Contents) > Health Care Reform Act.

Member Billing

Balance Billing Policy

Care providers in our network are contracted with Oxford to provide specific services to members. Care providers participating with Oxford must follow Oxford referral, precertification and privileging policies and procedures. You may not bill members for unpaid charges related to covered services except for applicable copays, co-insurance or permitted deductibles. This includes balance billing a member for a covered service denied by Oxford because there was no referral or authorization on file with Oxford when one was required.

Exceptions: The instances in which you are authorized to balance bill a member are as follows. You are still required to follow Oxford's privileging, referral and/or precertification requirements. In these instances, you may balance bill the member billed charges. To the extent that the terms and conditions of your contract conflict with these guidelines, the terms and conditions of your contract prevail. You may balance bill a member when any of the following apply:

- A service or item is not a covered benefit (i.e., the service is excluded in the "Exclusions and Limitations" section of the member's certificate of coverage).
- A benefit limit is exceeded/exhausted.
- Oxford denied a request for precertification, before the service was rendered, and the member proceeded to receive the service anyway.
- Oxford denied a concurrent certification request (i.e., the member is currently receiving the service), and you obtained the member's signature to a clear, written statement that the service is not covered. They acknowledged they would be responsible for the cost of the service before you deliver the service.
- If you do not participate in a member's network, and a member self refers to you. (i.e., Liberty member self refers to you, and you do not participate in Oxford Liberty Network.) In this instance, if you participate in our W500 network, you may only bill up to your contracted rate for emergent services.

If you are uncertain whether a service is covered, you must make reasonable efforts to contact us and obtain coverage determination before seeking payment from a member. You are prohibited from balance billing the member for covered services when claims are denied for administrative reasons (lack of referral or authorization when one was required, etc.). If a member has been inappropriately balance billed by a care provider, the member has the right to file a complaint or grievance, verbally or in writing, regarding the balance billing. Participating care providers who repeatedly violate these restrictions will be subject to discipline up to and including termination of their provider Agreement. If you inappropriately balance-bill a member, Oxford will hold the member harmless and pursue the matter directly with you.

Member Out-of-Pocket Costs

Out-of-pocket amounts for outpatient and inpatient care vary by group, type of care provider and type of benefit plan. Check the member's health care ID for the out-of-pocket cost specific to their benefit plan.

Claims Recovery, Appeals, Disputes and Grievances

See *Claim Reconsideration and Appeals Process* found in *Chapter 9: Our Claims Process* for general appeal requirements.

Claims Submission and Status

To submit a claim, or verify the status of a claim, use any method outlined in the *How to Contact Oxford Commercial* section in this chapter.

Claims Recovery

The following information applies to care providers but does not apply to facilities or ancillaries.

Oxford periodically asks care providers to return overpayments due to either:

- Administrative reasons: Duplicate payments, payments relating to fee schedules or billing/bundling issues, payments made where Oxford was not the primary insurer).
- Behavioral issues: Upcoding, misrepresentation of service provided, services not rendered at all, frequent waiver of member financial responsibility.

Oxford may pursue such claim overpayments as permitted by law and following the applicable statute of limitations (usually six years). We use random sampling, examination by external experts, and reliable statistical methods to determine claim overpayments in situations involving large volumes of potentially overpaid claims.

Note: Once a care provider is given notice, we initiate discussions and take action during the following one year period.

We do not pursue collection of overpayments from individual participating care providers when overpayments are identified as isolated mistakes or where the care provider is not at fault if the overpayments were more than

one year before the date of notice of the overpayment or use extrapolation. Examples include overpayments related to duplicate claims, fee schedule issues, isolated situations of incorrect billing/unbundling, and claims paid when Oxford was not the primary insurer.

Exception: Oxford will pursue collection of overpayments beyond one year and use statistical methods and extrapolation in situations where:

1. Oxford has a reasonable suspicion of fraud or a sustained or high level of billing errors related to:
   - Extensive or systemic upcoding.
   - Unbundling.
   - Misrepresentation of services or diagnosis.
   - Services not rendered.
   - Frequent waiver of member financial responsibility.
   - Misrepresentation of care provider rendering the services or licensure of such care provider, and similar issues.
2. A care provider affirmatively requests additional payment on claims or issues older than one year.
3. The Centers for Medicare and Medicaid Services (CMS) makes a retroactive change to enrollment or to primary versus secondary coverage of a Medicare benefit plan member.

Participating Care Provider Claims Reconsiderations and Appeals

Our administrative procedures for members with an Oxford product require facilities, and care providers participating in our network, to file a claim reconsideration and/or appeal before proceeding to arbitration under their contract.

Claim Reconsideration

See *Claim Reconsideration and Appeals Process* found in *Chapter 9: Our Claims Process* for general reconsideration requirements and submission steps. Continue below for Oxford-specific requirements.

1. **Pre-Appeal Claim Review**
   Before requesting an appeal determination, contact us, verbally or in writing, and request a review of the claim's payment. We make every effort to clarify or explain our actions. If we determine that additional payment is justified, we reprocess the claim and remit the additional payment.
2. **Who May Submit a Reconsideration or Appeal**
   a. Participating care providers appealing a decision on their own behalf, according to the terms of their Agreement with us.
   b. Any care provider or practitioner when appealing on behalf of the member, with signed member consent. You must follow the process for member administrative claims appeals. Refer to the Member Administrative Grievance & Appeal (Non UM) Process & Time frames policy at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > **Medical & Administrative Policy Index** or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. (Refer to the back of the member's health care ID card for the applicable website.)
3. **Time Frame for Submitting a Reconsideration or Appeal**
   a. **Claim Reconsideration and Appeal Process**
   If you disagree with the way a claim was processed, or need to submit corrected information, you must file your reconsideration and/or appeal request of an administrative claim determination within 12 months (or as required by law or your Agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). You must include all relevant clinical documentation, along with a Participating Provider Review Request Form.

   The two-step process described here allows for a total of 12 months for timely filing – not 12 months for step one and 12 months for step two. If an appeal is submitted after the time frame has expired, Oxford upholds the denial.

   Exceptions: There are separate processes for New Jersey Participating Providers and Unilateral Coding Adjustments for New York Hospitals. Refer to the *New Jersey Participating Provider Appeal Process* and*Unilateral Coding Adjustments for New York Hospitals* sections for additional information.

   1. **Step One – Reconsideration Level:** The request must include the *Claim Reconsideration Form* located on **UHCprovider.com/claims** > Submit a Claim Reconsideration and all supporting documentation. If after reconsideration, we do not overturn our decision, the EOB or response letter includes next-level rights and where to submit a request for further review.
   2. **Step Two – Appeal Level:** Participating care provider and practitioner appeals must be submitted in writing within the same 12 month time frame. The appeal must include all relevant documentation, including a letter requesting a formal appeal and a *Participating Provider Review Request Form*. If the appeal does not result in an overturned decision, the care provider must review their contract for further dispute resolution steps.

   b. **New Jersey Participating Provider Appeal Process**
   New Jersey (NJ) participating care providers are subject to the NJ state-regulated appeal process. If a

NJ participating care provider has a dispute relating to payment of a claim involving a NJ commercial member, the dispute is eligible for an individual two-step process.

1. **First Level:** The first-level appeal is made through Oxford's internal appeal process. A written request for appeal must be submitted by the *Health Care Provider Application to Appeal a Claims Determination Form* created by the NJ Department of Banking and Insurance. This appeal must be submitted within 90 days of the date on Oxford's initial determination notice to:

   UnitedHealthcare
   Attn: Provider Appeals
   P.O. Box 29136
   Hot Springs, AR 71903

   The review is conducted and results are communicated to the care provider in a written decision within 30 calendar days of receipt of all material necessary for such appeal.

2. **Second Level:** The second-level appeal must be made through the external dispute resolution process. If a NJ participating care provider completed the internal appeal process and is not satisfied with the results of that internal appeal, the care provider has the right under their contract to arbitrate the dispute with Oxford. Care providers should submit their request to:

   MAXIMUS, Inc.
   Attn: New Jersey PICPA
   50 Square Drive, Suite 210
   Victor, NY 14564

   Requests may be submitted by fax to 585-425-5296. (MAXIMUS, Inc. requests that faxes be limited to 25 pages.)

   Consult your contract to determine the appropriate arbitration authority. Most such contracts provide for arbitration before the American Arbitration Association (AAA).The costs of arbitration are borne equally by the participating care provider and Oxford, unless the arbitrator determines otherwise. The decision in such arbitration depends on the participating care provider and Oxford, pursuant to the terms of the Agreement. To commence arbitration, the care provider must file a statement of claim with the AAA.

c. **Unilateral Coding Adjustments for New York Hospitals**
If a New York hospital receives a remittance advice/payment indicating that Oxford adjusted payment based on a particular coding (i.e., assignment of diagnosis and or CPT/HCPCS or other procedure code), the hospital has the right to resubmit the claim, along with the related medical record supporting the initial coding of the claim, within 30 days of receipt/notification of payment. Oxford must review the medical records within the normal review time frames (45 days). If Oxford's initial determination:

- Remains unchanged, the insurer's decision must be accompanied by a statement providing the specific reasons why the initial adjustment was appropriate.
- Changes, and the payment is increased based on the information submitted by the hospital, Oxford must provide the additional reimbursement within the 45-day review time frame.

If Oxford fails to provide the additional reimbursement within the 45-day review time frame, Oxford must pay to the hospital interest on the amount of the increase. The interest must be computed from the end of the 45-day period after resubmission of the additional medical record information.

Note: Neither the initial or subsequent processing of the claim by Oxford may be considered an adverse determination if it is based solely on a coding determination.

4. **Method for Submitting a Reconsideration or Appeal**
Find the correct mailing address on Oxford's Participating Provider Claim(s) Review Request Form. There are separate processes for the following appeal types:

   - Internal and external claims payment appeals for NJ participating care providers who treat NJ commercial members.
   - The appeal of unilateral coding adjustments made to New York hospital claims.

5. **Appeal Decision and Resolution**
Full documentation of the substance of the appeal and the actions taken will be maintained in an appeal file (paper or electronic). Written notification to the care provider is issued by means of a letter or updated Remittance Advice (RA) statement at the time of determination of the appeal. This decision constitutes Oxford's final internal decision. If the care provider is not satisfied with Oxford's decision, they may arbitrate the issue as set forth in their contract with Oxford. Refer to the Time frame Standards for Benefit Administrative Initial Decisions policy at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > **Medical & Administrative Policy Index** or **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website.

6. **Arbitration**
If the care provider wants to file for arbitration after the

first-level appeal has been completed, the care provider must file a statement of claim with the AAA at the following address:

American Arbitration Association
Northeast Case Management Center
950 Warren Avenue 4th Floor
East Providence, RI 02914
Phone: 800-293-4053

Care providers located outside of New York, New Jersey and Connecticut should refer to the AAA website (adr.org) for submission guidelines.

- Participating care providers appealing an adverse determination are entitled under their care provider contract to bring the issue before the AAA. They have this right only under the following circumstances:
  1. The first-level internal grievance process has been completed.
  2. The appeal is on their own behalf (not on behalf of the member).
- Participating hospitals and ancillary facilities also have arbitration rights, but those rights vary depending on contracts. If a hospital or ancillary facility calls to inquire about arbitration rights, they should be referred to their contract for the specific arbitration entity. Hospitals and ancillary facilities still must use the first-level internal appeal process.

New York State-Regulated Process for External Review

For participating care providers and other health care professionals treating New York members, this external appeals process applies only to services provided to commercial members who have coverage by virtue of an insurance benefit plan licensed in the state of New York.

This appeals process does not apply to the self-funded line of business. Care providers may use this process to appeal concurrent and retrospective utilization review decisions. Other external appeals require written consent from the member. In connection with retrospective decisions, if the care provider's Agreement includes arbitration language or alternate dispute language, the care provider must follow that process. The external review process is no longer an option for dispute resolution.

Medical Necessity Appeals

Standard Medical Necessity Appeals Process

If members or their designees would like to file an appeal, they must hand-deliver or mail a written request within 180 days of receiving the initial denial determination notice to:

Oxford Clinical Appeals Department
P.O. Box 29139
Hot Springs, AR 71903

Expedited Medical Necessity Appeals Process for Members:

- Members have the right to request an expedited appeal.
- To request an expedited appeal, the member or care provider or other health care professional must state specifically that the request is for an expedited appeal.
- The Clinical Appeals department determines whether or not to grant an expedited request.
- If the Clinical Appeals department determines the request does not meet expedited criteria set by the Clinical Appeals department, the member is notified.

Benefit Appeals

Appeals of benefit denials issued by the Clinical Services and Disease Management departments are handled by the Clinical Appeals department.

Administrative Appeals (Grievances)

Administrative appeals without the Clinical Services department's involvement are handled by the Member Appeals unit. If a member would like to file an appeal on a claim determination, they must mail all administrative appeals to the UnitedHealthcare Grievance Review Board. See *How to Contact Oxford Commercial* section for address information.

Second-level Member Appeals

Members have the right to take a second-level appeal* to our Grievance Review Board (GRB). If they remain dissatisfied with the first-level appeal determination, they may request a second-level appeal. Members with a Connecticut line of business do not have the option of submitting a second-level appeal request for a benefit or administrative issue. The request for appeal and any additional information must be submitted to the UnitedHealthcare Grievance Review Board. See *How to Contact Oxford Commercial* section for address information.

External Appeal Process for Members

New York, New Jersey and Connecticut members have the right to appeal a medical necessity determination to an external review agent. They may file a consumer complaint with one of the following applicable regulatory bodies. The applicable regulatory body is determined by the state in which the member's certificate of coverage was issued, not where the member resides.

Connecticut	State of Connecticut Insurance Department 153 Market Street P.O. Box 816 Hartford, CT 06142-0816 860-297-3800

*In New York, a second-level appeal is not required by us to be eligible for an external appeal.

New Jersey	Division of Insurance Enforcement and Consumer Protection 20 West State Street P.O. Box 329 Trenton, NJ 08625-0329
	Consumer Protection Services Dept. of Banking and Insurance P.O. Box 329 Trenton, NJ 08625-0329 800-446-7467 (in NJ) 609-292-5316 **Fax:** 609-545-8468
New York	Consumer Services Bureau State of New York Insurance Department 25 Beaver Street New York, NY 10004-2349 212-480-6400
	Office of Managed Care Certification and Surveillance New York Department of Health Corning Tower, Room 1911 Empire State Plaza Albany, NY 12237 518-474-2121

New York Notice of Care Provider Contract Termination and Appeal Rights

UnitedHealthcare immediately removes any health care provider from the network who is unable to provide health care services due to a final disciplinary action.

UnitedHealthcare may not prohibit, terminate or refuse to renew a contract with a care provider solely for the following:

- Advocating on behalf of a member.
- Filing a complaint against UnitedHealthcare.
- Appealing a decision made by UnitedHealthcare.
- Providing information or filing a report per PHL4406- c regarding prohibitions.
- Requesting a hearing or review.

We grant care providers and certain health care professionals the right to appeal certain disciplinary actions imposed by us.

The appeals process is structured so most appeals for terminations, not including non-renewal of the care provider's contract with us, may be heard before disciplinary action is implemented.

A care provider or health care professional may request an appeal (fair hearing or review) after we take adverse action to restrict, suspend or terminate a care provider or health care professional's ability to provide health care services to our members for reasons relating to the professional competence or conduct that adversely affects or could adversely affect the member's health or welfare.

A notice is provided within 30 calendar days after the adverse action is taken. It includes the following:

1. UnitedHealthcare determined an adverse action is necessary, and the final action will be reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and appropriate state licensing board.
2. A description of and reason for the action.
3. Right to request an appeal in writing within 30 calendar days after receipt of the notice. Failure to file such request shall constitute a waiver of all rights to the appeal process, unless such a right is provided under state law.
4. A summary of the care provider's or health care professional's appeal rights provided.

We will notify the care provider or health care professional of the fair hearing or review date within 30 calendar days of our receipt of request for appeal, or within the time frame required by state law. The fair hearing or review takes place within 60 calendar days of the date we receive the request for appeal, or within the time frame required by state law.

The hearing panel will be comprised of at least three persons appointed by UnitedHealthcare. At least one person on the panel will have the same discipline or same specialty as the care provider under review. The panel may consist of more than three members, provided the number of clinical peers constitutes one-third or more of the total panel membership.

The hearing panel will render a decision in a timely manner. Decisions will be provided in writing and include one of the following:

1. Reinstatement.
2. Provisional reinstatement with conditions set forth by us.
3. Termination.

Quality Assurance

Medical Records Requirements

As a participating care provider or other health care professional, you must provide us with copies of medical records for our members within a reasonable time period following our request for the records. We may request records for various reasons, including an audit of your practice. An audit may be performed at our discretion and for several different purposes as we deem appropriate for our business needs.

Standards for Medical Records

A comprehensive, detailed medical record is vital to promoting high-quality medical care and improving patient safety. Our recommended medical record standards are published each November for commercial benefit plans in the Network Bulletin at **UHCprovider.com/news** > Network Bulletin. Our requirements include, but are not limited to:

- Separate medical record for each member.
- The record verifies the PCP is coordinating and managing care.
- Medical record retention period of six years after date of service rendered and for a minor, three years after majority or six years after the date of the service, whichever is later.
- Prenatal care only: A centralized medical record for the provision of prenatal care and all other services.

Transferring Member Medical Records
If you receive a request from a member to transfer their medical records, do so within seven days to help ensure continuity of care. To safeguard the privacy of the member's records, mark them as "Confidential." Be sure no part of the record is visible during transmission.

Electronic Medical Records
An electronic medical record (EMR) is any type of electronic concurrent medical information management system. This process improves efficiency and quality inpatient care through integrated decision support which provides better information storage, retrieval and data sharing capabilities. EMR systems allow care providers, nurses and other health care staff to access and share information smoothly and quickly, enable them to work more efficiently, and make better-quality decisions.

UnitedHealthcare's Credentialing and Re-credentialing Notifications

We complete our credentialing process and give notification of the results (within 60 days for NY, 45-60 days for NJ) of receiving a completed application. The notification tells you whether you are credentialed, if more time is needed, or if UnitedHealthcare is not in need of additional care providers at this time. If more information is needed, we notify the applicant ASAP but no more than 90 days from the receipt of the application.

For more information on our credentialing program, refer to *Chapter 14: Credentialing and Re-Credentialing*.

Healthcare Provider Performance Evaluations

UnitedHealthcare is required to provide health care professionals with any information and profiling data used to evaluate your performance. Periodically, and at your request, we provide the information, profiling data and analysis used to evaluate your performance. You are given the opportunity to discuss the unique nature of your patient population which may have bearing on your profile and we work with you to improve your performance as needed.

Case Management and Disease Management Programs

We created a number of programs designed to improve outcomes for our members and to allow us to better manage the use of medical services. You may refer members to these programs, or members may self-refer.

For more information, go to **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > **Managing Disease** or by calling our Member Service Department.

Case Management and Disease Management Programs Referrals

You may refer members, or members may self-refer to several Case Management and Disease Management programs. These programs are designed to improve outcomes for members and to help us better manage the use of medical services.

For a complete list of Case Management/Disease Management programs go to **oxhp.com** > Providers (or Facilities) > Tools & Resources > Managing Disease: Programs for Members.

Healthcare Effectiveness Data and Information Set measures
The annual Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA). NCQA is an independent group established to provide objective measurements of the performance of managed health care benefit plans, including access to care, use of medical services, effectiveness of care, preventive services, and immunization rates, and each benefit plan's financial status.

CMS, state regulators (commercial) and prospective members use HEDIS measures to evaluate the value and quality of different health plans.

Each year we collect data from a randomly selected sample of our members' medical records for HEDIS. HEDIS is mandated by the New York Department of Health, New Jersey Department of Health and Senior Services, Connecticut Department of Health, and CMS. The HEDIS medical record study measures our participating care providers' adherence to nationally accepted clinical practice guidelines.

Clinical Process Definitions

Some services may be subject to prior authorization and/or ongoing medical necessity reviews.

Acute Hospital Day (AHD)
An AHD is any day when the severity of illness (clinical instability) and/or the intensity of service are sufficiently high, and care may not reasonably be provided safely in another setting.

Alternative Level of Care (ALC)*
We determine that an inpatient ALC applies in any of the following scenarios:

- An acute clinical situation has stabilized.

*ALC only applies if the facility has a contracted rate.

- The intensity of services required may be provided at less than an acute level of care.
- An identified skilled nursing and/or skilled rehabilitative service is medically indicated.
- ALC is prescribed by the member's care provider or other health care professional.
- Inpatient ALC must meet both the following criteria:*
  - The skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists are required.
  - Such services must be provided directly by or under the general supervision of those skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and achieve the medically desired result.

New Technology
New technology refers to a service, product, device or drug that is new to our service area or region. Any new technology must be reviewed and approved for coverage by the Medical Technology Assessment Committee or the Clinical Technology Assessment Committee for Behavioral Health technologies.

Potentially Avoidable Days (PAD)
A PAD arises in the course of an inpatient stay when, for reasons not related to medical necessity, a delay in rendering a necessary service results in prolonging the hospital stay. PADs must be followed by a medically necessary service.

There are several types of PADs:

- **Approved potentially avoidable day (AOPAD):** We caused delay in service; the day will be payable.
- **Approved care provider or other health care professional potentially avoidable day (APPAD):** The care provider or other health care professional caused delay in service; the day will be payable.
- **Approved mixed potentially avoidable day (AMPAD):** A delay due to mixed causes not solely attributable to us, the care provider, other health care professional, or the hospital; the day is payable.
- **Denied hospital potentially avoidable day (DHPAD):** The hospital caused the delay in service; DHPAD is a non-certification code, and the day is not payable.

We will not reverse any certified day unless the decision to certify was based on erroneous information supplied by the care provider or other health care professional, or a potentially avoidable day was identified.

When a member is readmitted to the hospital for the same clinical condition or diagnosis within 30 days of discharge, the second hospital admission will not be reimbursed when any of the following conditions apply:

- The member was admitted for surgery, but surgery was canceled due to an operating room scheduling problem.
- A particular surgical team was not available during the first admission.
- There was a delay in obtaining a specific piece of equipment.
- A pregnant woman was readmitted within 24 hours and delivered.
- The member was admitted for elective treatment for a particular condition, but the treatment for that condition was not provided during the admission because another condition that could have been detected and corrected on an outpatient basis prior to the admission made the treatment medically inappropriate.

In any of these situations, the hospital may not bill the member for any portion of the covered services not paid for by us.

Diagnosis-Related Group (DRG) Hospitals
DRG is a statistical system of classifying an inpatient stay into groups of specific procedures or treatments. When a hospital contracts for a full DRG, we reimburse the hospital a specific amount (determined by the contract) based on the billed DRG rather than paying a per diem or daily rate (DRG facility). A DRG is determined after the member has been discharged from the hospital.

When admission information is received through our website, we consider this to be notification only. First-day approval is granted to hospitals with a DRG contract. When we receive notification of an admission to a hospital with a DRG contract, our case manager reviews the admission for appropriateness. If the case manager cannot make a determination based on the admitting diagnosis, the case manager requests an initial review to determine whether the admission is medically necessary. The hospital is required to provide admission notification.

Prepayment DRG Validation Program
We may request a DRG hospital to send the inpatient medical record before claim payment so we may validate the submitted codes. After review of all available medical information, the claim is paid based on substantiated codes following review of the medical record. See the *Claims Recovery, Appeals, Disputes and Grievances* section of this supplement for Appeal Rights.

Hospital records may be requested to validate ICD-10-CM or its successor codes and/or revenue codes billed by participating facilities for inpatient hospital claims. If the billed ICD-10-CM codes (or successor codes) or revenue codes are not substantiated, the claim is paid only with the validated codes.

*Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria may result in denial of coverage.

Disposition Determination
A disposition determination is a technical term describing a process of care determination that results in payment as agreed at specific contracted rates. It helps eliminate certain areas of contention among participating parties and allows processing of claims. Specific instances where a disposition determination may apply:

- Delay in hospital stay
- APPAD/AMPAD when so contracted
- ALC determinations when so contracted, unless there is a separate ALC rate
- Discharge delays that prolong the hospital stay under a case rate

Late and No Notification
Late notification is defined as notification of a hospital admission after the contracted 48-hour notification period and before discharge. No notification is defined as failure to notify us of a member's admission to a hospital after discharge, up to and including at the time of submitting the claim.

Mental Health and Substance Use Services
The behavioral health department specializes in the administration of mental health and substance use benefits. The department consists of a medical director who is licensed in psychiatry, facility care advocates (licensed RNs and licensed/certified social workers) and intake staff who collectively handle certification, referrals and case management for our members.

We encourage coordination of care between our participating behavioral health clinicians and primary care providers as the best way to achieve effective and appropriate treatment. For this purpose, we developed a Release of Information (ROI) Form to help facilitate member consent and share information with the PCP in the presence of their behavioral health clinician. See the *How to Contact Oxford Commercial* section for telephone numbers.

Clinical Definitions and Guidelines
The behavioral health department uses the Optum Level of Care Guidelines when determining the medical necessity of inpatient psychiatric, partial hospitalization substance use treatment and rehabilitation, and outpatient mental health treatment. For a complete list of programs and detailed information on the level of care guidelines, visit the Optum network website at **providerexpress.com**.

Inpatient Mental Health
Inpatient (or acute) care for a mental health condition is indicated when it involves a sudden and quickly developing clinical situation characterized by a high level of distress and uncertainty of outcome without intervention.

Partial Hospitalization - Mental Health
Partial hospitalization for mental health treatment involves day treatment of a mental health condition at a hospital or ancillary facility with the following criteria:

- The primary diagnosis is psychiatric.
- The facility is licensed and accredited to provide such services.
- The duration of each treatment is four or more hours per day.

Residential Treatment
Residential treatment services are provided in a facility or a freestanding residential treatment center that provides overnight mental health services for members who do not require acute inpatient care but require 24-hour structure.

Outpatient Mental Health
Psychotherapeutic approaches to treatment of mental health conditions, including methods from different theoretical orientations (e.g., behavioral, cognitive, and interpersonal) may be administered to an individual, family or group on an outpatient basis.

Inpatient Detoxification
Inpatient detoxification is the treatment of substance dependence to treat a life-threatening withdrawal syndrome, provided on an inpatient basis.

Outpatient Substance Use Rehabilitation
Outpatient substance use rehabilitation is the treatment of a substance use disorder including dependence at an accredited, licensed substance use treatment facility.

Member Rights and Responsibilities

For the entire list of **Member Rights and Responsibilities**, go to **UHC.com** > Individuals & Families > Member Resources > Legal > **Annual Member Notices**, > Select Your Code.

Medical/Clinical and Administrative Policy Updates

We amend the contents of this supplement annually to reflect changes in policies or as required by regulation. A complete library of Oxford's Clinical, Administrative and Reimbursement Policies is available for your reference at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** or at **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare® Oxford Clinical, Administrative and Reimbursement Policies**. Refer to the back of the member's health care ID card for the applicable website.

You may also request a paper copy of a Clinical, Administrative or Reimbursement Policy by writing to:

Oxford Policy Requests and Information
4 Research Drive
Shelton, CT 06484

Policy Update Bulletin

We publish monthly editions of the Oxford Policy Update Bulletin. This online resource provides notice to our network care providers of changes to our Clinical, Administrative and Reimbursement Policies. The bulletin is posted on the first calendar day of every month on **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Policy Update Bulletins** and on **UHCprovider.com/policies** > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies** > Policy Update Bulletins. Refer to the back of the member's health care ID card for the applicable website. A supplemental reminder to the policy updates announced in the Oxford Policy Update Bulletin is also included in the monthly Network Bulletin available on **UHCprovider.com/news**.

Preferred Care Partners Supplement

About Preferred Care Partners

Preferred Care Partners (PCP), Inc., a wholly owned subsidiary of UnitedHealthcare, is a Medicare Advantage (MA) health plan. We offer MA plans in three Florida counties: Broward, Miami-Dade and Palm Beach.

Mission Statement

We improve the health of our members by providing:

- Access to health care services
- Choices for their health care needs
- Simplification of the health care delivery system

We streamline authorization and referral processes. We build care provider networks around the needs of our members. This provides the best experience for our members and care providers. We commit to giving direct access to expert customer service representatives who understand member needs and helping them make informed choices.

How to Contact Us

Questions or Comments

Email questions or comments to Network Management Services (NMS) at PCP-NetworkManagementServices@uhcsouthflorida.com, or send mail to:

Preferred Care Partners Network Management Services
9100 South Dadeland Blvd. Suite 1250
Miami, FL 33156-6420

Contact Us Table

Resources	Where to Go	What you can do there
Authorizations and Notifications	**Link:** Use the Prior Authorization and Advance Notification tool at **UHCprovider.com/paan** **Online:** **UHCprovider.com/priorauth** (policies, instructions and tips) **Phone:** 800-995-0480	• Submit notifications, prior authorizations, referrals, admissions and discharge planning. • Initiate requests for notifications and authorizations electronically. If the request cannot be completed electronically, our staff is available to answer questions or discuss any issues with referrals, prior authorizations, case management, concurrent review, and admission certification or notification.
Authorizations and Notifications (WellMed)	**Online:** **eprg.wellmed.net** **Fax:** 866-322-7276 **Fax (Inpatient notification):** 877-757-8885	
Claims	**Online:** **UHCprovider.com/claims** **Phone:** 866-725-9334 **Fax:** 866-725-9337 **Mail:** Preferred Care Partners P.O. Box 30448 Salt Lake City, UT 84130-0448	• Check claims, eligibility, benefits. • Use payer ID #65088.
Claims (WellMed)	**Online:** **eprg.wellmed.net** **Phone:** 800-550-7691 **Mail:** WellMed Claims P.O. Box 400066 San Antonio, TX 78229	• Check claims, eligibility, benefits. • Use payer ID #WELM2.

Resources	Where to Go	What you can do there
Technical Support for Change Healthcare Claims Submission Network	**Phone:** 800-845-6592	• Obtain assistance with password or technical support issues. • Obtain information on electronic claims submission.
Credentialing	**Phone:** 800-963-6495 Monday through Friday, 9 a.m. to 5 p.m. (ET) **Fax:** 844-897-6352	• Submit or update credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility.
Electronic Remittance (Facilitated by Change Healthcare)	**Online:** ChangeHealthcare.com **Phone:** 800-845-6592	• Get information and register for electronic payment services.
Eligibility and Benefits Verification	**Online:** UHCprovider.com/eligibility **Phone:** 866-725-9334	• Verify eligibility and benefits of enrolled members. • Access a summary of benefits for each plan online.
Fraud, Waste, and Abuse (FWA) Hotline	**Phone:** 866-678-8822 Monday through Friday, 9 a.m. to 5 p.m. (ET) **Fax:** 888-659-0617 **Email:** ReportFraud@UHCsouthflorida.com **Mail:** Preferred Care Partners Special Investigations Unit P.O. Box 56-5748 Miami, FL 33256-5748	• Report concerns related to fraud, waste or abuse.
Grievances & Appeals	**Phone:** Call the provider number listed on the back of the member's identification card. **Mail:** Preferred Care Partners, Inc. Grievances & Appeals Department P.O. Box 30997 Salt Lake City, UT 84130	• For information about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms.
Member Services	**Online:** mypreferredcare.com > Member Resources **Phone:** 866-231-7201 Monday through Friday, 8 a.m. to 5 p.m. (ET) **TTY:** 711 **Fax:** 888-659-0618	• Members may ask questions about care providers, benefits, and claims • This toll-free phone number is also printed on the member's plan ID card.
Network Management Services Provider Relations and Contracting	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. (ET) **Fax:** 888-659-0619 **Email:** PCP-NetworkManagementServices@uhcsouthflorida.com	• Ask questions regarding your Agreement, in-servicing and follow-up or outreaches. • Report demographic changes. • Submit informal complaints. • Request forms or other materials.
Pharmacy (OptumRx)	**Online:** professionals.optumrx.com **Phone:** 800-711-4555	• Verify pharmacy benefits and eligibility, adjudications, or authorizations. • See pharmacy benefit updates.
Risk Management	**Phone:** 952-406-4806	• Report incidents involving all privacy issues (potential breaches of PHI or PII) immediately to our risk manager.

Resources	Where to Go	What you can do there
Ancillary and Enhanced Benefit Providers		
Optum Behavioral Health	**Online:** providerexpress.com **Phone:** 800-985-2596 No DSNP 800-496-5841 iSNP Member Services available 24 hours. Licensed clinicians are on call 24 hours a day, seven days a week.	• Obtain information about behavioral health and substance use services for all members. • Access a list of behavioral health care providers in the provider directory.
Dental (Solstice)	**Online:** SolsticeBenefit.com **Phone:** 855-351-8163	• Access a list of Solstice dental providers in the provider directory.
DME/Infusion (MedCare)	**Phone:** 800-819-0751 Monday through Friday, 9 a.m. to 5 p.m. (ET) **On call:** 24 hours a day, seven days a week	• Contact MedCare to arrange for these services. • Call UM or Network Management for additional assistance.
Fitness (Renew Active)	**Online:** Preferredcare.myrenewactive.com **Phone:** 866-231-7201	
Hearing (Hear-X/HearUSA)	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. (ET)	
Home Health (MedCare)	**Phone:** 305-883-2940	• Contact MedCare to arrange for these services. • Call UM or Network Management for additional assistance.
Laboratory **LabCorp**	**Online:** labcorp.com **Phone:** 855-277-8669 Automated Line **Phone:** 800-877-7831 Live Scheduling	• Find information on locations, make an appointment, order lab tests and view results.
QUEST	**Online:** questdiagnostics.com **Phone:** 866-697-8378	
Mail Order Pharmacy (OptumRx)	**Online:** optumrx.com **Phone:** 877-889-6358	• Obtain mail-order medications.
Nurse Hotline (Optum NurseLine)	**Phone:** 855-575-0293 Available 24 hours a day, seven days a week.	• Only available under certain plans • Speak to a nurse to triage emergency or urgent care, or to refer them to their primary care physician.
Podiatry—Network Mgmt Services (Foot and Ankle Network)	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. (ET)	• Access a list of podiatrists in our provider directory.
Transportation (Member Services)	**Phone:** 888-774-7772 Monday through Friday, 9 a.m. to 5 p.m. (ET)	• Request services.
Vision - Network Mgmt Services (iCare)	**Phone:** 877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. (ET)	• Access a list of vision providers in our provider directory.

WellMed Medical Management, Inc. (WellMed)

WellMed handles utilization management (UM) and claim services for members who belong to a primary care physician (PCP) in the Preferred Care Partners Medical Group (PCPMG). To identify these members, refer to the member ID card. The payer ID is listed as WELM2. “WellMed” is listed in the lower right corner of the card.

Claims Processing for WellMed Members

Submit claims electronically to payer ID WELM2. If mailing, send to: WellMed Claims, P.O. Box 400066, San Antonio, TX 78229.

Confidentiality of Protected Health Information (PHI)

All employees, participating care providers, and delegates of Preferred Care are required to maintain the confidentiality of PHI. All information used for UM activities is kept as confidential in accordance with federal and state laws and regulations. We limit PHI access to the minimum necessary.

You must report all privacy issues immediately to Risk Management at 952-406-4806.

Examples of privacy incidents that must be reported include:

- Reports and correspondence containing PHI or Personally Identifiable Information (PII) sent to the wrong recipient
- Member or care provider correspondence that includes incorrect member information
- Complaint received indicating that PHI or PII may have been misused
- Concern about compliance with a privacy or security policy
- PHI or PII sent unencrypted outside of your office
- Lost or theft of laptops, PDAs, CDs, DVDs, flash or USB drives and other electronic devices
- Caller mentions they are a regulator (i.e., person is calling from the Office for Civil Rights, Office of E-Health Standards & Services, State Insurance Departments, Attorney General's Office, Department of Justice), or threatens legal action or contacting the media in relation to a privacy issue
- Caller advises your office of a privacy risk

Physician Extender Responsibilities

Physician extenders are state-licensed health care professionals who may be employed or contracted by physicians to examine and treat Medicare members. Physician extenders are advanced registered nurse practitioners (ARNP) and physician assistants (PA). When physician extenders provide care, they must:

- Be supervised by a physician. The physician must be on the premises at all times when the physician extender is seeing patients.
- Help ensure the member knows of their credentials. Make the member aware they might not see a medical doctor.
- Get the sponsoring physician's signature on all progress notes.
- Provide services as defined and approved by the sponsoring physician.

Prior Authorizations and Referrals

We do not require prior authorization for certain services. Please use the Enterprise Prior Authorization List (EPAL) to see what services do require authorization on UHCprovider.com/priorauth > **Advance Notification and Plan Resources** > under Plan requirement resources – Medica HealthCare and Preferred Care Partners Prior Authorization Requirements.

WellMed and Utilization Management

Prior authorization requests for Preferred Care Partners members assigned to a Primary Care Physicians belonging to Preferred Care Partners Medical Group (PCPMG) may be done online at **eprg.wellmed.net** or by fax at 866-322-7276.

Simple Referral Process

Palm Beach Members: The Simple Referral Process helps PCPs coordinate member care. Referrals are necessary for most participating specialists.* Requests for non-participating care providers need additional authorization.

- You may request a referral for one or multiple visits.
- The referral is good for the number of visits approved, valid for six months from the date issued.
- No supporting documentation is needed for referrals to specialists.
- Requests for referrals must be submitted electronically on **UHCprovider.com**
- Upon submitting a referral request, the system automatically generates the referral number.
- For member convenience, you may also provide members with a copy of the referral confirmation.
- The specialist has the ability to view referral via UnitedHealthcare portal.
- For additional questions call us at 877-670-8432 or email us at **NetworkManagementServices@uhcsouthflorida.com**.

WellMed Members: Fax inpatient hospital admission notification to 877-757-8885. Notifications must be received no later than the first business day following the admission.

WellMed requires a referral from the assigned PCP prior to rendering services for selected specialty care providers.

The referral must be entered by the PCP in the WellMed provider portal at **eprg.wellmed.net**.

The WellMed Florida Specialty Protocol List gives more information about which specialties/services may be exempt from the referral process. Providers may view the WellMed Specialty Protocol List in the WellMed Provider portal at **eprg.wellmed.net** in the Provider Resource Tab.

*Contact Network Management Services for a complete list of specialty types that need referrals.

Authorization Requirements

- Obtain prior authorization for all services requiring authorization before the services are scheduled or rendered.
- Submit prior authorization for outpatient services or planned Acute Hospital Admissions and admissions to Skilled Nursing Facilities (SNF), Acute Rehabilitation Hospital and Long-Term Acute Care (LTAC) as far in advance of the planned service as possible to allow for coverage review. We require prior authorizations to be submitted at least seven calendar days prior to the date of service.
- Submit prior authorizations for home health and home infusion services, durable medical equipment (DME), and medical supply items to MedCare Home Health at 305-883-2940 and Infusion/DME at 800-819-0751.
  Note: Request an expedited (72 hours) review if waiting for a standard (14 calendar days) review could place the member's life, health, or ability to regain maximum function in serious jeopardy.
- We require prior authorizations to out-of-network specialty or ancillary care providers when the member requires a necessary service that cannot be provided within the available Preferred Care network. The referring physician must submit a completed Prior Authorization Form for approval.
- You and the member should be fully aware of coverage decisions before services are rendered.
- If you provide the service before the coverage decision is rendered, and we determine the service was not a covered benefit, we may deny the claim. You must not bill the member. Without a coverage determination, a member does not have the information needed to make an informed decision about receiving and paying for services.

Notification Requirements

- For any inpatient or ambulatory outpatient service requiring prior authorization, the facility must confirm, prior to rendering the service, that the coverage approval is on file. The purpose of this protocol is to enable the facility and the member to have an informed pre-service conversation. If the service will not be covered, the member may decide whether to receive and pay for the service.
- Facilities are responsible for admission notification for inpatient services, even if the coverage approval is on file.
- If a member is admitted through the emergency room, you must notify us no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.
- If a member receives urgent care services, you must notify us within 24 hours of the services being rendered.

Admission Notification Requirements

Facilities are responsible for admission notification for:

- Planned elective admissions for acute care
- Unplanned admissions for acute care
- Admissions following observation
- Admissions following outpatient surgery
- Skilled Nursing Facility (SNF) admissions
- Long Term Acute Care Hospital (LTACH)
- Acute Inpatient Rehab (AIR)
- Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission (or by 5 p.m. ET on the next business day if 24-hour notification would require notification on a weekend or federal holiday).
- Admission notification by the facility is required even if notification was supplied by the physician and a coverage approval is on file.
- Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual member's benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility's Agreement with us.
- Admission notifications must contain the following:
  - Member name and member health care ID number
  - Facility name
  - Admitting or attending physician name
  - Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
  - Actual admission date
  - Admission orders written by a physician
- For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us as soon as the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

If the requirements are not followed, the services may be denied. You may not bill the member.

A notification or prior authorization approval does not ensure or authorize payment, subject to state rules and MA policies. Payment is dependent upon the member's coverage, the care provider's eligibility, and Agreement and claim requirements.

To initiate member discharge or to request authorization for transition to AIR and LTAC, call 800-995-0480.

Clinical Coverage Review

Certain services require prior authorization, which results in:

1. A request for clinical information,
2. A clinical coverage review based on medical necessity, and
3. A coverage determination.

You must cooperate with all requests for information, documents or discussions for purposes of a clinical coverage review including providing pertinent medical records, imaging studies or reports and appropriate assessments for determining degree of pain or functional impairment.

As a network care provider, you must respond to calls from our UM staff or medical director. You must provide complete clinical information as required within the time frame specified on the outreach form.

In addition:

- We may use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. These tools assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. They do not constitute the practice of medicine or medical advice.
- For MA members, we use CMS coverage determinations, the National Coverage and Local Coverage Determinations (LCD), to determine benefit coverage for Medicare members. If other clinical criteria, such as the MCG™ Care Guidelines or any other coverage determination guidelines, contradict CMS guidance, we follow the CMS guidance.

Clinical Coverage Review Criteria

We use scientifically based clinical evidence to identify safe and effective health services for members for inpatient and outpatient services. For Inpatient Care Management (ICM's), we use evidence-based MCG Care Guidelines. Clinical coverage decisions are based on the member's eligibility, state and federal mandates, the member's certificate of coverage, evidence of coverage or summary plan description, UnitedHealthcare medical policies and medical technology assessment information. For Medicare Advantage members, we use CMS NCDs and LCDs and other evidence-based clinical literature.

Coverage Determination Decisions

Coverage determinations for health care services are based upon the member's benefit documents and applicable federal requirements. Our UM staff, its delegates, and the physicians making these coverage decisions are not compensated or otherwise rewarded for issuing adverse non-coverage determinations. Preferred Care and its delegates do not offer incentives to physicians to encourage underutilization of services or to encourage barriers to receiving the care and services needed.

Coverage decisions are made based on the definition of "reasonable and necessary within MA coverage regulations and guidelines." Hiring, promoting, or terminating physicians or other individuals are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Prior Authorization Denials

We may deny a prior authorization request for several reasons:

- Member is not eligible;
- Service requested is not a covered benefit;
- Member's benefit has been exhausted; or
- Service requested is identified as not medically necessary (based upon clinical criteria guidelines).

We must notify you and the member in writing of any adverse decision (partial or complete) within applicable time frames. Our notice states the specific reasons for the decision. It also references the benefit provision and clinical review criteria used in the decision-making process. We provide the clinical criteria used in the review process for making a coverage determination along with the notification of denial.

Peer-to-Peer (P2P) Clinical Review

For Inpatient Care Management Cases, P2P requests may come in through the P2P Support team by calling 800-955-7615.

P2P discussions may occur at different points during case activity in accordance with time frames, once a medical director has rendered an adverse determination.

The post-decision peer-to-peer consult process must conclude for the Medicare population. This requires establishing a pre-decision medical director outreach for standard (14 day turn-around-time) requests for both inpatient and outpatient adverse determinations. It excludes expedited pre-service requests and administrative denials.

We must treat the following situations as reconsiderations or appeals:

- Clinical information received after notification is complete.
- Peer-to-peer requests received after notification is complete.

Additional UM Information

External Agency Services for Members

Some members may require medical, psychological and social services or other external agencies outside the scope of their plan benefits (for example, from Health and Human Services or Social Services). If you encounter a member in this situation, contact Network Management

Services. You may also have the member contact our Member Services Department at 866-231-7201 for assistance with, and referral to, appropriate external agencies.

Technology Assessment Coverage Determination
The technology assessment process helps evaluate new technologies and new applications of existing technologies. Technology categories include medical procedures, drugs, pharmaceuticals, or devices. This information allows us to support decisions about treatments that best improve member's health outcomes, efficiently manage utilization of health care resources, and make changes in benefit coverage to keep pace with technology changes. It also helps ensure members have equitable access to safe and effective care. If you have any questions regarding whether a new technology or a new application of existing technologies are a covered benefit for our members, please contact Utilization Management at 800-995-0480.

Hospitalist Program for Inpatient Hospital Admissions

The Hospitalist Program is a voluntary program for members. Hospitalists are physicians who specialize in the care of members in an acute inpatient setting (acute care hospitals and SNFs). A hospitalist oversees the member's inpatient admission and coordinates all inpatient care. The hospitalist communicates with the member's selected physician by providing records and information, such as the discharge summary.

Discharge Planning
Discharge planning is a collaborative effort between the inpatient care manager, the hospital/facility case manager, the member, and the admitting physician. It helps ensure coordination and quality of medical services through the post-discharge phase of care.

Although not required to do so, we may help identify health care resources available in the member's community following an inpatient stay.

UM nurses conduct telephone reviews to support discharge planning, with a focus on coordinating health care services prior to the discharge.

The facility or physician is required to contact us and provide clinical information to support discharge decisions under the following circumstances:

- An extension of the approval is needed. Contact must be made prior to the expiration of the approved days.
- The member's discharge plan indicates transfer to an alternative level of care is appropriate.
- The member has a complex plan of treatment that includes home health services, home infusion therapy, total parenteral nutrition, or multiple or specialized durable medical equipment identified prior to discharge.

To initiate patient discharge, update the case directly online at UHCprovider.com/paan or call us at 800-995-0480.

Appeal & Reconsideration Processes

MA Hospital Discharge Appeal Rights Protocol

MA members have the right to appeal their hospital discharge to a Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO) for immediate review. The BFCC-QIO for Florida is KEPRO.

The BFCC-QIO notifies the facility and Preferred Care of an appeal and:

- Preferred Care facility onsite Concurrent Review Staff completes the Detailed Notice of Discharge (DNOD), and delivers it to the MA member or their representative as soon as possible but no later than 12 p.m. ET the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC- QIO; or
- When no Preferred Care facility onsite staff is available, the facility completes the DNOD and delivers it to the MA member or their representative as soon as possible but no later than 12 p.m. ET the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO and Preferred Care.

Facility (SNF, HHA, CORF) Notice of Medicare Non-Coverage (NOMNC) Protocol

CMS requires SNFs, HHAs, and CORFs deliver the NOMNC-required notice to members at least two calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If a member's services are expected to be fewer than two calendar days in duration, deliver the notice at the time of admission or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds two calendar days, give the notice no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of the member or their authorized representative if the member is incompetent. You must use the most current version of the standard CMS-approved form titled, "Notice of Medicare Non-Coverage" (NOMNC). You may find the standardized form and instructions on the CMS website. You may also contact KEPRO the BFCC-QIO for Florida at kepro.com for more information. You may not change the NOMNC notification text.

Clinical Appeals: Standard and Expedited

To appeal an adverse decision (a decision to deny the authorization of a service or procedure because the service is determined not to be medically necessary or appropriate) on behalf of a member, submit a formal letter outlining the issues. Include supporting documentation. The denial letter you received provides you with the filing deadlines and the address to use to submit the appeal.

Submit the member's written consent with your appeal.

When we make a final decision, we notify you by mail. If we overturn the original determination, the service will be authorized. If we uphold the original denial determination, there is no additional action.

Benefit Summaries

For information on benefits, please visit mypreferredcareprovider.com > Provider Resources > Summary of Benefits.

Member Rights and Responsibilities

The Member Rights and Responsibilities Statement is published each year in the Evidence of Coverage (EOC). It is available on our website at mypreferredcare.com or by contacting the Network Management Department at 877-670-8432. If our member has questions about their rights, please refer them to the Member Services phone number on the back of their ID card.

Member Participation in Treatment Options

Members have the right to freely communicate with their physician and participate in the decision-making process regarding their health care, regardless of their benefit coverage. Each member has the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law, as applicable.

Competent members have the right to refuse recommended treatment, counsel or procedure. The health care professional may regard such refusal as incompatible with the continuance of the care provider/patient relationship and the provision of proper medical care. If this occurs, and the health care professional believes that no professionally acceptable alternatives exist, they must so inform the member in writing, by certified mail. The health care professional must give the member 30 calendar days to find another care provider. During this time, the health care professional is responsible for providing continuity of care to the member.

Advance Directives

The federal Patient Self-Determination Act (PSDA) of 1990 gives individuals age 18 and older the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive.

This law states that members' rights and personal wishes must be respected, even when the member is too sick to make decisions on their own. You may find the Patient Self-Determination Act at gpo.gov.

To help ensure a person's choices about health care are respected, the Florida legislature enacted Chapter 765, Florida Statutes. It requires all care providers and facilities to provide their patients with written information regarding treatment options.

Document this discussion at least once in the member's record.

To comply with this requirement, we also inform members of state laws on advance directives through our members' benefit material. We encourage you to have these discussions with our members.

Online Resources: You may find the federal Patient Self-Determination Act at gpo.gov. You may download free forms from the state at floridahealthfinder.gov/reports-guides/advance-directives.aspx.

Information is also available from the Robert Wood Foundation, Five Wishes. The information there meets the legal requirements for an advance directive in Florida and may be helpful to members. Five Wishes is available on AgingWithDignity.org.

Member Financial Responsibility

Members are responsible for the copayments, deductibles and coinsurance associated with their benefit plan. Collect copayments at the time of service. To determine the exact member responsibility related to benefit plan deductibles and coinsurance, we recommend you submit claims first. You will then receive the Summary of Benefits (SOB) to see what the member needs to pay.

If you prefer to collect payment at the time of service, you must make a good faith effort to estimate the member's responsibility using our Claims & Payment tool. This tool is available on UHCprovider.com/claims.

Documentation and Confidentiality of Medical Records

You are required to protect records, correspondence and discussions regarding the member.

You must keep a medical records system that:

- Follows professional standards.
- Allows quick access of information.
- Provides legible information that is correctly documented and available to appropriate health care providers.
- Maintains confidentiality.

Have our member sign a Medical Record Release Form as a part of their medical record. Contact Network Management Services, 877-670-8432, to request a copy of this form. The member should sign a Refusal Form when declining a preventative screening referral.

Please follow these confidentiality guidelines:

- Records that contain medical, clinical, social, financial or other data on a patient are treated as confidential. They

must be protected against loss, tampering, alteration, destruction, or inadvertent disclosure;

- Release of information from your office requires that you have the patient sign a Medical Record Release Form that is retained in the medical record;
- Release of records is in accordance with state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Records containing information on mental health services, substance use, or potential chronic medical conditions that may affect the member's plan benefits are subject to additional specific waivers for release and confidentiality.

Exemption from Release Requirements

HIPAA regulations allow us to give PHI to government programs without member permission. This is given to determine member eligibility.

Medical Records Requirements

You must ensure your medical records meet the standards described in this section. The following are expanded descriptions of these requirements:

Patient Identifiers: Consist of the patient name and a second unique identifier, and should appear on each page of the medical record.

Advance Directives: Provide the member with advance directive information and encourage them to retain a copy for their personal records. Document this conversation at least once in the member's medical record.

Biographical Information: Include the member's name, date of birth, address, home and work phone numbers, marital status, sex, primary language spoken, name and phone number of emergency contact, appropriate consent forms and guardianship information, if relevant.

Signatures: For paper medical records, have all entries dated and signed or initialed by the author. Author identification may be a handwritten signature or initials followed by the title (e.g., MD, DO, PA, ARNP, RN, LPN, MA or OM). There must be a written policy requiring, and evidence of, physician co-signature for entries made by those other than a licensed physician (e.g., MD, DO). Electronic signatures are acceptable for electronic medical records.

Family History: Document the family medical history no later than the first visit.

Past Medical History: Include a detailed medical, surgical, and social history.

Immunizations: Include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. At a minimum, you must have members' vaccination history.

Medication List: List the member's current medications, with start and end dates, if applicable. Reconcile within 30 days after inpatient admissions.

Referral Documentation: If a referral was made to a specialist, file the consultation report in the medical record. Include documentation that the physician has discussed abnormal results with the member, along with recommendations.

Chart Organization: Maintain a uniform medical record system of clinical recording and reporting with respect to services, which includes separate sections for progress notes and the results of diagnostic tests.

Preventive Screenings: Promote the appropriate use of age- or gender-specific preventive health services for members to achieve a positive effect on the member's health and better medical outcomes.

Required Encounter Documentation: For every visit, document the following:

- Date;
- Chief complaint or purpose;
- Objective findings;
- Diagnosis or medical impression;
- Studies ordered (lab, X-ray, etc.);
- Therapies administered or ordered;
- Education provided; disposition, recommendations or instructions to the member and evidence of whether there was follow-up; and,
- Outcome of services.

You must document that a written policy regarding follow-up care and written procedures for recording results of studies and therapies and appropriate follow-up is in place.

We recommend that medical records include copies of care plans whenever you provide home health or skilled nursing services.

Case Management and Disease Management Program Information

Optum provides Case Management (CM) and Disease Management (DM) services for Preferred Care Partners.

Below is the criteria for referrals to Optum CM and DM Programs:

- **Complex Case Management — (Special Needs Plan [SNP] members only)**
  - Three or more unplanned admissions and/or emergency room (ER) visits in the last six months or
  - Multiple, complex co-morbid conditions and/or
  - Coordination of multiple community resources/ financial supports to cover basic services

- **Heart Failure (HF) Disease Management Program**
  - › Diagnosis of HF and
  - › Has CHF on an inpatient claim or
  - › HF admission in last three months
- **Diabetes Disease Management Program**
  - › Diabetic with A1C 9% or greater or
  - › An inpatient admission related to diabetes in the past 12 months or
  - › Two or more ER visits related to diabetes
- **Advanced Illness Case Management** — The primary goal is to facilitate and support end-of-life wishes and services
  - › Life expectancy of 12-18 months
  - › Chronic, irreversible disease or conditions and declining health
  - › Reduce disease and symptom burden
- **Transplant Case Management and Network Services**
  - › Bone marrow/stem cell, including chimeric antigen receptor T-Cell (CAR-T) therapy for certain hematologic malignancies, kidney and kidney/pancreas, heart, liver, intestinal, multi-organs and lung transplants
  - › Case management for one year post-transplant
- **End-Stage Renal Disease Case Management** — The member is diagnosed with end-stage renal disease and is undergoing outpatient dialysis including in-center or home hemodialysis, home peritoneal dialysis, etc.

If the member does not qualify for one of these programs, they have 24/7, 365 days a year access to speak with a nurse by calling the Optum NurseLine number on the back of their ID card.

NOTE: South Florida Preferred Care Partners no longer provides social worker evaluations without skilled services. Please direct your patient to their local social services department or the Florida State Department of Elder Affairs Help Line at 800-963- 5337.

To request CM or DM services for one of our members, select only one program based on the program criteria that most closely matches the member's medical condition. Then submit the CM/DM referral form, available on **mypreferredprovider.com**, to **southfl@optum.com**.

Behavioral Healthcare Programs

We work with Optum Behavioral Health to provide behavioral health care services for our members. For more information on how to access the Behavioral Healthcare programs, you or our members may contact a representative through the phone number listed on the back of their health care ID card.

Special Needs Plans

Special Needs Plans (SNP) Model of Care (MOC)

The MOC is the framework for care management processes and systems to help enable coordinated care for SNP members. The MOC contains specific elements that delineate implementation, analysis, and improvement of care.

These elements include description of SNP population (including health conditions), Care Coordination, Provider Network and Quality Measurement and Performance Improvement.

The MOC is a quality improvement tool and MOC helps ensure the unique needs of our SNP members are identified and addressed through care management practices. MOC goals are evaluated annually to determine effectiveness. To learn more, contact us via email at: **snp_moc_providertraining@uhc.com**.

The Centers for Medicare and Medicaid (CMS) requires annual SNP MOC training for all care providers who treat SNP members. The Annual SNP MOC Provider Training is available at **UHCprovider.com**. Reminders about the training requirements are communicated annually through the Network Bulletin described in *Chapter 17*.

Risk Management

Risk management addresses liability, both proactively and reactively. Proactive is avoiding or preventing risk. Reactive is minimizing loss or damage after an adverse or bad event. Risk management in health care considers patient safety, quality assurance, and patients' rights. The potential for risk is present in all aspects of health care, including medical mistakes, electronic record-keeping, care provider organizations, and facility management.

An adverse event is defined as an event over which health care personnel could exercise control rather than as a result of the member's condition. Identifying something as an adverse event does not imply "error," "negligence" or poor quality care. It indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process. Adverse events interfere with a care provider's delivery of medical care and may result in litigation.

Agency for Healthcare Administration

The Florida Agency for Healthcare Administration (AHCA), as directed under F.S. 641 Parts I, II, III and other applicable state laws, provides oversight and monitoring of health plans operating in the State of Florida as an HMO and their compliance to applicable regulations.

This includes implementation of a Risk Management Program (RMP). The program helps identify, investigate, analyze and evaluate actual or potential risk exposures by a state licensed risk manager. The RMP also corrects,

reduces and eliminates identifiable risks through instruction and training to staff and care providers.

For more information, go to the AHCA website at ahca.myflorida.com.

Care Provider Reporting Responsibilities

You are required to report all adverse events as identified above, whether actual or potential. To report such incidents, call 952-406-4806.

You must report incidents to AHCA within 24 hours of it happening. You must report all serious incidents, such as those listed below, immediately. This allows us to quickly access the risk and address liability. Examples of adverse and serious incidents include:

- Death or serious injury;
- Brain or spinal damage;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong site surgical procedure;
- Performance of a wrong surgical procedure;
- Medically unnecessary surgical procedure;
- Surgical repair of damage from a planned surgical procedure; and
- Removal of unplanned foreign object remaining from a surgical procedure.

Care provider contracts include the obligation to participate in quality management inquiries upon request from the clinical quality analyst.

What are the Responsibilities of Physicians and Care Providers?

You must report the ICD-10-CM diagnosis codes to the highest level of specificity and accurately. This requires accurate and complete medical record documentation. You are required to alert the MA organization of wrong information submitted. You must follow the MA organization's procedures for correcting information. Finally, you must report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

Links to resources for the latest ICD guidelines and MRA resources are available online at mypreferredprovider.com.

CPT and HCPCS Codes

The American Medical Association (AMA) and the CMS update procedure codes quarterly, with the largest volume effective January 1 of each year. CPT and HCPCS codes may be added, deleted or revised to reflect changes in health care and medical practices.

If a claim is submitted with an invalid or deleted procedure code, it will be denied or returned. A valid procedure code is required for claims processing.

We encourage you to purchase current copies of CPT and HCPCS reference guides. You may access CPT, HCPCS and ICD-10 coding resources and materials at the American Medical Association's website, ama-assn.org.

River Valley Entities Supplement

Information Regarding the Use of this Supplement

This supplement applies to covered services rendered to River Valley entities members (does not include MA).

It also applies to care providers who have the following:

1. A UnitedHealthcare Agreement with:
   - A reference to the River Valley or John Deere Health protocols or guides, or
   - A direct contract with one or more River Valley entities that participate in River Valley entities networks
2. Located in AR, GA, IA, TN, VA, WI or the following Illinois counties: Jo Daviess, Stephenson, Carroll, Ogle, Whiteside, Lee, Mercer, Rock Island, Henry, Bureau, Putnam, Henderson, Warren Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford, McLean.

The following River Valley entities sponsor, issue and administer River Valley benefit plans:

- UnitedHealthcare Services Company of the River Valley, Inc.
- UnitedHealthcare Plan of the River Valley, Inc.
- UnitedHealthcare Insurance Company of the River Valley, Inc.

The River Valley entity is listed on the front of members' ID card (bottom left).

Health care providers who are not subject to this supplement (including care providers in Louisiana, North Carolina, Ohio and South Carolina) may disregard this information. You may work with us when providing services to River Valley members in the same way as you do when providing services to other UnitedHealthcare members.

For protocols, policies and procedures not specified in this supplement, refer to appropriate chapter in the main guide.

For policies and procedures relating to the TennCare®, Iowa Medicaid/hawk-i®, and Secure Plus Complete Medicaid Plans®, refer to the UnitedHealthcare Community Plan administrative guides available on **UHCprovider.com/communityplan**.

Eligibility

Call the number on the back of the member's ID card to get information about a River Valley member, such as eligibility information and claims status information.

Member ID Cards

When members enroll, they will get a new ID card with a member ID number. The phone number, website and claims address for our core UnitedHealthcare systems are listed on the back. Refer to the section titled *Health Care Identification (ID) Cards* in Chapter 2: Provider Responsibilities for more guidance regarding ID cards.

How to Contact River Valley

Care providers who practice in Illinois, Iowa and Wisconsin may refer to the "Midwest" references in the following grid. Care providers who practice in Arkansas, Georgia, Tennessee and Virginia may refer to the "Southeast" references in the following grid.

Resource	Where to go
UnitedHealthcare Provider Website	**UHCprovider.com**, or **UHCprovider.com/Link**
Cardiology: • Diagnostic Catheterization • Electrophysiology Implants • Echocardiogram and Stress Echocardiogram	**Online:** **UHCprovider.com/cardiology** **Phone:** 866-889-8054
Case Management/Utilization Management Initiate case management and utilization management	• Congenital Heart Disease: The number on the back of the member's health care ID card. • Kidney Resource Services: The number on the back of the member's health care ID card. • Transplant Resource Services **Fax:** 855-250-8157 • Ventricular Assist Devices: **Phone:** 888-936-7246, prompt 2

Resource	Where to go
Claims (Information and Submissions)	**EDI:** Medical claims payer ID: 87726 Dental claims payer ID: 95378 **Link:** UHCprovider.com/claimslink **Online:** UHCprovider.com/claims (policies, instructions and tips) **Phone:** 866-509-1593 Mail paper claims to: UnitedHealthcare P.O. Box 740800 Atlanta GA 30374-0800
Claims Reconsiderations and Appeals	**Online:** UHCprovider.com/claims > Submit a Corrected Claim, Claim Reconsideration / Begin Appeal Process Refer to the *Claim Reconsideration and Appeals Process* section in Chapter 9: Our Claims Process for more information, or: **Mail to:** UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 **Fax:** 801-938-2100
Disease Management	**Phone:** 800-369-2704, Option # 4 (Monday through Friday, 8 a.m - 4:30 p.m., CT) **Fax:** 866-950-7759, Attn: CMT Coordinator **Email:** MailWebCDM@uhc.com
Electronic Data Interchange (EDI) EDI Support	**Online:** UHCprovider.com/edi **Help:** UHCprovider.com > Contact Us > Technical Assistance **Phone:** 800-842-1109 (Monday through Friday, 7 a.m. – 9 p.m. CT)
Electronic Payments and Statements (EPS)	**Online:** UHCprovider.com/EPS **Or:** Optumbank.com > Partners > Providers > Electronic Payments and Statements **Or:** the EPS app on Link **Help Desk:** 877-620-6194
Eligibility (Member)	**EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse **Online:** Using eligibilityLink
Eligibility for: End-Of-Life Care • Home Health Care • Infusion Services (Prior Authorizations)	**Online:** UHCprovider.com/paan **Phone:** 877-842-3210 **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive Moline, IL 61265
Inpatient Admissions (Notifications)	**Online:** UHCprovider.com/paan **Phone:** 877-842-3210 **Fax:** 844-831-5077
Mental Health/Substance Use **Vision** **Transplant Services**	**Phone:** 877-842-3210
Pharmacy Services/Prescription Drugs Requiring Preauthorization	**Online:** UHCprovider.com/pharmacy or professionals.optumrx.com **Phone OptumRx:** 800-711-4555 **Urgent Pharmacy Appeal Fax:** 801-994-1058

Resource	Where to go
Prior Authorization Including preauthorization for certain DME. See Cardiology, Radiology, Inpatient Admissions, and End-of-Life Care, for specific contact information	**EDI:** See EDI transactions and code sets on UHCprovider.com/edi. We accept EDI 278 submissions directly to UnitedHealthcare or through a clearinghouse. **Link:** Use the Prior Authorization and Advance Notification tool at UHCprovider.com/paan. **Online:** UHCprovider.com/priorauth (policies, instructions and tips) **Phone:** (Inpatient requests only) 877-842-3210, option 3, or the number on the back of the member's ID card
Appeals (Urgent)	**Fax:** 801-994-1058 (Urgent Appeals Only)
Radiology/Advanced Outpatient Imaging Procedures: Certain CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online:** UHCprovider.com/radiology **Phone:** 866-889-8054
Referrals	
Skilled/Extended Care	**Online:** UHCprovider.com/paan **Phone:** 877-842-3210
Tax ID Numbers (TIN)/ Provider ID Numbers	**Phone:** 866-509-1593 or email RVITEDISolutions@uhc.com
United Voice Portal (Provider Services)	**Phone:** 877-842-3210

Use UHCprovider.com and Link to perform secure transactions, including checking member eligibility and benefits as well as managing claims and prior authorization requests.

Reimbursement Policies

Claim payment is subject to reimbursement policies on UHCprovider.com/policies > Commercial Policies > Reimbursement Policies for Commercial. Claims Estimator tools are not available for River Valley members.

Changes to these policies are announced in the Network Bulletin available on UHCprovider.com/news.

Coding edits may also affect reimbursements. We apply coding edits based primarily on the National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare and Medicaid Services (CMS) as well as the CMS' Outpatient Code Editor (OCE). You may find NCCI and OCE edits on cms.gov > Medicare > Coding > National Correct Coding Initiative Edits.

Referrals

Network Referrals

Primary Care Coordinator Plans (PCC Plans) do not require a referral.

Out-of-Network Referrals

An out-of-network (OON) referral means a written authorization provided by a participating care provider and approved by us for services to be received from a non-participating care provider. OON referrals must be requested by the member's PCP. If an OON referral is obtained, services received from a non-participating care provider are covered at a network level of benefits under the member's benefit plan. An OON referral is needed when services are not available from a participating care provider and may be needed for various services including, but not limited to, podiatry, chiropractic and mental health/substance use services.

Out-of-Network Referral Approval

A referral to an OON care provider must be approved by us before the services are rendered. We must also give prior approval for modified or expired OON referrals as described in this supplement. We may approve an OON referral when services are needed but not available from a participating care provider. Prior approval of an OON referral is required for each follow-up visit unless we indicate otherwise. A medical director will review requests that do not meet approval criteria.

In the case of emergencies, notify us the first business day following the referral.

Out-of-Network Referral Process

To determine whether an OON referral is necessary under a member's benefit plan, contact us at the number on the back of the member's health care ID card.

Refer to the section *Non-Participating Care Provider Referrals (All Commercial Plans)*, in Chapter 5: Referrals, for more instructions.

- We will make decisions within the time frames required by state and federal law (including ERISA) and in accordance with NCQA standards.
- We will send a letter confirming our approval or denial of a referral to the member and your office.

If a member requests approval after the fact, advise them this is against policy. Ask them to call 877-842-3210.

Participating care providers may not refer their own family members to non-participating physicians/facilities due to conflict of interest. If the care provider denies a referral, the care provider must refer the member to their benefit document for any appeal rights. Or have them call 877-842-3210.

Utilization Management

The term "prior authorization" is also referred to as "preauthorization."

Our Utilization Management (UM) Program has several parts. These include but are not limited to:

- Preauthorization for various procedures, medical services, treatments, prescription drugs and durable medical equipment (DME).
- Review of the appropriateness of inpatient admissions and ongoing inpatient care coverage.
- Prior approval for referrals to non-participating care providers, if applicable.
- Case management.

Our goal is to encourage the highest quality of care in the right place at the right time from the right care provider.

Care providers must cooperate with our UM program. You will allow us access, in the form we request, to data about covered services provided to our members. You will allow us to collect data to conduct UM reviews and decisions.

Medical & Drug Policies and Coverage Determination Guidelines

River Valley uses UnitedHealthcare's Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, Quality of Care Guidelines, and Utilization Review Guidelines on UHCprovider.com/policies > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans**.

For more information refer to *Medical & Drug Policies and Coverage Determination Guidelines for Commercial Members* in *Chapter 6: Medical Management*.

Preauthorization

Services that Require Preauthorization

We require preauthorization for certain procedures, DME, prescription drugs and other services.

The list of services requiring preauthorization is available on UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > **UnitedHealthcare of the River Valley Advance Notification Procedure Codes**

Submit Adequate Clinical Documentation

You must request preauthorization when required. Provide complete clinical information and supporting medical documentation for each procedure, device, drug or service when you submit your request. That way, we may promptly determine whether the services are covered and medically necessary. We consider additional information provided within the time period allowed for review. However, delayed submissions increase administrative time.

Refer to our Medical & Drug Policies and Coverage Determination Guidelines for what information to provide.

How to Request Preauthorization

Refer to *How to Contact River Valley* in this supplement for how to submit a request for preauthorization.

If you do not get a required preauthorization, the claim may be denied. You may not bill the member for denied services.

Preauthorization Review Hours of Operation

Staff may review your preauthorization requests Monday through Friday from 8 a.m. until 4:30 p.m. CT. Medical directors are available to discuss clinical policies or decisions by calling 877-842-3210. The office is closed for national holidays and the day after Thanksgiving.

Clinical Review of a Preauthorization Request

When we receive a preauthorization request, our Clinical Coverage Review Department evaluates the information to determine whether the procedures, devices, drugs or other services are medically necessary and appropriate. Our nursing staff makes decisions to approve care based on specific criteria. Care and/or services that do not fall within the criteria are referred to a medical director or other appropriate reviewer. This may include a board-certified specialty physician or a registered pharmacist. Only physicians and other appropriate care providers may issue a medical necessity denial.

River Valley's staff and our delegates who make these decisions are not rewarded for denying coverage. We do not offer incentives that encourage underutilization of care or services.

The treating physician has the ultimate authority for the member's medical care. The medical management process does not override this responsibility.

Utilization Management Decisions

We make UM decisions within the time frames set by state and federal law (including ERISA). We make UM decisions in accordance with National Committee for Quality Assurance (NCQA) standards.

We also tell care providers and members our decisions according to applicable state and federal law as well as to NCQA standards and River Valley policy. Denial letters explain members' applicable appeal rights, which may include the right to an expedited and/or external review. They also explain the requirements for submitting an appeal and receiving a response. A member may have a health care professional appeal a decision on their behalf. We require a copy of the member's written consent with the appeal.

Facility Utilization Review

Notification of Inpatient Admission Required

Facilities must notify us of an inpatient admission within 24 hours of admission or on the next business day after a holiday or weekend. We need the member's name, ID number, admitting diagnosis and attending physician's name.

Facilities are responsible for admission notification even if advance notification was provided by the physician and coverage approval is on file.

Failure to Notify

If the facility does not tell us about an admission as required, claims will be returned as not allowed. The facility may not bill the member for the services. Retrospective reviews may be completed, and any approved services may be re-billed.

Inpatient Review

Our UM activities include inpatient review. We usually begin our review on the first business day following admission. The medical director and clinical staff review member hospitalizations for over- and under-utilization. Then they decide whether the admission and continued stay are medically appropriate and align with evidence-based guidelines.

Where appropriate, River Valley also uses MCG™ Care Guidelines. These are nationally recognized clinical guidelines that help clinicians make informed decisions, on a case-by-case basis, in many health care settings. These settings include acute and sub-acute medical, rehabilitation, skilled nursing facilities (SNF), home health care and ambulatory facilities. Other criteria may be used when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay.

When the guidelines are not met, the medical director considers community resources and the availability of alternative care settings. These include skilled facilities, sub-acute facilities or home care, and the ability of the facilities to provide all necessary services within the estimated length of stay.

Inpatient review also helps us contribute to decisions about discharge planning and case management. In addition, we may identify opportunities for quality improvement and cases appropriate for referral to one of our disease management programs.

If a nurse reviewer believes an admission or continued stay does not meet criteria, you may be asked for more information about the treatment and case management plan. The nurse then refers the case to our medical director. If the medical director determines an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, we tell the facility and the care provider.

You may speak with our medical director within one business day of the request. When decisions require expertise outside the scope of the physician advisor, we have a board-certified physician of the relevant specialty (or similar specialty) review the case. We use external independent review when we decide it is appropriate or by member request, according to applicable law.

Admission to Rehabilitation Units

We require prior authorization for admission for all rehabilitation confinements. We review them concurrently for continued services. Refer to the Skilled/Extended Care row in the *How to Contact River Valley* section in this supplement for how to submit a preauthorization request.

Admission to Skilled Nursing Units

A member may require inpatient skilled nursing care due to acute illness, injury, surgery, or exacerbation of a disease process.

- We require notification for all admissions to a SNF (or skilled level of care within an acute facility). Refer to *How to Contact River Valley* in this supplement for how to submit a notification request.
- The facility must submit the care plan along with treatment goals, summary of services to be provided, expected length of stay (LOS), and discharge plan.
- We authorize admission consistent with the level of care required based on the treatment plan.

Concurrent Review

- The skilled facility provider must provide appropriate documentation, including changes in the level of care.
- Approval for additional days of authorized coverage must be obtained before the authorization expires.
- Decisions about levels of care must consider not only the level of service but the member's medical stability.
- Our medical director will speak with the physician managing the member in the skilled facility about disagreements concerning the level of care required. The member or authorized representative may request an appeal when coverage is not approved. We determine whether the admission, stay and care are covered and medically necessary based on the following clinical guidelines, among others:
  - Physicians must order services. The services must be necessary for treatment. They must align with the nature and severity of the illness or injury, medical needs, and accepted medical practice standards.

The member must be stable. Clinical and lab findings must have either improved or not changed for the last 24 hours. Diagnosis and initial treatment plan must be established before admission. The services must be reasonable in terms of duration and quantity. The member must require daily (i.e., available on a 24-hour basis, seven days/week) skilled services. If skilled rehabilitation services are not available on this basis, a member whose stay is based on the need for them would meet the daily basis requirement when they need and receive those services at least five days a week. Skilled services, however, are required and provided at least three times per day. How often a service must be performed does not make it a skilled service.

› We consider the nature and complexity of a service and the skills required for safe and effective delivery when determining whether a service is skilled. Skilled care requires trained medical personnel to frequently review the treatment plan for a limited time. It ends when a condition is stabilized or a predetermined treatment plan is completed. Skilled care moves the member to functional independence.

Observation

Observation helps care providers determine whether a member needs to be admitted to a hospital. It may be needed to monitor or diagnose a condition when testing or treatment exceeds usual outpatient care. Observation is used when physicians need 48 hours or less to determine a member's condition. In some cases, more than 48 hours may be necessary. Members may be admitted when a condition is diagnosed requiring a long-term stay (e.g., acute MI). This condition may involve long-term treatment or further monitoring (e.g., persistent severe asthma).

Notice of Termination of Inpatient Benefits

We may determine that an admission, continued hospital stay, rehabilitation unit or SNF are not covered. These reasons include but are not limited to:

- A medical director determines an admission or continued stay, which was not preapproved at an OON facility, is not medically necessary at the facility's level of care.
- Preauthorization was not obtained for a procedure or service that needed it.
- A medical director determines the member's condition is custodial and is not covered.
- A medical director, upon consulting with the attending physician, determines continued acute inpatient rehabilitation/SNF level of care is no longer medically necessary, but the member refuses discharge.
- The member has used all inpatient or skilled care benefits under their benefit plan. If a non-coverage determination is made, we provide written notification to the physician, the member and facility that day.

Services Obtained Outside the River Valley Service Area

- We process treatment authorizations as directed by you and the out-of-area (OOA) attending physician.
- With you and the OOA attending physician, we coordinate a member's transfer back to the service area when medically feasible and appropriate.
- We cover OOA urgent or emergent stabilization services according to the member's benefit plan. This includes the time they are stabilized in the emergency room before admission as an inpatient and are discharged.
- We cover post-stabilization care services.
- We cover OOA inpatient services until the member is stable enough to be transferred to a participating hospital. Transfers should happen within 48 hours of that point. Payment for preventive or non-emergent/urgent services performed outside the network varies by benefit plan. Determinations on benefit coverage may include but are not limited to non-covered, covered at a lower benefit level, or covered at the network level with a referral. Call Member Services if you have questions.

Special Requirements DME

Preauthorization is required for some DME. Refer to the *How to Contact River Valley* section of this supplement for how to submit a preauthorization request.

Subject to the noted exceptions, members must get all DME, orthotics, prosthetics and supply items from a contracted vendor. If an item is not available from a contracted vendor, whether or not preauthorization is required, you must get an OON referral. Otherwise, payment will be denied unless the member has an OON DME benefit.

Note: Even when medically necessary, certain items (e.g., orthotic devices) may not be covered. Others (e.g., prosthetic devices) may be subject to benefits limits.

Contact Member Services for information about a member's plan and preauthorization requirements.

Prescription Drugs

We require preauthorization for some prescription drugs. Refer to the *How to Contact River Valley* section of this supplement for how to submit a preauthorization request

Some drugs have special rules and require special management services. These include drugs with therapy prerequisites, quantity limitations and/or a multiple copays. A list of some drugs with such rules is on **UHCprovider.com/pharmacy**.

- If you order and/or administer any medication that requires preauthorization or clinical management services, you may need to get those medications from a participating specialty pharmacy unless we authorize a non-specialty pharmacy.
- Certain drugs are available in quantities up to 90- or 100-day supplies, depending on plan benefit design.

A list of drugs on the three-month supply list is on UHCprovider.com/pharmacy.

- River Valley's Prescription Drug Lists (PDL) is on UHCprovider.com/pharmacy.

Not all drugs on a PDL are covered under the pharmacy benefit.

Sleep Studies to Diagnose Sleep Apnea and Other Sleep Disorders
We require preauthorization for laboratory-assisted and polysomnography treatment. We also require it for the site of service (e.g., sleep lab v. portable home monitoring).

Home Health Care (Including Home Infusion Services)
- We require preauthorization for home health care. This may include home infusion services.
- If requested services are required after business hours, notify us within 24 hours or the next business day following a holiday or weekend. Include the member's name, ID number, diagnosis, the attending physician's name and requested services.
- If you do not notify us, we will deny your claim. You may not bill the member for the service.

Assisted Reproduction Program
Most River Valley benefit plans exclude coverage for infertility evaluation or treatment. Some employer groups have a variation or rider to cover these services. Some states, however, require fertility treatment coverage for some groups. Refer to *How to Contact River Valley* section of this supplement for pre-authorization contact information.

Transplants
- We require preauthorization for transplants. Call the Optum transplant case manager at 888-936-7246. They will request medical records to see whether the transplant is appropriate for a member. We send all information to a physician expert in the related transplantation field for review.
- If authorized, the case manager coordinates referrals and helps select a transplant center based on the member's needs. They also provide information about our transplant management program.
- If a transplant candidate needs home care or is involved with a participating center, the transplant care manager will arrange service.
- Any post-transplant lab or pathology that cannot be performed or interpreted by a network physician may be sent to the transplant center for interpretation. Tell the transplant case manager if you need help making arrangements. Most of these services are covered under the transplant contract. The transplant center should be involved in the member's continuing care.

Post-Transplant Care
- We require preauthorization for all follow-up care. Make requests using the standard River Valley preauthorization process.
- One year after the transplant, members are transferred to their local physician for any other needed care management services.

End-of-Life Care
Some members have end-of-life care benefits, which may include hospice services. These services require preauthorization. Approved care is coordinated by our care managers.

Claims Process

Electronic Data Interchange
Use electronic data interchange (EDI) to submit claims and conduct other business with us electronically. To enroll, call EDI customer service at 866-509-1593, or email RVITEDISolutions@uhc.com.

Claims Transmission
Tell your office software vendor that you want to begin transmitting electronic claims to the River Valley payer ID 87726 for medical claims and 95378 for dental.

We receive all claims through our clearinghouse, OptumInsight. The clearinghouse sets up claims as commercial. Your EDI software vendor must establish connectivity to the clearinghouse. They can make sure you meet the requirements to transmit claims.

EDI Acknowledgment & Status Reports
Your software vendor will give you a report showing an electronic claim left your office. It does not confirm we or the clearinghouse received or accepted the claim.

Clearinghouse acknowledgment reports show the status of your claims. They are given to you after each transmission. This lets you confirm whether a claim reached us, rejected because of an error or needed additional information.

We will also send you status reports providing more data on claims. These include copies of EOBs/remittance advice and denial letters that may request more information.

Carefully review all vendor reports, clearinghouse acknowledgment reports and the River Valley status reports when you receive them.

Paper and Electronic Claims Format
Submit all medical or hospital services claims using, as applicable, the CMS 1500 or UB-04 claim forms. Or use their successor forms for paper claims and HIPAA-standard professional or institutional claim formats for electronic claims. Use black ink when completing a CMS 1500 claim form. This helps us scan the claim into our processing system.

Electronic Claims Submission and Billing

We require you to submit claims electronically, with few exceptions. For electronic claims submission requirements, refer to *Requirements for Complete Claims and Encounter Data Submission* section in Chapter 9: Our Claims Process.

Share this document with your software vendor. We update the Companion Guide regularly, so review it to help ensure you have the most current information about our requirements.

For more information about electronic claims, refer to UHCprovider.com/claims.

Exceptions to Electronic Claims Submission Guidelines
The following claims require attachments. This means they must be submitted on paper:

- Claims submitted for dental pre-treatments for crown lengthening, periodontics, implants and veneers.
- Claims submitted with unlisted procedure codes if sufficient information is not in the notes field.

Modifier 59 helps identify procedures/services commonly bundled together but may be appropriate to report separately. No special rules apply to electronic claims joined using Modifier 59 or for dental pre-treatment claims.

Special Rules for Electronic Submission

- **Corrected Claims** must include the words "corrected claims" in the notes field. Your software vendor may help you with correct placement of all notes.
- **Unlisted Procedure Code Claims** must include details in the notes field. If you cannot, you must submit a paper claim.
- **Claims for Occupational Therapy, Speech Therapy, Physical Therapy, Dialysis, and Mental Health or Substance Use Services** must have the date of service by line item. We do not accept span dates for these types of claims.
- **Secondary Coordination Of Benefits (COB) Claims** must include the following fields:
  - **Institutional:** Payer Prior Payment, Medicare Total Paid Amount, Total Non-Covered Amount, Total Denied Amount.
  - **Professional:** Payer-Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (contractual discount amount of other payer), Patient-Paid Amount (amount that the payer paid to the member, not the care provider).
  - **Dental:** Payer Paid Amount, Patient Responsibility Amount, Discount Amount, Patient Paid Amount.
  - **Span Dates:** We require exact dates of service when the claim spans a period of time. Put the dates in Box 24 of the CMS 1500, Box 45 of the UB-04, or the Remarks field. This will prevent the need for an itemized bill and allow electronic submission.

Requirements for Claims (Paper or Electronic) Reporting Revenue Codes

- We require the exact dates of service for all claims reporting revenue codes.
- If you submit revenue code 270 by itself on an institutional claim for outpatient services, we require a valid CPT or HCPCS code or description.
- If you report revenue code 274, describe the services or include a valid CPT or HCPCS code.
- We require an itemized statement for claims with revenue codes 250-259 if the charges exceed $1,000.
- All claims reporting the revenue codes on the following list require you to report the appropriate CPT and HCPCS codes.

Revenue Codes Requiring CPT® and HCPCS Codes	
260	IV Therapy (General Classification)
261	Infusion Pump
262	IV Therapy/Pharmacy Services
263	IV Therapy/Drug/Supply Delivery
264	IV Therapy/Supplies
269	Other IV Therapy
290	DME (other than renal) (General Classification)
291	DME/Rental
292	Purchase of New DME
293	Purchase of Used DME
300	Laboratory(General Classification)
301	Chemistry
302	Immunology
303	Renal Patient (Home)
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology & Microbiology
307	Urology
309	Other Laboratory
310	Laboratory-Pathology (General Classification)
311	Cytology
312	Histology
319	Other Laboratory Pathological

Revenue Codes Requiring CPT® and HCPCS Codes	
320	Radiology-Diagnostic (General Classification)
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray
329	Other Radiology-Diagnostic
330	Radiology-Therapeutic and/or Chemotherapy Administration (General Classification)
331	Chemotherapy Administration-Injected
332	Chemotherapy Administration-Oral
333	Radiation Therapy
335	Chemotherapy Administration-IV
339	Other Radiology-Therapeutic
340	Nuclear Medicine (General Classification)
341	Diagnostic Procedures
342	Therapeutic Procedures
350	CT Scan (General Classification)
351	CT-Head Scan
352	CT-Body Scan
359	CT-Other
360	Operating Room Services (General Classification)
361	Minor Surgery
362	Organ Transplant-Other Than Kidney
367	Kidney Transplant
369	Other Operating Room Services
400	Other Imaging Services (General Classification)
401	Diagnostic Mammography
402	Ultrasound
403	Screening Mammography
404	Positron Emission Tomography
409	Other Imaging Services
410	Respiratory Services (General)
412	Inhalation Services

Revenue Codes Requiring CPT® and HCPCS Codes	
419	Other Respiratory Services
460	Pulmonary Function(General Classification)
469	Other-Pulmonary Function
470	Audiology (General Classification)
471	Audiology/Diagnostic
472	Audiology/Treatment
480	Cardiology (General Classification)
481	Cardiac Cath Lab
482	Stress Test
483	Echocardiology
489	Other Cardiology
490	Ambulatory Surgical Care (General Classification)
499	Other Ambulatory Surgical Care
610	Magnetic Resonance Technology (MRT) (General Classification)
611	Magnetic Resonance Imaging (MRI)-Brain/Brain Stem
612	MRI-Spinal Cord/Spine
614	MRI-Other
615	Magnetic Resonance Anglogram (MRA)-Head and Neck
616	MRA-Lower Extremities
618	MRA Other
618	Other MRT
623	Surgical Dressing
624	FDA Investigational Devices
634	Erythropoietin (EPO) < 10,000 units
635	Erythropoietin (EPO) > 10,000 units
636	Drugs Requiring Detail Coding
730	EKG/ECG (Electrocardiogram) (General Classification)
731	Holter Monitor
732	Telemetry
739	Other EKG/ECG
740	EEG (Electroencephalogram) (General Classification)

Revenue Codes Requiring CPT® and HCPCS Codes	
750	Gastro-Intestinal (GI) Services (General Classification)
790	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
921	Peripheral Vascular Lab
922	Electromyogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
929	Additional Diagnostic Services
940	Other Therapeutic Services (General Classification)
941	Recreational Therapy
942	Education/Training (Diabetic Education)
949	Other Therapeutic Services (HRSA-approved weight loss providers)

Claim Reconsideration and Appeals Process and Resolving Disputes

Refer to *Claim Reconsideration and Appeals Process* in *Chapter 9: Our Claims Process* and in the *How to Contact River Valley* section of this supplement.

If you have a question about a pre-service appeal, please see *Pre-Service Appeals* in Chapter 6: Medical Management.

UnitedHealthcare West Supplement

Applicability of This Supplement

This supplement is intended for use by **non-capitated** physicians, health care professionals, facilities, ancillary care providers and their respective staff. Unless otherwise specified, any references to UnitedHealthcare West in this supplement are intended to apply to any or all of the entities and benefit plans listed below. This information is subject to change.

Capitation is a payment arrangement for health care providers. If you have a capitation Agreement with us, you are paid a set amount for each member assigned to you, whether or not that person seeks care. If you have a UnitedHealthcare West capitation Agreement with us, this supplement does not apply to you.

Care providers who participate in the listed benefit plans are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location when applicable. For protocols, policies and procedures not referenced in this supplement please refer to appropriate chapter in the main guide.

You may identify a UnitedHealthcare West member by a reference to "WEST" on the back of their ID card. Information may vary in appearance or location on the card due to unique benefit plan requirements.

You may see more detailed information on ID cards and a sample health care ID card, in the section titled *Commercial Health Care ID Card Legend* in Chapter 2: Provider Responsibilities and Standards. You may see a sample ID card image specific to the member when you verify eligibility using eligibilityLink.

Benefit Plans Referenced in this Supplement

We offer a wide range of products and services for employer groups, families and individual members. Benefit plan availability may vary. Contact us for more information about benefit plan availability and service areas where each of these products and supplemental benefits are available.

State	Products Offered	Benefits Plans
Arizona	Medicare Advantage (MA)	• AARP® Medicare Advantage • UnitedHealthcare® Group Medicare Advantage
California	Commercial and MA	**Commercial:** UnitedHealthcare SignatureValue® family of products including but not limited to: • UnitedHealthcare SignatureValue • UnitedHealthcare SignatureValue Advantage • UnitedHealthcare SignatureValue VEBA • UnitedHealthcare SignatureValue Alliance • UnitedHealthcare SignatureValue Flex • UnitedHealthcare SignatureValue Focus **Medicare:** • AARP® Medicare Advantage SecureHorizons® • AARP® Medicare Advantage SecureHorizons® Essential • AARP® Medicare Advantage SecureHorizons® Focus • AARP® Medicare Advantage SecureHorizons® Premier • AARP® Medicare Advantage SecureHorizons® Value • AARP® Medicare Advantage Walgreens • Sharp® SecureHorizons® Plan by UnitedHealthcare® • UnitedHealthcare® Canopy Health® Medicare Advantage • UnitedHealthcare® Group Medicare Advantage • UnitedHealthcare® Medicare Advantage Assure
California	Commercial	UnitedHealthcare Core℠* and Core Essential℠ *This UnitedHealthcare West Supplement does not apply to this benefit plan. Please refer to the main guide for regulations, processes and contact information

State	Products Offered	Benefits Plans
Colorado	MA	• AARP® Medicare Advantage SecureHorizons® • AARP® Medicare Advantage SecureHorizons® Essential • UnitedHealthcare® Group Medicare Advantage HMO
Nevada	MA	• AARP® Medicare Advantage • AARP® Medicare Advantage Premier • AARP® Medicare Advantage Walgreens • UnitedHealthcare® Group Medicare Advantage • UnitedHealthcare® Medicare Advantage Assist (Chronic SNP) • UnitedHealthcare® Medicare Advantage Focus
Oklahoma	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP® Medicare Advantage SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
Oregon	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP® Medicare Advantage • UnitedHealthcare® Group Medicare Advantage
Texas	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP® Medicare Advantage • AARP® Medicare Advantage SecureHorizons® • AARP® Medicare Advantage SecureHorizons® Essential • UnitedHealthcare® Chronic Complete (Chronic SNP) • UnitedHealthcare Dual Complete® (Dual SNP) • UnitedHealthcare® Group Medicare Advantage
Washington	Commercial and MA	**Commercial:** • UnitedHealthcare® SignatureValue® **Medicare:** • AARP® Medicare Advantage • AARP® Medicare Advantage Walgreens • UnitedHealthcare® Group Medicare Advantage

Commercial products
Commercial benefit plans consist of Health Maintenance Organizations (HMOs) or Managed Care Organizations (MCOs). Members access health services through a network primary care physician (PCP). PCPs manage the member's medical history and individual needs. HMOs/MCOs offer minimal paperwork and low, predictable out-of-pocket costs. Members pay a predetermined copayment or a percentage copayment each time they receive health care services.

MA products
Please reference *Chapter 4: Medicare Advantage Products* for a description of Medical Advantage (MA) products offered. You may see a complete list of health plans on **UHCprovider.com/plans**.

Administrative services are provided by the following affiliated companies: UnitedHealthcare Services, Inc. OptumRx or OptumHealth CareSolutions, Inc.

Behavioral health products are provided by U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California or United Behavioral Health operating under the brand Optum.

MA Special Needs Plans (SNP)
SNPs are part of the MA program. These plans are designed for members with unique health care needs. They offer benefits in addition to those covered under Original Medicare (including Part D prescription drug coverage) and intended to keep the member healthy and as independent as possible. UnitedHealthcare offers two types of MA SNPs within the plans covered by this supplement.

UnitedHealthcare West Information Regarding our Care Provider Website

This supplement is located at **UHCprovider.com**, our care provider website. The News and Network Bulletin page has the latest information. Certain care providers will also receive notices by mail, where required by state law.

To access Link apps, go to **UHCprovider.com** and use the Link button in the upper right corner. Sign in with your Optum ID. Information on all available apps is on **UHCprovider.com/Link**. We offer several live webinar options; information and registration is available on **UHCprovider.com/training**. For on-demand videos, go to the UHC On Air app on your Link dashboard and select the UHC News Now channel > Link > Provider Self-Service.

An Optum ID is required to access Link and perform online transactions, such as eligibility verification, claims status, claims reconsideration, referrals, and prior authorizations. To get an Optum ID, go to **UHCprovider.com/newuser** to register for Link access.

For help with Link, call the UnitedHealthcare Connectivity Helpdesk at 866-842-3278, option 1, Monday through Friday 9 a.m. to 11 p.m. Central Time (CT).

How to Contact UnitedHealthcare West Resources

Resource	Where to go
Helpful Health Plan Service Phone Numbers	UHCprovider.com > scroll down to 'Support and Privacy, Contact Us'> Health Plan Support by State.
Benefit Interpretation Policies and Medical Management Guidelines	**Online:** Benefit Interpretation Policies: UHCprovider.com/policies > Commercial Policies > UnitedHealthcare West Benefit Interpretation Policies Medical Management Guidelines: UHCprovider.com/policies > Commercial Policies > UnitedHealthcare West Medical Management Guidelines.
Provider Website	UHCprovider.com
Preauthorization	To view the most current and complete Advance Notification List, including procedure codes and associated services, go to: **Online:** UHCprovider.com/priorauth, or Prior Authorization and Notification App on Link Arizona & Colorado **Medicare Advantage Phone: 800-746-7405** California, Oregon and Washington: SignatureValue, Medicare Advantage, direct contract network and medical group/IPA carve-out **Phone:** 800-762-8456 Nevada **Medicare Advantage Phone:** 888-866-8297 Texas and Oklahoma: Medicare Advantage, SignatureValue Inpatient Notification/Utilization Management **Phone:** 800-668-8139
Radiology-Advanced Outpatient Imaging Procedures CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online:** UHCprovider.com/radiology; Go to Prior Authorization and Notification App. **Phone:** 866-889-8054 Request prior authorization of radiology services as described in *Outpatient Radiology Notification/Prior Authorization Protocol* in Chapter 6: Medical Management.
Cardiology Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress	**Online:** UHCprovider.com/cardiology; Go to Prior Authorization and Notification App. **Phone:** 866-889-8054 Request prior authorization of cardiology services as described in *Outpatient Cardiology Notification/Prior Authorization Protocol* in Chapter 6: Medical Management.
Hospital Inpatient Notification (Non-delegated) Inpatient includes: Acute Inpatient, Skilled Nursing Admission, Long-Term Acute Care, Inpatient Rehabilitation Places of Service.	**Online:** UHCprovider.com/paan **Phone:** 800-799-5252 **Fax:** Commercial: 844-831-5077 Medicare Advantage & Medicare Dual Special Needs: 844-211-2369 Mental health Medicare Advantage: 800-508-0088 Transplant: 866-300-7736 **Fax:** 888-361-0502
EDI Support Encounter Collection, Submission & Controls, including ERA/835 transactions	Password and user ID are not required to review and access EDI information on UHCprovider.com. **Online:** UHCprovider.com/edi > EDI Contact > EDI Transaction Support Form **Phone:** 800-842-1109 (For UnitedHealthcare West ERA/835 questions, select option 4 and then option 2) **Email:** supportedi@uhc.com **Payer IDs:** UnitedHealthcare West encounters, 95958. For claims, the payer ID is 87726. For a complete list of payer IDs, refer to the **Payer List for Claims**.

Resource	Where to go
Electronic Funds Transfer (EFT) (SignatureValue and Medicare Advantage Plans only) Have claims payments deposited electronically or make changes to an existing EFT enrollment	**Online:** UHCprovider.com/claims > Request Change to Electronic Funds Transfer (EFT) for UnitedHealthcare West > UnitedHealthcare West EFT Enrollment App Overview **Link:** UnitedHealthcare West EFT app on your Link dashboard **Email:** paymentservicesuhcwest@uhc.com with questions about UnitedHealthcare West EFT.
Eligibility	**EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse **Link:** Using eligibilityLink **Online:** UHCprovider.com/eligibility
United Voice Portal (Follow prompts to access information)	Commercial & Medicare Advantage HMO/ MCO: • California: 800-542-8789 • Arizona/Colorado/Nevada: 888-866-8297 • Oklahoma/Texas: 877-847-2862 • Oregon: 800-920-9202 • Washington MCO: 800-213-7356
Standard Commercial Member Appeals (Applies only to Commercial UnitedHealthcare Signature Value HMO/ MCO)	*California, Oklahoma, Oregon, Texas, Washington* **Mail:** Mailstop CA124-0160 P.O. Box 6107 Cypress, CA 90630 **Phone:** California: 800-624-8822 Oklahoma/Texas: 800-825-9355 Oregon/Washington: 800-932-3004 **Fax:** 866-704-3420
Medicare Advantage Member Appeals	Mailstop CA124-0157 P.O. Box 6106 Cypress, CA 90630 **Fax:** 888-517 7113 AARPMedicareComplete.com
Expedited Commercial Member Appeals (Applies only to Commercial UnitedHealthcare SignatureValue HMO/ MCO)	*California Oklahoma, Oregon, Texas, Washington* **Phone:** 888-277-4232 **Fax:** 800-346-0930
Urgent Clinical Appeals (medical or pharmacy appeals)	**Fax:** 800-346-0930
Pharmacy Services	Commercial products: UHCprovider.com • UHCprovider.com/specialtyrx • UHCprovider.com/pharmacy Medicare products: UHCMedicareSolutions.com > Our Plans > Medicare Prescription Drug Plans **Phone:** 800-711-4555
Mental Health/Substance Use, Vision or Transplant Services	See member's health care ID card for carrier information and contact numbers. View the member's health care ID when you verify eligibility on UHCprovider.com.

Resource	Where to go
California Language Assistance Program (applies only to commercial products in California)	**Online:** UHCprovider.com > UnitedHealthcare Links (scroll to bottom right) > **Language Assistance** **Phone:** 800-752-6096
Health Management and Disease Management Programs	**Phone:** 877-840-4085 **Fax** completed referral form to: 877-406-8212

Care Provider Responsibilities

Electronic Data Interchange

The fastest way for us to talk is electronically. Electronic Data Interchange (EDI) is the preferred method for doing business transactions. Find more information on **UHCprovider.com/edi**.

Panel Restriction

The issues of confidentiality and objective medical observations are the key in the diagnosis and treatment of our members. Therefore, a care provider or other licensed independent health care professional who is also a UnitedHealthcare member shall not serve as PCP for themselves or their dependents.

Monitor Eligibility

You are responsible for checking member eligibility within two business days prior to the date of service. You may be eligible for reimbursement under the Authorization Guarantee program described in the *Capitation and/or Delegation Supplement* for authorized services if you have checked and confirmed the member's eligibility within two business days before the date of service.

Member Eligibility

You must verify the member's eligibility each time they receive services from you. We provide several ways to verify eligibility:

- **Online:** **UHCprovider.com/eligibility** > eligibilityLink.
- **EDI:** 270/271 transactions through your vendor or clearinghouse
- **Phone:** (See *How to Contact UnitedHealthcare West Resources* for specific numbers.)
- Electronic eligibility lists (upon request)

Get more details regarding a specific member's benefit plan in the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage. Benefit plans may be addressed in procedures/protocols communicated by us. Details may include the following:

- Selection of a PCP;
- Effective date of coverage;
- Changes in membership status while a member is in a hospital or skilled nursing facility (SNF);
- Member transfer/disenrollment; or
- Removal of member from receiving services by a PCP

Health Care Identification (ID) Cards

Each member receives a health care ID card with information to help you submit claims accurately. Information may vary in appearance or location on the card due to payer or other unique requirements. Check the member's health care ID card at each visit, and keep a copy of both sides of the card for your records. Sample health care ID cards specific to the member are available when you verify eligibility online.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the *Health Care Identification (ID) Cards* section of Chapter 2: Provider Responsibilities and Standards.

Services Provided to Ineligible Members (does not apply in CA)

If we provide eligibility confirmation indicating that a member is eligible at the time the health care services are provided, and it is later determined that the patient was not eligible, we are not responsible for payment of services provided to the member, except as otherwise required by state and/or federal law. In such event, you are entitled to collect the payment directly from the member (to the extent permitted by law) or from any other source of payment.

Eligibility Verification Guarantee (TX Commercial)

We reimburse Texas care providers who request a guarantee of payment through the verification process. The verification is based on the Agreement and the guidelines in Texas Senate Bill SB 418.

We will guarantee payment for proposed medical care or health care services if you provide the services to the member within the required time frame. We reduce the payment by any applicable copayments, coinsurance and/or deductibles.

You must include the unique UnitedHealthcare West verification number on the claim form (Field 23 of CMS 1500 or Field 63 of UB-04).

You must request eligibility prior to rendering a service. Otherwise, we are not responsible for payment of those services. You are entitled to collect the payment directly from the member to the extent permitted by law or from any other source of payment.

Submit service verification requests to:

- **Phone:** 877-847-2862

  or

- **Mail:** Care Provider Correspondence
  P.O. Box 30975
  Salt Lake City, UT 84130-0975

Access & Availability: Exception Standards for Certain UnitedHealthcare West States

We monitor members' access to medical and behavioral health care to make sure that we have an adequate care provider network to meet the members' health care needs. We use member satisfaction surveys and other feedback to assess performance against standards.

We have established access standards for appointments and after-hours care. Exceptions or additions to those standards are shown in the following table.

Type of Care	Guideline
Regular or routine	UnitedHealthcare Standard: 14 calendar days Exceptions: California Commercial HMO: Members are offered appointments for non-urgent PCP within 10 business days of request, within 15 business days for non-urgent specialist request; Texas: Within three weeks for medical conditions.
Preventive care	UnitedHealthcare Standard: Four weeks Exceptions: California: Preventive care services and periodic follow-up care, including but not limited to standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. Texas: Within two months for child and within three months for adult. Medicare Advantage within 30 days.
Urgent exam (PCP or Specialist)	UnitedHealthcare Standard: Same day (24 hours) Exceptions: California Commercial Members: Within 48 hours when no prior authorization required, within 96 hours when prior authorization required.
In-office wait time	California Members: In-office wait time is less than 30 minutes.
Referral process	Complete notification to the member in a timely manner, not to exceed five business days of a request for non-urgent care or 72 hours of a request for urgent care.
Non-urgent ancillary (diagnostic)	15 business days

1. Our members must have access to all physicians and support staff who work for you and must not be limited to particular physicians. We recognize that some substitution between physicians who work out of the same office/building may occur due to urgent/emergent situations.
2. Members must have access to appointments during all normal office hours and not be limited to appointments on certain days or during certain hours.
3. Members must have access to the same time slots as all other patients who are not our members.
4. You must work cooperatively with our Medical Management Department toward*:
   - Managing inpatient and outpatient utilization; and
   - Member care and member satisfaction;
5. Use your best efforts to refer members to our network care providers. You must use only our network laboratory and radiology care providers unless specifically authorized by us.

Timely Access to Non-Emergency Health Care Services (Applies to Commercial in California)

For details on these access standards refer to Chapter 2: Provider Responsibilities, *Timely Access to Non-Emergency Health Care Services (Applies to Commercial in California)*.

Notification of Practice or Demographic Changes

Report all demographic changes, open/closed status, product participation or termination to us.

For complete information please the *Demographic Changes* section of Chapter 2: Provider Responsibilities and Standards.

Compliance with the Medical Management Program

Complying with the Medical Management Program includes but is not limited to:

- Allowing our staff to have onsite access to members and their families while the member is an inpatient;
- Allowing our staff to participate in individual case conferences;
- Facilitating the availability and accessibility of key personnel for case reviews and discussions with

* As an "authorization representative" of UnitedHealthcare, physicians are responsible to notify the member about the prior authorization determination, unless State regulation requires otherwise.

the medical director or designee representing UnitedHealthcare West, upon request; and

- Providing appropriate services in a timely manner.

Benefit Interpretation Policies & Medical Management Guidelines

A complete library of Benefit Interpretation Policies (BIPs), and Medical Management Guidelines (MMGs) is available on UHCprovider.com/policies > **Commercial Policies** > UnitedHealthcare West Benefit Interpretation Polices or UnitedHealthcare West Benefits Plan of California Medical Management Guidelines.

We publish monthly editions of the BIP and MMG Update Bulletins. These online resources provide notice to our network care providers of changes to our BIPs and MMGs. The bulletins are posted on the first calendar day of every month on:

- UHCprovider.com/policies > Commercial Policies > **UnitedHealthcare West Benefit Interpretation Policies** > Benefit Interpretation Policy Update Bulletins, and
- UHCprovider.com/policies > Commercial Policies > **UnitedHealthcare West Medical Management Guidelines** > Medical Management Guideline Update Bulletins.

A supplemental reminder to the policy updates announced in the BIP and MMG Update Bulletins is also included in the monthly Network Bulletin available on **UHCprovider.com/news**.

Continuity of Care

Continuity of care is a short-term transition period, allowing members to temporarily continue to receive services from a non-participating care provider.

Examples of an Active Course of Treatment Considered for Continuity of Care

- **An Acute Condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services provided for the duration of the acute condition.
- **A Serious Chronic Condition** is a medical condition due to disease, illness, medical problem, mental health problem, or medical or mental health disorder that is serious in nature and that persists without full cure or worsens over an extended period, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services provided for the period necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a network care provider. The active course of treatment is determined by a UnitedHealthcare West or medical group/IPA medical director in consultation with the member, the terminated care provider or the non-network care provider and as applicable, the receiving network care provider, consistent with good professional practice. Completion of covered services for this condition will not exceed 12 months from the Agreement's termination date, or 12 months after the effective date of coverage for a newly enrolled member.
- **A Terminal Illness** is an incurable or irreversible condition that has a high probability of causing death within one year. Completion of covered services may be provided for the duration of the terminal illness, which could exceed 12 months, provided that the prognosis of death was made by the: (i) terminated care provider prior to the Agreement termination date, or (ii) non-network care provider prior to the newly enrolled member's effective date of coverage with UnitedHealthcare West.
- **A Pregnancy** diagnosed and documented by the: (i) terminated care provider prior to termination of the Agreement, or (ii) by the non-network care provider prior to the newly enrolled member's effective date of coverage with UnitedHealthcare West. Completion of covered services provided for the duration of the pregnancy and immediate postpartum period.
- **The Care of a Newborn** service provided to a child between birth and age 36 months. Completion of covered services will not exceed (i) 12 months from Agreement, termination date, (ii) 12 months from the newly enrolled member's effective date of coverage with UnitedHealthcare West, or (iii) the child's third birthday.
- **Surgery or Other Procedure**
  Performance of a surgery or other procedure that was authorized by UnitedHealthcare West or the member's PCP. Parts of a documented course of treatment have been recommended and documented by (i) the terminating care provider to occur within 180 calendar days of the Agreement's termination date, or (ii) the non-network care provider to occur within 180 calendar days of the newly enrolled member's effective date of coverage with UnitedHealthcare West.

Continuity of care does not apply when a member initiates a change of PCP or medical group/IPA. Authorizations granted by the previous medical groups shall be invalid in such situations at the commencement of the member's assignment to the new PCP or medical group/IPA; members shall not be entitled to continuing care unless the member's new PCP or medical group/IPA authorizes that care.

Virtual Visits (Commercial HMO Plans CA only)

UnitedHealthcare of California added a new benefit for Virtual Visits to some member benefit plans. We define Virtual Visits as primary care services that include the diagnosis and treatment of low-acuity medical conditions for members through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology.

Virtual Visit primary care services are typically delivered by the capitated care provider groups. Not all UnitedHealthcare West benefit plans will have the Virtual Visit benefit option.

To read more about Virtual Visits, refer to the *"Capitation and/or Delegation Supplement" on page 92*.

Utilization and Medical Management

Medical Emergencies & Emergency Medical Conditions

For benefit plan definitions of an emergency refer to the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable. Additional definitions are found in our glossary.

Direct the member to call 911, or its local equivalent, or to go to the nearest emergency room. Prior authorization or advance notification is not required for emergency services. However, you should tell us about the member's emergency by calling 800-799-5252 between 8 a.m. and 5 p.m. PT, Monday through Friday.

Provide after-hours and weekend emergency services as clinically appropriate; enter the notification online or call 800-799-5252 the next business day.

Urgently Needed Services

Please check the member's benefits with Member Services or at **UHCProvider.com**, as applicable, for the benefit plan definition of urgent care. For our commercial members, you must contact the member's PCP or hospitalist on arrival for urgently needed services. Request these services by calling 800-799-5252 between 8 a.m. and 5 p.m. PT, Monday through Friday.

Routine Authorizations

We consider all other services as routine. To request preauthorization, the PCP must enter all the necessary information into **UHCprovider.com/priorauth**, contact the delegated medical group for approval, or complete and submit the appropriate Preauthorization Request Form to obtain approval. Routine and urgent requests are responded to within the following time frames, if all required clinical information is received:

Product	State	Time frame
Medicare Advantage Urgent	All	72 hours
Medicare Advantage Routine	All	14 calendar days
Commercial Urgent	OR, WA	2 business days
	CA, OK	72 hours
	TX	3 calendar days
Commercial Routine	OR, WA	2 business days; exception: - A delay of decision (DOD) letter
	CA	5 business days; exception: - A delay of decision (DOD) letter
	OK	15 calendar days
	TX	3 calendar days

Authorization Status Determination

Only a physician (or pharmacist, psychiatrist, doctoral-level clinical psychologist or certified addiction medicine specialist, as applicable and appropriate) may determine whether to delay, modify or deny services to a member for reasons of medical necessity.

Prior Authorization Process

A list of services that require prior authorization is available on **UHCprovider.com/priorauth**.

We will deny payment for services you provide without the required prior authorization. Such services are the care provider's liability, and you may not bill the member.

Primary Care Services

Most PCP services do not require prior authorization. However, if prior authorization is required, the following guidelines apply:

1. The PCP/requesting care provider is responsible for verifying eligibility and benefits prior to rendering services.
2. To request prior authorization, use our online processes, contact the delegated medical group, or complete and submit the appropriate prior authorization request form (unless the services are required urgently or on an emergency basis). The completed form must include the following information:
   - Member's presenting complaint,
   - Physician's clinical findings on exam,
   - All diagnostic and lab results relevant to the request,
   - Conservative treatment that has been tried,
   - Applicable CPT and ICD codes.

3. The fastest way to check the status of a treatment request is online.
4. If approved, the treatment request is given a reference number that may be viewed when you check the status, or by contacting the delegated medical group, or faxed back to the physician office depending on how the PCP/servicing care provider submitted the form.
5. Notate the reference number on the claim when you submit it for payment.
6. All authorizations expire 90 calendar days from the issue date.
7. Participating care providers should refer members to network care providers. Referrals to non-network care providers require prior authorization.
8. Once the PCP refers a member to a network specialist, that specialist may see the member as needed for the referring diagnosis. The specialist is not required to direct the member back to the PCP to order tests and/or treatment.
9. If a specialist feels a member needs other services related to the treatment of the referral diagnosis, the specialist may refer the member to another participating care provider.

We or our delegates conduct reviews throughout a member's course of treatment. Multiple prior authorizations may be required throughout a course of treatment because prior authorizations are typically limited to specific services or time periods.

Serious or Complex Medical Conditions

The PCP should identify members with serious or complex medical conditions and develop appropriate treatment plans for them, along with case management. Each treatment plan should include a prior authorization for referral to a specialist for an adequate number of visits to support the treatment plan.

Specialty Care (Including Gynecology) in an Office-Based Setting

We send the status of the prior authorization request (approved as requested, approved as modified, delayed, or denied) to the specialist by fax or online. For those services that do not require prior authorization, the PCP sends a referral request directly to the specialists.

1. All specialist authorizations will expire 90 calendar days from the date of issuance.
2. Plain film radiography rendered by a network care provider, or in the specialist's office in support of an authorized visit, does not require prior authorization.
3. Routine lab services performed in the specialist's office, or are provided by a designated participating care provider in support of an authorized visit, do not require prior authorization.
4. Members may self-refer to a gynecologist who is a participating care provider for their annual routine gynecological exams. For women's routine and preventive health care services, female MA members may self-refer to a women's health specialist who is a participating care provider.
5. Female MA members older than 40 years may self-refer to a participating radiology care provider for a screening mammogram.

Note: Mammograms may require prior authorization in California.

Obstetrics

1. A member may self-refer to an obstetrician who is a participating care provider for routine obstetrical (OB) care. If the member is referred by her PCP to a non-participating health care specialist, the specialist must notify us using online tools. This helps ensure accurate claims payment for ante and postpartum care.
2. Routine OB care includes office visits and two ultrasounds.
3. Plain film radiography that is performed by a participating care provider or in the obstetrician's office in support of an authorized visit, does require prior authorization.
4. Routine labs performed in the obstetrician's office, or provided by a participating care provider in support of an authorized visit, do not require prior authorization. In-office tests must follow CMS in-office testing CLIA requirements. Specimens collected in the physician's office and sent out to a nonparticipating laboratory for processing must follow the out-of-network member consent requirements.

Maternal Mental Health Screening Requirement (California Commercial Plans)

The California Department of Managed Health Care **(AB 2193)** requires licensed health care practitioners who provide prenatal or postpartum care for a patient to offer maternal mental health screening during the second and/or third trimester and/or at the postpartum visit. When screening pregnant and postpartum members for mental health issues, we recommend using the Patient Health Questionnaire 9 (PHQ-9). You can request hard copies of the PHQ-9 by emailing uhccscaqualitydepartment_dl@ds.uhc.com.

Second Opinions (California Commercial Plans)

We authorize and provide a second opinion by a qualified health care professional for members who meet specific criteria. A second opinion consists of one office visit for a consultation or evaluation only. Members must return to their assigned PCPs for all follow-up care. For purposes of this section, a qualified health care professional is defined as a PCP or specialist who is acting within the scope of practice and who possesses a clinical background,

including training and expertise related to the member's particular illness, disease or condition.

The PCP may request a second opinion on behalf of the member in any of the following situations:

- The member questions the reasonableness or necessity of a recommended surgical procedure.
- The member questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, or bodily function or threatens substantial impairment, including, but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt due to conflicting test results.
- The treating care provider is unable to diagnose the condition.
- The member's medical condition is not responding to the prescribed treatment plan within an appropriate period of time, and the member is requesting a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the treatment plan or has consulted with the treating care provider and has serious concerns about the diagnosis or treatment plan.

Turnaround Time for Second Opinion Reviews
We process requests for a second opinion in a timely manner to accommodate the clinical urgency of the member's condition and in accordance with established utilization management procedures and regulatory requirements. When there is an imminent and serious threat to the member's health, we or our delegate will make the second opinion determination within 72 hours after receipt of the request.

An imminent and serious threat includes the potential loss of life, limb, or other major bodily function. It may also be when a lack of timeliness would be detrimental to the member's ability to regain maximum function. For more detailed information and benefit exclusions, refer to **UHCprovider.com/policies**:

- UnitedHealthcare Medicare Advantage Coverage Summary titled Second and Third Opinions, or
- UnitedHealthcare West Benefit Interpretation Policy titled Member Initiated Second and Third Opinion: CA or
- UnitedHealthcare West Benefit Interpretation Policy titled Member Initiated Second and Third Opinion: OK, OR, TX, WA

Ventricular Assist Device (VAD)/Mechanical Circulatory Support Device (MCSD) Services/Case Management

We request that you notify the case management department when a member referred for evaluation, authorized for:

- VAD/MCSD and admitted for VAD/MCSD and/or may meet criteria for service denial.
- VAD/MCSD evaluations and surgery should be performed a facility in Optum VAD Network, or facility approved by UnitedHealthcare West medical directors, to align with heart transplant service centers.

Post-Stabilization Care

Members are covered for post-stabilization services following emergency services.

Post-stabilization care is considered approved if we do not respond within one hour of the request for post-stabilization care or we cannot be contacted for pre-approval.

Extension of Prior Authorization Services

The specialist must request an extension of prior authorization online, by contacting the delegated medical group/IPA, or by fax, if they desire to perform services:

- Beyond the approved visits;
- Beyond the allotted time frame of the approval (typically 90 calendar days);
- In addition to the approved procedures, and/or diagnostic or therapeutic testing.

The extension must be authorized before care is rendered to the member. The request for extension of services must include the following information:

- Member's presenting complaint;
- Care provider's clinical findings on exam;
- All diagnostic and laboratory results relevant to the request;
- All treatment that has been tried;
- Applicable CPT and ICD codes; and
- Requested services (e.g., additional visits, procedures).

The existing authorization is reviewed by the receiving party, who mails or faxes a response to the care provider and/or makes the information available online There is no need to contact the member's PCP.

Hospital Notifications

Independent from prior authorization, notification by the facility is required for inpatient admissions on the day of admission, even if an advanced notification was provided prior to the actual admission date.

Hospitals, rehabilitation facilities and skilled nursing facilities (SNFs) are required to notify us daily of all admissions, changes in inpatient status and discharge dates.

Facilities are responsible for admission notification, even if advance notification was provided by the physician and coverage approval is on file.

Definition of Facility-Based Outpatient Surgery (CA, OR, WA and NV)

Facility-Based Outpatient Surgery services are defined using CMS Guidelines, CPT/HCPCS coding conventions, and clinical and/or proprietary standards. The following denotes services considered Facility-Based Outpatient Surgery services under this definition:

- A procedure with an ASC grouping assigned;
- A procedure with a global period of 90 days (according to the care provider fee schedule);
- Core needle biopsies;
- Unlisted or new codes may be considered surgery in the following situations:
  - Unlisted or new code is related to other codes in the same APC group that had an ASC assigned is considered Facility-Based Outpatient Surgery.
- A procedure with surgical risk or anesthetic risk as determined by clinical review.

Admission Notification

Facilities are responsible for notifying us of all member inpatient admissions including:

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- SNF admissions
- Admissions following outpatient surgery
- Admissions following observation
- Newborns admitted to Neonatal Intensive Care Unit (NICU)
- Newborns who remain hospitalized after the mother is discharged (notice required within 24 hours of the mother's discharge)

We must receive the admission notification within 24 hours after actual weekday admission (or by 5 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or holiday). For weekend and holiday admissions, we must receive the notification by 5 p.m. local time on the next business day.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within the member's benefit plan, the facility being eligible for payment, compliance with claim processing requirements, and the facility's Agreement with UnitedHealthcare.

Admission notifications must contain the following details regarding the admission:

- Member name, health care ID number, and date of birth
- Facility name and TIN or NPI
- Admitting/attending physician name and TIN or NPI
- Description for admitting diagnosis or ICD-10-CM diagnosis code
- Actual admission date
- Primary medical group/IPA

For emergency admissions where a member is unstable and not capable of providing coverage information, the facility should notify us by phone or fax within 24 hours (or the next business day, for weekend or holiday admissions) from the time the information is known and communicate the extenuating circumstances.

The following reports must be faxed daily to our Clinical Information Department:

- Census report for all our members;
- Discharge report; and
- Face sheets to report outpatient surgeries and SNF admissions; or
- Inpatient Admission Fax Sheet to report "no UnitedHealthcare West admissions" for that day.

The census report or face sheets must include the following information:

- Primary medical group/IPA
- Admit date
- Member name (first and last) and date of birth
- Bed type/accommodation status/level of care (LOC)
- Expected length of stay (LOS)
- Admitting physician
- Admitting diagnosis (ICD-10-CM)
- Procedure/surgery (CPT Code) or reason for admission
- Attending physician
- Facility
- Address/city/state
- Policy number/member health care ID number
- Other insurance
- Authorization number (if available)
- Discharge report, including member demographic information, discharge date and disposition

Coordination of Care

Facilities are required to assist in the coordination of a member's care by:

- Working with the member's PCP;
- Notifying the PCP of any admissions; and
- Providing the PCP with discharge summaries.

After Hour Admissions/SNF Transfers

- For admissions or transfers after hours or on weekends, the member should be admitted to the appropriate

facility at the appropriate level of care. Authorization must be obtained on the next business day.

- Transfers/admissions to SNFs may be admitted directly from the emergency room or home to a SNF.

Out-of-Network Admissions

- A referral/transfer to a non-network facility requires prior authorization. However, in the case of an emergency, a non-participating hospital may be used without prior authorization.
- After initial emergency treatment and stabilization, we may request that a member be transferred to a network hospital, when medically appropriate.
- If a PCP directs a member to a non-network hospital for non-emergent care without prior authorization, the PCP may be held responsible.

Consultation with Providers During Inpatient Stays

Authorization is not required for a consultation with a participating network care provider during an inpatient stay. However, consultation with a non-network care provider requires prior authorization.

Concurrent Review

We conduct concurrent review on all admissions from the day of admission through the day of discharge. Clinical staff perform concurrent reviews by phone, as well as onsite at designated facilities. We have established procedures for onsite concurrent review which include: (a) guidelines for identification of our staff at the facility; (b) processes for scheduling onsite reviews in advance; and (c) staff requirements to follow facility rules. If the clinical reviewer determines that the member may be treated at a lower level of care or in an alternative treatment setting, we discuss the case with the hospital case manager and the admitting physician. If a discrepancy occurs, our medical director or designee discusses the case with the admitting physician.

Variance Days

Variance days are days we determine inpatient care coordination and provision of diagnostic services are not medically necessary or are not provided in a timely manner contributing to delays in care. We adjust reimbursement accordingly. Our concurrent review staff attempts to minimize variance days by working with the attending physicians and hospital staff. If a variance is noted in the member's acute care process, our concurrent review staff discusses the variance with the hospital's medical management/case management representative. If the variance exists after the discussion, our concurrent review staff documents the variance in our utilization records and submits to a UnitedHealthcare concurrent review manager for review. If upheld, the variance is entered into our database as a denial of reimbursement for the variance time period. We mail a letter to the facility stating the variance type and time period. The facility may appeal the variances in writing.

Our medical director will review the appeal and render a decision to overturn or uphold the decision.

Medical Observation Status

We authorize hospital observation status when medically appropriate. Hospital observation is generally designed to evaluate a member's medical condition and determine the need for actual admission, or to stabilize a member's condition and typically lasts less than 48 hours. For MA members, we also follow any applicable CMS guidelines to determine whether observation services are medically appropriate. Typical cases, when observation status is used, include rule-out diagnoses and medical conditions that respond quickly to care. Members under observation status may later convert to an inpatient admission if medically necessary.

Emergency and/or Direct Urgent Admissions (Commercial Plans)

If a hospital does not receive authorization from us within one hour of the initial call requesting authorization, the emergent and/or urgent services prompting the admission are assumed to be authorized and should be documented as such to us until we direct or arrange care for the member. Once we become involved with managing or directing the member's care, all services provided must be authorized by us.

Skilled Nursing Facilities

Before transfer/admit to a SNF, we must approve the member's treatment plan. The member's network physician must perform the initial physical exam and complete a written report within 48 hours of a member's admission to the SNF. We perform an initial review and subsequent reviews as we deem necessary. Federal and state regulations require that members at SNFs be seen by a physician at least once every 30 calendar days.

Discharge Planning

The initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

- Assessment and documentation of the member's needs as compared to those upon admission, including the member's functional status and anticipated discharge disposition, if other than a discharge to home;
- Development of a discharge plan, including evaluation of the member's financial and social service needs and potential need for post-hospital services, such as home health, DME, and/or placement in a SNF or custodial care facility;
- Approved authorizations for necessary post-discharge plan, as required by us;

- Organization, communication and execution of the discharge plan;
- Evaluation of the effectiveness of the discharge plan;
- Referrals to population-based disease management and case management programs, as indicated.

For after-hours or weekend discharges requiring home health and/or DME, facility should arrange the care and obtain authorization on the next business day.

Retrospective Review (Medical Claim Review)

Medical claim review, also known as medical cost review, medical bill review and/or retrospective review, is the examination of the medical documentation and/or billing detail after a service has been provided. Medical claim review is performed to provide a fair and consistent means to retrospectively review medical claims and make sure medical necessity criteria are met, confirm appropriate level of care and length of stay, correct payer source, and identify appropriate potential unbundling and/or duplicate billing occurrences.

The review includes an examination of all appropriate claims and/or medical records against accepted billing practices and clinical guidelines as defined by entities such as CMS, AMA, CPT coding and MCG™ Care Guidelines depending on the type of claims submitted.

Claims that meet any of the following criteria are reviewed before the claim is paid:

- High-dollar claims;
- Claims without required authorization;
- Claims for unlisted procedures;
- Trauma claims;
- Claims for implants that are not identified or inconsistent with the UnitedHealthcare West's Implant Guidelines;
- Claim check or modifier edits based on our claim payment software;
- Foreign country claims; and
- Claims with LOS or LOC mismatch.

To help ensure timely review and payment determinations, you must respond to requests for all appropriate medical records within seven calendar days from receipt of the request, unless otherwise indicated in your Agreement.

We may review specific claims based on pre-established retrospective criteria to make sure acceptable billing practices are applied.

For hospital care providers, we may reduce the payable dollars if line item charges have been incorrectly unbundled from room and board charges.

Minimum Content Denials, Delays, or Modification Requests

If we deny, delay delivery, or modify a request for authorization for health care services, our written or electronic notices will, at a minimum, include the following:

- The specific service(s) denied, delayed in delivery, modified or partially approved;
- The specific reference to the benefit plan provisions to support the decision;
- The reason the service is being denied, delayed in delivery, modified, or partially approved, including:
  - Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties may understand the rationale behind the decision;
  - Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based;
  - Clinical reasons for decisions regarding medical necessity; and
  - Contractual rationale for benefit denials.
- Notification that the member may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
- Notification that the member's physician may request a peer-to-peer review;
- Alternative treatment options offered, if applicable;
- Description of any additional material or information necessary from the member to complete the request, and why that information is necessary;
- Description of grievance rights and an explanation of the appeals and grievances processes, including:
  - Information regarding the member's right to appoint a representative to file an appeal on the member's behalf;
  - The member's right to submit written comments, documents or other additional relevant information;
  - Information notifying the member and their treating care provider of the right to an expedited appeal for time- sensitive situations (not applicable to retrospective review);
  - Information regarding the member's right to file a grievance or appeal with the applicable state regulatory agency, including information regarding the independent medical review process, as applicable;
  - Information that the member may bring civil action, under Section 502(a) of the Employee Retirement

Income Security Act (ERISA), if applicable (Commercial products);

› For the treating care provider, the name and direct phone number of the health care professional responsible for the decision.

Pharmacy Network

A member may fill prescriptions from any network care provider pharmacy in the pharmacy directory or online at optumrx.com.

A member who obtains a prescription from a non-network pharmacy will not be eligible for reimbursement of any charges incurred unless the prescription received was not available from a participating pharmacy (e.g., urgent or emergent prescriptions, after hours, out of the service area, or Part D-covered vaccines provided by the care provider).

Mail Service

Each UnitedHealthcare West member with a prescription drug benefit is eligible to use our prescription mail service.

When appropriate, you may write prescriptions for a three-month 90 calendar day supply and up to three additional refills. Only medications taken for chronic conditions should be ordered through the mail. The member may obtain acute prescription needs, such as antibiotics and pain medications, through a network pharmacy site to avoid delay in treatment.

You may also elect to discourage members from using the mail service for medications where large quantities dispensed at one time to the member may pose a problem (e.g., tranquilizer).

Pharmacy Formulary

The UnitedHealthcare formulary includes most generic drugs/medications and a broad selection of brand name drugs/medications. Prescription drugs and medications listed on the formulary are considered a covered benefit. However, select formulary medications may require prior authorization to be covered.

Many members have a three-tier pharmacy benefit plan with coverage of formulary generics, formulary brand name drugs, and non-formulary drugs. A prior authorization process may apply to certain non-formulary drugs.

We update the formulary twice a year, in January and July. Care provider requests for formulary review of medications or pre-authorization guidelines are welcome. Find formulary changes on UHCprovider.com/pharmacy, or UHCprovider.com/priorauth > Clinical Pharmacy and Specialty Drugs.

Non-Formulary Medications

Non-formulary prescriptions/medications not provided as a plan benefit are the member's financial responsibility, unless the prescribing care provider requests and receives prior authorization for the non-formulary medications and the member meets criteria for coverage.

Commercial plan members may also have coverage when their employer purchases an Open Formulary or Buy-up Plan. The member may be charged the usual and customary cost of the medication or the non-formulary copayment depending on the member's benefit design.

Drug Utilization Review Program

UnitedHealthcare West is dedicated to working with our network care providers to supply information and education needed for effective management in growing cost of pharmaceutical care. Our clinical pharmacists can identify and analyze areas where care providers may be able to prescribe products considered effective as well as economical.

Additionally, our pharmacy staff can help identify when a more detailed review of therapy may improve member care, such as:

- Overuse of controlled substances
- Duplicate therapies
- Drug interactions
- Polypharmacy

Through pharmacist review and information, care providers are given the data needed to better manage the quality of their members' care while also managing pharmacy program costs.

Prior Authorization Process

We delegate prior authorization services to OptumRx®. OptumRx staff adhere to benefit plan-approved criteria, National Pharmacy and Therapeutics Committee (NPTC) practice guidelines, and other professionally recognized standards.

Request authorizations:

- **Online:** professionals.optumrx.com > Prior authorizations
- To simplify the prior authorization experience, health care professionals can submit a real-time prior authorization request 24 hours per day, seven days per week, through one of the online services found at professionals.optumrx.com. After logging on with your unique National Provider Identifier (NPI) number and password, you may submit member details securely online, enter a diagnosis and medication justification for the requested medication and, in many cases, receive authorization instantly. Otherwise, you may verbally submit a prior authorization request by:
- **Phone:** 800-711-4555

California Commercial products: Prescribing providers in California must use the *Prescription Drug Prior Authorization Request Form* when submitting authorization requests to OptumRx based on the following regulations:

- California Health and Safety Code 1367.241 and California Code of Regulations, Chapter 28, section 1300.67.241. Section 1300.67.241 to Title 28 of the California Code of Regulations (CCR).
- Article 1.2 Section 2218.30 to the California Code of Regulations (CCR) Title 10, Chapter 5, Subchapter 2.

Also, the California utilization management delegates may have contractual responsibilities for payment of certain prescription medications. When the delegate requires prior authorization for use of those drugs prescribed by their care providers, the delegate must also require the use of Optum *Prescription Drug Prior Authorization Request Form*. The delegate must have a policy and process in place and be able to demonstrate compliance.

You can call the OptumRx Prior Authorization department at 800-711-4555 to either submit a verbal prior authorization request or to request a CA state-mandated fax form.

Claims Process

Find instructions and quick tips for EDI on **UHCprovider.com/edi**.

Claims and Encounters

EDI is the preferred method of claim submission for participating physicians and health care providers. Submit all professional and institutional claims and/or encounters electronically for UnitedHealthcare West and Medicare Advantage HMO product lines.

Do not resubmit claims that were either denied or pended for additional information using EDI or paper claims forms. Use the **ClaimsLink** application on Link.

Please refer to our online **Companion Guides** for the data elements required for these transactions found on **UHCprovider.com/edi**.

For information on EDI claim submission methods and connections, go to **EDI 837: Electronic Claims**.

OptumInsight Connectivity Solutions, UnitedHealthcare's managed gateway, is also available to help you begin submitting and receiving electronic transactions. For more information, call 800-341-6141.

Submit your claims and encounters and primary and secondary claims as EDI transaction 837.
For UnitedHealthcare West encounters, the payer ID is 95958. For claims, the payer ID is 87726. For a complete list of payer IDs, refer to the **Payer List for Claims**.

In some cases, the payer ID listed on **UHCprovider.com/edi** may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must validate with your clearinghouse for the appropriate payer ID number or refer to your clearinghouse published Payer Lists.

Electronic Funds Transfer

You may enroll or make changes to Electronic Funds Transfer (EFT) and ERA/835 for your UnitedHealthcare West claims using the UnitedHealthcare West EFT Enrollment tool on Link. Enrollment in UnitedHealthcare West EFT currently applies to payments from SignatureValue and MA plans only. You'll continue to receive checks by mail until you enroll in UnitedHealthcare West EFT. View our Payer List for ERA **Payer List for ERA** to determine the correct payer ID to use for ERA/835 transactions.

For more information, go to **UHCprovider.com/claims**, scroll down to "Enroll or Change Electronic Funds Transfer (EFT) for UnitedHealthcare West," and open the UnitedHealthcare West EFT Enrollment App Overview document.

Claims Adjudication

We use industry claims adjudication and/or clinical practices, state and federal guidelines, and/or our policies, procedures and data to determine appropriate criteria for payment of claims. To find out more, please contact your network account manager, physician advocate or hospital advocate or visit **UHCprovider.com/claims**.

Complete Claims Requirements

We follow the *Requirements for Complete Claims and Encounter Data Submission*, as found in Chapter 9: Our Claims Process.

National Provider Identification

We are able to accept the National Provider Identification (NPI) on all HIPAA transactions, including the HIPAA 837 professional and institutional (paper and electronic) claim submissions. A valid NPI is required on all covered claims (paper and electronic) in addition to the TIN. For institutional claims, please include the billing provider National Uniform Claim Committee (NUCC) taxonomy. We will accept NPIs submitted through any of the following methods:

- **Online:** **UHCprovider.com/mypracticeprofile**.
- **Phone:** 877-842-3210 through the United Voice Portal, select the "Health Care Professional Services" prompt. State "Demographic changes." Your call will be directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.

Level-of-Care Documentation and Claims Payment

Claims are processed according to the authorized level of care documented in the authorization record, reviewing all claims to determine if the billed level of care matches the authorized level of care.

If the billed level of care is at a higher level than the authorized level of care, we pay you the authorized level of care. You may not bill the member for any charges relating

to the higher level of care. If the billed level of care is at a lower level than authorized, we pay you based on the lower level of care, which was determined by you to be the appropriate level of care for the member.

Level of Specificity — Use of Codes
To track the specific level of care and services provided to its members, we require care providers to use the most current service codes (i.e., ICD-10-CM, UB and CPT codes) and appropriate bill type.

Member Financial Responsibility

Verify the eligibility of our members before you see them and obtain information about their benefits, including required copayments and any deductibles, out-of-pockets maximums or coinsurance that are the member's responsibility.

No Balance Billing
You may not balance bill our members. You may not collect payment from the member for covered services beyond the member's copayment, coinsurance, deductible, and for non-covered services the member specifically agreed on in writing before receiving the service. In addition, you shall not bill a UnitedHealthcare West member for missed office visit appointments.

Claims Status Follow-up

We can provide you with an Explanation of Payment (EOP). If you don't get one, you may follow-up on the status of a claim using one of the following methods:

- **EDI:** 276/277 Claim Status Inquiry and Response transactions are available through your vendor or clearinghouse.
- **Online:** UHCprovider.com/claimsLink; View real-time claim status information.
- **Phone:** See *How to Contact UnitedHealthcare West Resources* sections for telephone numbers. This system provides a fax of the claim status detail information that is available.

Claims Submission Requirements

Mail paper CMS 1500 or UB-04s to the address listed on the member's health care ID card. Refer to the *Prompt Claims Processing* section of Chapter 9: Our Claims Process, for more information about electronic claims submission and other EDI transactions. If your claim is the financial responsibility of a UnitedHealthcare West delegated entity (e.g., PMG, MSO, Hospital), then bill that entity directly for reimbursement.

Claims Submission Requirements for Reinsurance Claims for Hospital Providers
If covered services fall under the reinsurance provisions set forth in your Agreement with us, follow the terms of the Agreement to make sure:

- The stipulated threshold has been met;
- Only covered services are included in the computation of the reinsurance threshold;
- Only those inpatient services specifically identified under the terms of the reinsurance provision(s) are used to calculate the stipulated threshold rate;
- Applicable eligible member copayments, coinsurance, and/or deductible amounts are deducted from the reinsurance threshold computation;
- The stipulated reinsurance conversion reimbursement rate is applied to all subsequent covered services and submitted claims;
- The reinsurance is applied to the specific, authorized acute care confinement; and
- Claims are submitted in accordance with the required time frame, if any, as set forth in the Agreement. In addition, when submitting hospital claims that have reached the contracted reinsurance provisions and are being billed in accordance with the terms of the Agreement and/or this supplement, you shall:
  - Indicate if a claim meets reinsurance criteria; and
  - Make medical records available upon request for all related services identified under the reinsurance provisions (e.g., ER face sheets).

If a submitted hospital claim does not identify the claim as having met the contracted reinsurance criteria, we process the claim at the appropriate rate in the Agreement. An itemized bill is required to compute specific reinsurance calculations and to properly review reinsurance claims for covered services.

Interim Bills

We adjudicate interim bills at the per diem rate for each authorized bed day billed on the claim and reconcile the complete charges to the interim payments based on the final bill.

The following process increases efficiencies for both us and the hospital/SNF business offices:

- 112 Interim – First Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 113 Interim – Continuing Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 114 Interim – Last Claim: Review admits to discharge and discharge and apply appropriate contract rates, including per diems, case rates, stop loss/outlier and/or exclusions. The previous payments will be adjusted against the final payable amount.

Reciprocity Agreements

You shall cooperate with our participating care providers and our affiliates and agree to provide services to members enrolled in benefit plans and programs of UnitedHealthcare West affiliates and to assure reciprocity with providing health care services.

If any member who is enrolled in a benefit plan or program of any UnitedHealthcare West affiliate, receives services or treatment from you and/or your sub-contracted care providers (if applicable), you and/or your subcontracted care providers (if applicable), agree to bill the UnitedHealthcare West affiliate at billed charges and to accept the compensation provided pursuant to your Agreement, less any applicable copayments and/or deductibles, as payment in full for such services or treatment.

You shall comply with the procedures established by the UnitedHealthcare West affiliate and this Agreement for reimbursement of such services or treatment.

Overpayments

Please follow the instructions in the *Overpayments* section of *Chapter 9: Our Claims Process*.

End-Stage Renal Disease

If a member has or develops end-stage renal disease (ESRD) while covered under an employer's group benefit plan, the member must use the benefits of the plan for the first 30 months after becoming eligible for Medicare due to ESRD. After the 30 months elapse, Medicare is the primary payer. However, if the employer group benefit plan coverage were secondary to Medicare when the member developed ESRD, Medicare is the primary payer, and there is no 30-month period.

Medicaid (applies only to MA): Please follow the instructions in the *Member Financial Responsibility* section of *Chapter 10: Compensation*.

The calendar day we receive a claim is the receipt date, whether in the mail or electronically. The following date stamps may be used to determine date of receipt:

- Our claims department date stamp
- Primary payer claim payment/denial date as shown on the EOP
- Delegated provider date stamp
- TPA date stamp
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender

Note: Date stamps from other health benefit plans or insurance companies are not valid received dates for timely filing determination.

Time Limits for Filing Claims

You are required to submit to clean claims for reimbursement no later than 1) 90 days from the date of service, or 2) the time specified in your Agreement, or 3) the time frame specified in the state guidelines, whichever is greater.

If you do not submit clean claims within these time frames, we reserve the right to deny payment for the claim(s). Claim(s) that are denied for untimely filing may not be billed to a member.

We have claims processing procedures to help ensure timely claims payment to care providers. We are committed to paying claims for which we are financially responsible within the time frames required by state and federal law.

Care Provider Claims Appeals and Disputes

Claims Research and Resolution (Applies to Commercial in Oklahoma & Texas)

The Claims Research & Resolution (CR&R) process applies:

- If you do not agree with the payment decision after the initial processing of the claim; and
- Regardless of whether the payer was UnitedHealthcare West, the delegated medical group/IPA or other delegated payer, or the capitated hospital/provider, you are responsible for submitting your claim(s) to the appropriate entity that holds financial responsibility to process each claim.

UnitedHealthcare West researches the issue to identify who holds financial risk of the services and abides by federal and state legislation on appropriate timelines for resolution. We work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, care provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

Claim Reconsideration Requests (Does Not Apply to Capitated/Delegated Claims in California.)
You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). All rework requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your Agreement contains other filing guidelines. The most efficient way to submit your requests is through the claimsLink app. Learn more on **UHCprovider.com** > Service Links > **Link Self-Service Tools**. You may submit your request to us in writing by using the Paper Claim Reconsideration Form on **UHCprovider.com/claims**.

To mail your request refer to the chart titled *UnitedHealthcare West Provider Rework or Dispute Process Reference Table* at the end of this section.

Submission of Bulk Claim Inquiries

The Claims Project Management (CPM) team handles bulk claim inquiries. Contact the CPM team at the address below to initiate a bulk claim inquiry:

UnitedHealthcare West Bulk Claims Rework Reference Table

Provider's state	Contact information	Notes
Arizona	UnitedHealthcare Attn: WR Claims Project Management P.O. Box 52078 Phoenix, AZ 85072-2078	For requests with 20+ claims.
California	Claims Research Projects CA120-0360 P.O. Box 30968 Salt Lake City, UT 84130-0968	For requests with 19+ claims.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983	For requests with 20+ claims.
Nevada	For Medicare Advantage claims: UnitedHealthcare Attn: WR Claims Project Management Claims Research Projects 1) HealthCare Partners of NV P.O. Box 95638 Las Vegas, NV 89193-5638 2) OptumCare-NV P.O. Box 30539 Salt Lake City, UT, 84130	UnitedHealthcare uses two delegated payers in Nevada. Refer to the member's ID card to confirm which delegate is assigned for that member's claims. The Nevada delegate handles bulk claim inquiries received from providers of service. The provider of service should submit the bulk claims with a cover sheet indicating "Appeal" or "Review" to the Claims Research Department at the designated address to initiate a bulk claim inquiry. For requests with 10+ claims.
Oklahoma	Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967	For requests with 20+ claims.
Oregon	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	For requests with 10+ claims.
Texas	Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975	For requests with 20+ claims.
Washington	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	For requests with 10+ claims.

UnitedHealthcare West's Response

We respond to issues as quickly as possible.

- Reworks/disputes requiring clinical determination: Individuals with clinical training/background who were not previously involved in the initial decision review all clinical rework/dispute requests. We send a letter to you outlining our determination and the basis for that decision.
- Reworks/disputes requiring claim process determination: Individuals not previously involved in the initial processing of the claim review the rework/dispute request.

Response details: If claim requires an additional payment, the EOP serves as notification of the outcome on the review. If the original claim status is upheld, you are sent a letter outlining the details of the review.

California: If a claim requires an additional payment, the EOP does not serve as notification of the outcome of the review. We send you a letter with the determination. In addition, payment must be sent within five calendar days of the date on the determination letter. We respond to you within the applicable time limits set forth by federal and state agencies. After the applicable time limit has passed, call Provider Relations at 877-847-2862 to obtain a status.

Care Provider Dispute Resolution (CA Delegates OR HMO claims, OR and WA Commercial Plans)

If you disagree with our claim determination, you may initiate a care provider dispute. You must submit a care provider dispute, in writing, and with additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless your Agreement or state law dictates otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

The PDR process is available to provide a fair, fast and cost-effective resolution of care provider disputes, in accordance with state and federal regulations. We do not discriminate, retaliate against or charge you for submitting a care provider dispute. The PDR process is not a substitution for arbitration and is not deemed as an arbitration.

What to Submit

As the care provider of service, submit the dispute with the following information:

- Member's name and health care ID number
- Claim number
- Specific item in dispute
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved
- Your contract information

Disputes are not reviewed if the supporting documentation is not submitted with the request.

Where to Submit

State-specific addresses and other pertinent information regarding the PDR process may be found in the *UnitedHealthcare West Provider Rework or Dispute Process Reference Table* at the end of this section.

Accountability for Review of a Care Provider Dispute

The entity that initially processed/denied the claim or service in question is responsible for the initial review of a PDR request. These entities may include, but are not limited to, UnitedHealthcare West, the delegated medical group/IPA/payer or the capitated hospital/care provider.

Excluded From the PDR Process

The following are examples of issues excluded from the PDR process:

- A member has filed an appeal, and you have filed a dispute regarding the same issue. In these cases, the member's appeal is reviewed first. You may submit a care provider dispute after we make a decision on the member's appeal. If you are appealing on behalf of the member, we treat the appeal as a member appeal.
- An Independent Medical Review initiated by a member through the member appeal process.
- Any dispute you file beyond the timely filing limit applicable to you, and you fail to give "good cause" for the delay.
- Any delegated claim issue that has not been reviewed through the delegated payer's claim resolution mechanism.
- Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or capitated hospital/care provider and does not involve an issue of medical necessity or medical management.

UnitedHealthcare West Provider Rework or Dispute Process Reference Table		
Provider's state	**Contact information**	**Notes**
Arizona	PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078	First Review: Request for reconsideration of a claim is considered a grievance. Physicians and health care professionals are required to notify us of any request for reconsideration within one year from the date the claim was processed. Second Review: Request for reconsideration of a grievance determination is also considered a grievance. You are required to notify us of any second level grievance within one year from the date the first level grievance resolution was communicated to the care provider.
California	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	UnitedHealthcare of California acknowledges receipt of paper disputes within 15 business days and within two business days for electronic disputes. If additional information is required, the dispute is returned within 45 business days. A written determination is issued within 45 business days.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983	Upon receipt of a dispute, Colorado Resolution Team: • Acknowledges receipt of the dispute within 30 calendar days of the receipt of the dispute; • Conducts a thorough review of your dispute and all supporting documentation; • Acknowledges receipt, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute; • Processes payment, if necessary, within five business days of the written determination; • Replies to the care provider of service within 30 calendar days if additional information is required. If additional information is required, we will hold the dispute request for 30 additional calendar days.
Nevada	For Medicare Advantage claims: UnitedHealthcare 1) HealthCare Partners of NV P.O. Box 95638 Las Vegas, NV 89193-5638 2) OptumCare - NV P.O. Box 30539 Salt Lake City, UT 84130	All Nevada Medicare Advantage HMO claims are processed by delegated payers. Therefore, care provider appeals are reviewed primarily by the delegated payer. Refer to the member's ID card to confirm which delegate is assigned for that member's claims.
Oklahoma	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	
Oregon	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	UnitedHealthcare of Oregon allows at least 30 calendar days for you to initiate the dispute resolution process. We render a decision on care provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we render a decision within 60 calendar days of the complaint.
Texas	UnitedHealthcare West Claims Department P.O. Box 400046 San Antonio, TX 78229	
Washington	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	UnitedHealthcare of Washington allows at least 30 calendar days for care providers to initiate the dispute resolution process. We render a decision on care provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we render a decision within 60 calendar days of the complaint.

California Language Assistance Program (California Commercial Plans)

UnitedHealthcare of California members who have limited English proficiency have access to translated written materials and oral interpretation services, free of charge, to help them get covered services. For more program information, call 800-752-6096.

If the member's language of choice is not English or they have limited English proficiency, try to arrange for oral interpretive services before the date of service.

Verbal Interpreter/Written Translation Services

The UnitedHealthcare West Call Center is a central resource for both care providers and members. The following information and services are accessible through the call center:

- How to access and facilitate oral interpretation services for members needing language assistance in any language, or
- Request for an in-person interpreter for a member by selecting the appropriate phone number (based on language preference) to speak with a customer service representative and/or to conference in an interpreter:

  UnitedHealthcare SignatureValue (HMO/MCO): 800-624-8822; Dial 711 TDHI

Where to Obtain the Member's Language Preference

The member's preferences for spoken language, written language and eligibility for written language service is displayed in the **eligibilityLink** app on Link.

Documentation of Member Refusal of Interpreter Services

If a member refuses your offer of an interpreter, you must note the refusal in the medical record for that visit. Documenting the refusal of interpreter services in the medical record not only protects you, it also helps ensure consistency. We verify compliance with this documentation when we conduct site reviews of medical records.

If a member wants to use a family member or friend as an interpreter, consider offering a telephonic interpreter in addition to the family member/friend to help ensure accuracy of interpretation. For all Limited English Proficiency (LEP) members, document the member's preferred language in paper and/or electronic medical records (EMR) in the manner that best fits your practice flow.

Member Complaints & Grievances

Member Satisfaction (California)

In addition to the NCQA CAHPS® survey, we conduct an annual California HMO member assessment survey using a sample of members at the care provider organization or medical group level. We summarize the results at the medical group level and use them to identify improvement opportunities. These results are important for the evaluation of member perspectives about access to PCP, specialty and after-hours care. In addition to access, topics include care coordination and interactions with the doctor and the office staff.

We use the results from this survey to support the Integrated Healthcare Association's Pay-for-Performance Program.

Member disputes may arise from time to time with UnitedHealthcare West or with our participating care providers. UnitedHealthcare West respects the rights of its members to express dissatisfaction regarding quality of care or services and to appeal any denied claim or service.

Find instructions on how to file a complaint or grievance with us in the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage.

Availability of Grievance Forms

California Commercial HMO members may access grievance forms online. Please direct members to **myuhc.com** > Find a Form. The form accessible in two places: From the California member welcome page or, Library tab page, on the left side, and click on Grievance Form. You and your staff are required to assist the member to obtain a form if the member asks. You may print a form from **myuhc.com** or by provide a number for the member to call Member Services to file the grievance orally. Grievance forms are available in English, Spanish and Chinese.

California Quality Improvement Committee

The California Quality Improvement Committee (CA-QIC) oversees activities specific to members in health plans operating in California to help ensure that state-specific interests are met and the committee activities carried out in collaboration with the West Regional Quality Oversight Committee (RQOC) to avoid duplication of effort.

The CA-QIC is chaired by the chief medical officer physician licensed in CA. The committee meets at least quarterly and reports to the UHC of CA Board of Directors and, as needed, to the West RQOC.

UnitedHealthOne Individual Plans Supplement

Applicability of This Supplement

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers individual personal health products, including Golden Rule Insurance Company (GRIC) and some individual products offered by Oxford Health Insurance, Inc.

This supplement applies to services provided to members enrolled in GRIC and UnitedHealthcare Oxford Navigate Individual benefit plans offered by Oxford Health Insurance, Inc.

You are subject to both the main guide and this supplement and the member's benefit plan. This supplement and the member's benefit plan controls if it conflicts with information in the main guide. If additional protocols, policies or procedures are available online, we direct you to that location when applicable. For protocols, policies and procedures not referenced in this supplement, refer to appropriate chapter in the main guide.

How to Contact UnitedHealthOne Resources

Resource	Where to go	Requirements and Notes
GRIC– Group Number 705214		
Notification Admission notification is required for all inpatient services as described in *Chapter 6: Medical Management*.	Call the number on the back of the member's health care ID card or go to **UHCprovider.com/priorauth**.	
Benefits and Eligibility	Call the number on the back of the member's health care ID card, or go to **myuhone.com**.	To inquire about a member's plan benefits or eligibility
Claims	Go to **myuhone.com**.	To view pending and processed claims
Pharmacy Services	**Prior Authorizations:** • **Online:** **professionals.optumrx.com** **Benefit Information:** Call the pharmacy number on the back of the member's health care ID card.	For information on the Prescription Drug List (PDL), go to **UHCprovider.com**.
Oxford– Group Number 908410		
Behavioral Health Services	**Online:** **providerexpress.com** **Phone:** 855-779-2859	Submit admission notification or prior authorization for behavioral health, including substance use and autism.
Cardiology: Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online:** **UHCprovider.com/cardiology**; Go to Prior Authorization and Notification Tool **Phone:** 866-889-8054	Request prior authorization for services as described in the *Outpatient Cardiology Notification/Prior Authorization Protocol* section of *Chapter 6: Medical Management*.
Chiropractic, Physical and Occupational Therapy	**Online** (clinical submission request): **myoptumhealthphysicalhealth.com**. **Phone:** 888-676-7768	Follow the clinical submission process for chiropractic, physical and occupational therapy as described in *Chapter 6: Medical Management*.
Claims Submission	**Electronic Claims Submission:** Payer ID 37602 **Paper Claims Submission:** Mail to the address listed on the back of the ID card.	

Resource	Where to go	Requirements and Notes
Pharmacy Services	**Prior Authorizations:** • **Online:** professionals.optumrx.com **Benefit Information:** Call the pharmacy number on the back of the member's health care ID card.	For information on the Prescription Drug List (PDL), go to **UHCprovider.com/pharmacy**.
Prior Authorization and Notification	**Online:** **UHCprovider.com/priorauth** **Phone:** 800-999-3404	Prior authorization and admission notification is required as described in *Chapter 6: Medical Management*. EDI 278A transactions are not available.
Radiology/Advanced Outpatient Imaging Procedures: CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online:** **UHCprovider.com/radiology**; Go to Prior Authorization and Notification Tool **Phone:** 866-889-8054	Request prior authorization for services as described in the *Outpatient Radiology Notification/Prior Authorization Protocol* section of *Chapter 6: Medical Management*.

Health Care ID Card

Members receive health care ID cards with information to help you submit claims accurately. Information varies in appearance or location on the card. However, cards display the same basic information (e.g., claims address, copayment information, and phone numbers).

Check the member's health care ID card at each visit and copy both sides of the card for your files. When filing electronic claims use the electronic payer ID on the health care ID card.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the *Health Care Identification (ID) Cards* Section of Chapter 2: Provider Responsibilities and Standards.

Claims Process

We know you want to be paid promptly for your services. To help prompt payment:

1. Notify us, based on the notification requirements in this supplement.
   - For Navigate referrals, refer to *Chapter 5: Referrals*.
2. Prepare a complete and accurate claim form. For facility (UB-04/8371) claims see number four below.
3. Submit electronic claims using the electronic payer ID on the health care ID card, or submit paper claims to the address listed on the member's health care ID card. GRIC payer ID is 37602.
4. Requirements for claims (paper or electronic) reporting revenue codes:
   - All claims reporting revenue codes require the exact dates of service if they are span dates.
   - If you report revenue code 274, you are required to provide a description of the services or a valid CPT or HCPCS codes.
   - All claims reporting the revenue codes on the following list require that you report the appropriate CPT and HCPCS codes.

Revenue codes requiring CPT® and HCPCS codes
260 IV Therapy (General Classification)
261 Infusion Pump
262 IV therapy/pharmacy services
263 IV therapy/drug/supply delivery
264 IV Therapy/Supplies
269 Other IV therapy
290 Durable Medical Equipment (DME) (other than renal) (General Classification)

Revenue codes requiring CPT® and HCPCS codes
291 DME/Rental
292 Purchase of new DME
293 Purchase of used DME
300 Laboratory (General Classification)
301 Chemistry
302 Immunology
303 Renal Patient (Home)

Revenue codes requiring CPT® and HCPCS codes
304 Non-Routine Dialysis
305 Hematology
306 Bacteriology & Microbiology
307 Urology
309 Other Laboratory
310 Laboratory-Pathology (General Classification)
311 Cytology Histology
312 Other Laboratory Pathological
319 Radiology–Diagnostic (General Classification)
320 Angiocardiography
321 Arthrography
322 Arteriography
323 Chest X-Ray
324 Other Radiology-Diagnostic
329 Radiology-Therapeutic and/or Chemotherapy Administration (General Classification)
330 Chemotherapy Administration-Injected Chemotherapy Administration-Oral Radiation Therapy
331 Chemotherapy Administration-Injected
332 Chemotherapy Administration-Oral
333 Radiation Therapy
335 Chemotherapy Administration-IV
339 Other Radiology-Therapeutic
340 Nuclear Medicine (General Classification)
341 Diagnostic Procedures
342 Therapeutic Procedures
350 CT Scan (General Classification)
351 CT-Head Scan
352 CT-Body Scan
359 CT-Other
360 Operating Room Services (General Classification)
361 Minor Surgery
362 Organ Transplant-Other Than Kidney Transplant

Revenue codes requiring CPT® and HCPCS codes
367 Other Operating Room Services
369 Other Imaging Services (General Classification)
400 Diagnostic
401 Mammography
402 Ultrasound
403 Screening Mammography
404 Positron Emission
409 Tomography Other Imaging Services
410 Respiratory Services (General)
412 Inhalation Services
419 Other Respiratory Services
460 Pulmonary Function (General Classification)
469 Other-Pulmonary Function
470 Audiology (General Classification)
471 Audiology/Diagnostic
472 Audiology/Treatment
480 Cardiology (General Classification)
481 Cardiac Cath Lab
482 Stress Test
483 Echocardiology
489 Other Cardiology
490 Ambulatory Surgical Care (General Classification)
499 Other Ambulatory Surgical Care
610 Magnetic Resonance Technology (General Classification)
611 MRI-Brain/Brain Stem
612 MRI-Spinal Cord/Spine
614 MRI-Other
615 MRA-Head and Neck
616 MRA-Lower Extremities
618 MRA Other
618 Other MRT
623 Surgical Dressing

Revenue codes requiring CPT® and HCPCS codes
624 FDA Investigational Devices
634 Erythropoietin (EPO) < 10,000 units
635 Erythropoietin (EPO) > 10,000 units
636 Drugs Requiring Detail Coding
730 EKG/ECG (Electrocardiogram) (General Classification)
731 Holter Monitor
732 Telemetry
739 Other EKG/ECG
740 EEG (Electroencephalogram) (General Classification)
750 Gastro-Intestinal (GI) Services (General Classification)
790 Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
921 Peripheral Vascular Lab
922 Electromyogram
923 Pap Smear
924 Allergy Test
925 Pregnancy Test
929 Additional Diagnostic Services
940 Other Therapeutic Services (General Classification)
941 Recreational Therapy
942 Education/Training (Diabetic Education)
949 Other Therapeutic Services (HRSA)

Note: Use the payer ID number on the member's health care ID card. The electronic claims submission number does vary. The claim will reject if the correct payer ID is not used.

Claim Adjustments

If you believe your claim was processed wrong, call the number on the back of the member's health care ID card and request an adjustment as soon as possible, in accordance with applicable statutes and regulations. If you identify a claim overpayment, or we notify you of an overpayment, send us the overpayment within 30 calendar days from the date of identification or notification.

Claim Reconsideration, Appeals and Disputes

If you disagree with a claim payment determination or adjustment, you may appeal. Send a letter requesting a review to the following address:

Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard Fax: 801-478-5463
Phone: 800-657-8205

If you feel your situation is urgent, request an expedited (urgent) appeal by phone, fax or in writing to:

Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Expedited Fax: 866-654-6323
Phone: 800-657-8205

Your appeal must be submitted within 12 months from the date of payment shown on the EOB, unless your Agreement with us or applicable law provide otherwise.

Please refer to *Claim Reconsideration and Appeals Process* section in Chapter 9: Our Claims Process.

If you disagree with the outcome of the claim appeal, you may file an arbitration proceeding as described in your Agreement.

Claim reconsideration does not apply to some states based on applicable state law (e.g. Arizona, California, Colorado, New Jersey, Texas). For states with applicable law, dispute requests will follow the state specific process.

New Jersey Care Provider Dispute Process

Disputes involving New Jersey (NJ) commercial members are subject to the NJ state-regulated care provider dispute process.

The state-regulated care provider dispute process does not apply in the following situations:

- Our determination involves a utilization management (UM) denial. UM denials are refusals to pay a claim or to authorize a service or supply because we have determined the service or supply is:
  - Not medically necessary;
  - Experimental or investigational;
  - Cosmetic;
  - Dental rather than medical; or
  - Treatment of a pre-existing condition.

UM denials include prescription quantity limit denials and requests for in-plan exception denials. You may appeal a UM denial by going through the Internal UM Appeals Process described under the Member Complaints and Grievances section. You must submit a completed Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical

Records in UM Appeals and Independent Arbitration of Claims form to begin the UM appeal process.

- Our determination indicates we denied the service or supply as not covered under the terms of the plan or because the person is not our member.
- The dispute is due to coordination of benefits.
- We have provided you notice that we are investigating this claim (and related ones, as appropriate) for possible fraud.

The process does apply for the following situations:

- The claim was not paid for any reason other than previously listed;
- The claim was paid at a rate you did not expect based on your network contract or the terms of the plan;
- The claim was paid at a rate you did not expect because of differences in our treatment of the codes in the claim from what you believe is appropriate;
- We required additional substantiating documentation to support the claim, and you believe the required information is inconsistent with our stated claims handling policies and procedures or is not relevant to the claim;
- You believe we failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law and the terms of your network contract, if any;
- Our denial was due to lack of appropriate authorization, but you believe you obtained appropriate authorization from us or another carrier for the services;
- You believe we failed to appropriately pay interest on the claim;
- You believe our statement that we overpaid on one or more claims; a claim is erroneous or the amount we calculated as overpaid is erroneous;
- You believe we have attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims.

If the dispute is eligible, the following process will apply: Submit a written request for appeal using the Health Care Provider Application to Appeal a Claims Determination Form created by the New Jersey Department of Banking and Insurance. Submit the request within 90 days following receipt of our initial determination notice to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard Fax: 801-478-5463

We will review the request and tell you our decision in writing within 30 calendar days of receipt of the form.

If you are not satisfied with the decision, you may initiate the New Jersey Program for Independent Claims Payment Arbitration (PICPA) process. Submit your requests to Maximus, Inc. within 90 calendar days from receipt of the internal dispute decision. A dispute is eligible if the payment amount in dispute is $1,000 or more. The arbitration decision is binding.

Member Complaints & Grievances

Member disputes may arise from time to time with UnitedHealthOne or with our participating care providers. We respect the rights of our members to express dissatisfaction regarding quality of care or services and to appeal any denied claim or service. Instructions on how to file a complaint or grievance with us are in the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage. Please refer to *Member Appeals, Grievances or Complaints* section in Chapter 9: Our Claims Process for detailed information about your role in the member appeal process.

UnitedHealthcare Oxford Navigate Individual - Internal Utilization Management Appeals Process

You or the member should identify UM appeals 180 calendar days from initial adverse UM determination receipt. UM appeals include denials as not medically necessary, experimental or investigational, cosmetic, dental rather than medical, prescription quantity limit denial, denial of a request for an in-plan exception, or excluded as a pre-existing condition.

To initiate the standard internal UM appeal process, write to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard Fax: 801-478-5463

If you feel the situation is urgent, request an expedited (urgent) appeal by phone, fax or in writing to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Expedited Fax: 866-654-6323
Phone: 800-291-2634

All UM appeals are done by clinical peer reviewers other than the clinical peer reviewer who rendered the initial UM determination.

Expedited appeal requests involving continued inpatient care in a network facility for a substance use disorder are determined within 24 hours. Expedited appeal requests for urgent care, emergency care, an admission, availability of care, continued stay, or health care services for which the member received emergency services, but has not been discharged from a facility, are determined within 72 hours.

Standard UM appeals are determined within 10 calendar days of appeal receipt.

If the member or designee is not happy with the results of the appeal process, they may pursue an external appeal through an Independent Utilization Review Organization (IURO) for final internal UM determinations. You must complete an internal appeal before you may request a review by an IURO, except when:

1. We fail to meet the deadlines for completion of the internal appeals process:
   a. Without demonstrating good cause, or
   b. Because of matters beyond our control, and
   c. While in the context of an ongoing, good faith exchange of information between parties, and
   d. It is not a pattern or practice of non-compliance;
2. We, for any reason, expressly waive our rights to an internal review of an appeal; or
3. The treating care provider and/or member have applied for expedited external review at the same time as applying for an expedited internal review.

To initiate the external appeal, the member or designee must:

1. File a written request with the New Jersey Department of Banking and Insurance within four months of receiving a final determination on an appeal.
2. Sign a release that allows the IURO to review all the necessary medical records related to the appeal; and
3. Send a check or money order in the amount of $25 made payable to: New Jersey Department of Banking and Insurance with the request. The form, release and check must be sent to:

   Department of Banking and Insurance
   Consumer Protection Services
   Office of Managed Care
   P.O. Box 329
   Trenton, NJ 08625-1062
   Phone: 888-393-1062

The IURO completes the review within 45 days of receipt.

The IURO completes its review within 48 hours if the appeal involves:

- Urgent or emergency care
- An admission
- Availability of care
- Continued stay
- Health care services for which the member received emergency services and not yet discharged
- A medical condition that would put the member's life or health in danger when waiting for the normal appeal process

If UnitedHealthcare Oxford Navigate Individual has good cause for not meeting the appeal process deadlines, members or their designee and/or their care provider may request a written explanation of the delay. UnitedHealthcare Oxford Navigate Individual must provide the explanation within 10 days of the request. If an external reviewer or court agrees with UnitedHealthcare Oxford Navigate Individual and rejects the request for immediate review, the member has the opportunity to resubmit their appeal.

Internal Administrative Appeal Process

The administrative appeal process is used to appeal an initial determination concerning a claim for benefits or an administrative issue. Issues include but are not limited to:

- Denials based on benefit exclusions or limitations not involving UM decisions;
- Claims payment disputes; and
- Administrative issues concerning other requirements of the health plan. Administrative issues include but are not limited to issues involving:
  - Eligibility;
  - Enrollment issues; and
  - Rescission of coverage.

Please Note: Benefit and administrative issues do not include initial determinations that the service or supply is not medically necessary, experimental or investigational, cosmetic, dental rather than medical, prescription quantity limit denials, denials of a request for an in-plan exception, or treatment of a pre-existing condition. Those determinations are UM decisions.

You or the member must initiate administrative appeals in writing unless expedited.

Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis. Expedited administrative appeals are determined within 72 hours from receipt of the appeal. All other appeals are determined within 30 calendar days of receipt of the appeal.

Notice to Texas Providers

To verify benefits for GRIC members, call 800-395-0923.

Tools have been developed by third parties, such as the MCG® Care Guidelines (formerly known as Milliman Care Guidelines®), to assist in administering health benefits and making informed decisions in many health care settings, including acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As affiliates of UnitedHealthcare, GRIC and Oxford Health Insurance, Inc. may also use UnitedHealthcare's medical policies as guidance. These policies are available on **UHCprovider.com/policies**.

Notification does not guarantee coverage or payment (unless mandated by law). The member's coverage eligibility is determined by the health benefit plan. For benefit or coverage information, please contact the insurer at the phone number on the back of the member's health care ID card.

To obtain a verification as required by 28 TAC §19.1719, please call 800-842-1792.

Important Information Regarding Diabetes (Michigan)
Michigan requires insurers to provide coverage for certain expenses to treat diabetes. It also requires insurers to establish and provide members and participating care providers with a program to help prevent the onset of clinical diabetes. We have adopted the American Diabetes Association (ADA) Clinical Practice Guidelines.

The program for participating care providers emphasizes best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. The Standards of Medical Care in Diabetes and Clinical Practice Recommendations are on **care.diabetesjournals.org**.

Subscription information for the American Diabetes Journals is available on the website. You may also call 800-232-3472 and select option one, 8:30 a.m. to 8 p.m. ET, Monday through Friday. View journal articles without an online subscription.

Glossary

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the health insurance plan, improper payment, payment for services that fail to meet professionally recognized standards of care, or medically unnecessary services. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Accreditation: A process that a care provider goes through to be recognized for meeting certain standards such as quality.

Acute Inpatient Care: Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Adjudication: The process of determining the proper payment amount on a claim.

Ambulatory Care: Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term "ambulatory care" usually implies that the patient has come to a location other than their home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility: A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services: Health services ordered by a care provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal: An oral or written request by a member or member's personal representative received by UnitedHealthcare for review of an action.

Authorization: Approval obtained by care providers from UnitedHealthcare for a designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Authorized Care Provider: A care provider who meets UnitedHealthcare's licensing and certification requirements and has been authorized by UnitedHealthcare to provide services.

Balanced Billing: When a care provider bills a member for the difference between billed charges and the UnitedHealthcare allowable charge after UnitedHealthcare pays a claim.

Benefit: The amount of money UnitedHealthcare pays for care and other services.

Capitation: Per-person way of payment for medical services. UnitedHealthcare pays a participating capitated care provider a fixed amount for every member they care for, regardless of the care provided.

Care Provider: A person who provides medical or other health care (doctor, nurse, therapist or social worker) or office support staff. A care provider may be a doctor practicing alone, in a hospital setting, or in a group practice. A care provider could work from a remote location, in a public space, or any combination of locations.

Claim: The documentation of the services that have occurred during the course of a visit to a health care provider.

Clinical Laboratory Improvement Amendments of 1988 (CLIA): United States federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research.

Clean Claim: A claim that has no defect, impropriety (including lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

Centers for Medicare & Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services.

Coordination of Benefits (COB): Allows benefit plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance benefit plan has the primary payment responsibility and the extent to which the other benefit plans will contribute when an individual is covered by more than one benefit plan).

Coinsurance: The member's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. Members may pay coinsurance plus any deductibles owed.

Commercial: Refers to all UnitedHealthcare medical products that are not Medicare Advantage, Medicare Supplement, Medicaid, CHIP, workers' compensation, TRICARE, or other governmental programs (except that "Commercial" also applies to benefit plans for the Health Insurance Marketplace, government employees or students at public universities).

Copayment: A fixed amount members may pay for a covered health care service, usually upon receiving the service.

Covered Services: Medically necessary services included in the member's benefit plan. Covered services change periodically and may be mandated by federal or state legislation.

Credentialing: The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare.

Current Procedural Terminology (CPT) Codes: American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Deductible: The amount a member owes for health care services the health insurance or benefit plan covers before the health insurance or benefit plan begins to pay.

Delivery System: The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, health care facilities, care provider offices, and home health care.

Dependent: A child, disabled adult or spouse covered by the health benefit plan.

Disallow Amount: Medical charges for which the network care provider is not permitted to receive payment from the health benefit plan and may not bill the member. Examples are:

- The difference between billed charges and contracted rates; and
- Charges for services, bundled or unbundled, as detected by Correct Coding Initiative edits.

Discharge Planning: Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Disease Management: A prospective, disease-specific approach to improving health care outcomes by providing education to members through non-physician.

Disenrollment: The discontinuance of a member's eligibility to receive covered services from a contractor.

Dual-Eligibles: Members who qualify for both Medicare and Medicaid.

Durable Medical Equipment (DME): Medical equipment that is all of the following:

- Ordered or provided by a physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a sickness or injury.
- Primarily used within the home.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS): In November 2006, the Centers for Medicare & Medicaid Services (CMS) approved 10 national accreditation organizations that will accredit suppliers of DMEPOS as meeting new quality standards under Medicare Part B.

Electronic Data Interchange (EDI): The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT): The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR): The electronic version of a member's health records.

Emergency Care: The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that sets minimum standards for most voluntarily established pension and health benefit plans in private industry to provide protection for individuals in these benefit plans.

Encounter: An interaction between a patient and health care providers, for the purpose of provider health care services or assessing the health status of a patient.

Expedited Appeal: An oral or written request by a member or member's personal representative received by UnitedHealthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Fee for Service: Care providers are paid for each service (like an office visit, test, or procedure).

Fraud: Health care fraud is a crime that involves misrepresenting information, concealing information, or deceiving a person or entity to receive benefits, or to make a financial profit (18 U.S.C.§1347).

Grievance: An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan.

Health Insurance Portability and Accountability Act (HIPAA) Act of 1996: A federal legislation that provides data privacy and security provisions for safeguarding medical information.

Health Plan Employer Data and Information Set (HEDIS): Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

Home Health Care or Home Health Services: Medical care services provided in the home, often by a visiting nurse, usually for recovering patients, aged homebound patients, or patients with a chronic disease or disability.

Link Password Owners: Individuals at a care provider's organization who set up and maintain co-workers' access to our care provider websites, Link and UHCprovider.com. Find your **Link Password Owner**.

Managed Care: A system designed to better manage the cost and quality of medical services. Managed care products not only offer less member liability but also less member control. Managed care aims to improve accessibility to health care, reduce cost, and improve quality of service. Many managed care health insurance programs work with Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) boards to promote use of specific health treatment procedures. Managed care health insurance benefit plans also educate and work with consumers to improve overall health by addressing disease prevention. The common types of managed care products are HMO, PPO, and Point of Service (POS) benefit plans.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Medically Necessary: To determine medical necessity, we use generally accepted standards of medical practice, based on credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community. We may also use standards based on physician specially recommendations, professional standards of care, and other evidence-based, industry-recognized resources and guidelines, such as MCG® Care Guidelines.

For Medicare Advantage and Medicaid members, we use Medicare guidelines, including National Coverage Determinations and Local Coverage Determinations to determine medical necessity of services requested.

If other nationally recognized criteria contradict MCG, Care Guidelines UnitedHealthcare and delegated medical group/IPAs follow the Medicare guidelines for Medicare Advantage members. Individual criteria is provided to you upon request.

Member: Refers to an individual who has been determined UnitedHealthcare-eligible and is enrolled with UnitedHealthcare to receive services pursuant to the Agreement. Other common industry terms: customer, patient, beneficiary, insured, enrollee, subscriber, dependent.

National Provider Identification (NPI): NPI is a unique 10-digit identification number issued to health care providers in the United States by CMS.

Network Care Provider: A professional or institutional care provider who has an Agreement with UnitedHealthcare member's plan to provide care at a contracted rate. A network care provider agrees to file claims and handle other paperwork for UnitedHealthcare member. A network care provider accepts the negotiated rate as payment in full for services rendered.

Non-Network Health Care Provider: A non-network care provider does not have an Agreement with UnitedHealthcare but is certified to provide care to UnitedHealthcare members. There are two types of non-network care providers: non-participating and participating.

- **Non-participating care provider:** A non-participating care provider is a UnitedHealthcare-authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to UnitedHealthcare members but who does not have an Agreement and does not accept the UnitedHealthcare allowable charge or file claims for UnitedHealthcare members. A non-participating care provider may only charge up to 15 percent above the UnitedHealthcare allowable charge.
- **Participating care provider:** A health care provider who has agreed to file claims for UnitedHealthcare members, accept payment directly from UnitedHealthcare, and accept the UnitedHealthcare allowable charge as payment in full for services received. Non-network care providers may participate on a claim-by-claim basis. Participating care providers may seek payment of applicable copayments, cost-shares and deductibles from the member. Under the UnitedHealthcare outpatient prospective payment system, all Medicare participating care providers and hospitals must, by law, also participate in UnitedHealthcare for inpatient and outpatient care.

Nurse Practitioner: A registered nurse who has graduated from a program which prepares registered nurses for

advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

Optum: A UnitedHealth Group™ health services and innovation company that designs and implements custom information technology systems, and offers management consulting, in the health care industry nationwide. Optum offers behavioral health care programs including integrated behavioral and medical programs, depression management, employee assistance, work/life management, disability support and pharmacy management programs.

Out-Of-Area Care: Care received by a UnitedHealthcare member when they are outside of their geographic territory.

Physician Assistant: A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

Policy: A contract between the insurer and the insured, known as the policyholder, which determines the claims which the insurer is legally required to pay.

Primary Care Provider (PCP): A physician such as a family practitioner, pediatrician, internist, general practitioner, or obstetrician, who serves as a gatekeeper for their assigned members' care. Other providers may be included as primary physicians such as nurse practitioners and physician assistants as allowed by state mandates.

Pre-Service Appeals: A pre-service appeal is a request to change a denial of coverage for a planned health care service. The member's rights in the member's benefit plan govern this process.

Primary Care Team: A team comprised of a care manager, a PCP, and a Nurse Practitioner or Physician Assistant.

Prior Authorization and Notification: A unit under the direction of the UnitedHealthcare Clinical Services Department that is an essential component of any managed care organization. Prior authorization is the process where health care providers seek approval prior to rendering services as required by UnitedHealthcare policy.

Provider Group: A partnership, association, corporation, or other group of providers.

Provider Manual: This document is referred to as a care provider manual or guide. It may also be referred to as the provider administrative guide or handbook.

Qualified Medicare Beneficiary (QMB): A Medicaid program for beneficiaries who need help paying for Medicare services.

Quality Management (QM): A methodology used by professional health personnel to the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Reinsurance: The contract made between an insurance company and a third party to protect the insurance company from losses.

Risk Adjustment Data: All data used in the development and application of a risk adjustment payment model, as defined in **42 CFR 422.310**.

Secondary Payer: A source of coverage that pays after the primary insurance benefit has been applied.

Self-Funded Plan: Self-funded health care, also known as Administrative Services Only (ASO), is a self insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds.

Self- Insured: A self-insured group health benefit plan is one in which the employer assumes the financial risk for providing health care benefits to its employees.

Service Area: A geographic area serviced by a UnitedHealthcare contracted provider, as stated in the health care provider's Agreement with us.

Skilled Nursing Facility: A Medicare-certified nursing facility that (a) provides skilled nursing services and (b) is licensed and operated as required by applicable law.

Stop-loss: A product that provides protection against catastrophic or unpredictable losses. It is purchased by employers who have decided to self-fund their employee benefit health benefit plans, but do not want to assume 100% of the liability for losses arising from the benefit plans.

Subrogation: A health plan's right, to the extent permitted under applicable state and federal law and the applicable benefit plan, to recover benefits paid for a member's health care services when a third party causes the member's injury or illness.

Subscriber: Person who owns an insurance policy.

Supplemental Benefits: Supplemental insurance includes health benefit plans specifically designed to supplement UnitedHealthcare standard benefits.

Third-Party Administrator (TPA): An organization that provides or manages benefits, claims or other services, but it does not carry any insurance risk.

Transitional Care: A program that is designed for members to help ensure a coordinated approach takes place across the continuum of care.

UnitedHealthcare Assisted Living Plan: A Medicare Advantage Institutional-Equivalent Special Needs Plan that:

- Exclusively enrolls special needs individuals who living in a contracted Assisted Living Facility, have Medicare A and B, and meet the local state's criteria for "institutional level of care".
- Is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare's affiliates; and

- Is offered through our UnitedHealthcare Medicare Advantage business unit, as indicated by a reference to Assisted Living Plan name listed on the face of the valid health care ID card.

UnitedHealthcare Nursing Home Plan: A Medicare Advantage Institutional Special Needs Plan that:

- Exclusively enrolls special needs individuals who for 90 calendar days or longer, have had or are expected to need the level of service requiring an institutional level of care (as defined in **42 CFR 422.2**);
- Is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare's affiliates; and
- Is offered through our UnitedHealthcare Medicare Advantage business unit, as indicated by a reference to Nursing Home Plan or Erickson Advantage Guardian in the benefit plan name listed on the face of the valid health care ID card.

Us: "Us," "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual.

Utilization Management (UM): The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning and case management.

Waste: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a health care benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather misuse of resources.

Workers' Compensation: Workers' compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue their employer for the tort of negligence.

You: "You," "your" or "provider" refers to any health care provider subject to this guide, including physicians, health care professionals, facilities and ancillary providers; Except when indicated all items are applicable to all types of providers subject to this guide.