2019
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 and select the state

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.

Depending upon the version of PDF software you have, you may also use the binoculars icon to search for key words.

This 2019 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, 2019 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, 2019. 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, including physicians, health care professionals, facilities and ancillary providers; except when indicated and 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.

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, but 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 protocol. Payment will be denied, in whole or in part, for failure to comply with a protocol.

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*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 **Myallsaversprovider.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 up-state) Some Counties in: PA.	*Oxford Commercial Supplement* to this guide. For commercial benefits: **OxfordHealth.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

Self Service
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**.

Our contracts generally require you to conduct business with us electronically. Using electronic transactions is fast, efficient, and supports paperless work environment. Use both EDI and Link for maximum efficiency in conducting business electronically.

You can 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 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**.
- **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**—When you use Document Vault to access claim letters, your Link Password Owner may turn off delivery of paper copies by mail. 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.

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
UnitedHealthcare Provider Website To make navigating to our provider portal even easier, we have created 'vanity URLs' such as UHCprovider/priorauth. These are more direct hyperlinks to frequently used pages.	**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 clams 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)
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, Fixed-Wing Non-Emergency Transport	**Online:** **UHCprovider.com/findprovider** For more information on Air Ambulance, go to *Chapter 8: Specific Protocols*.

Online Resources and How to Contact Us	Where to go
Appeal – (Clinical) Urgent Submission (Commercial members) (MA – 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 **Online:** For a complete instructions and a list of fax numbers by benefit plan, please refer to the FAQ document on **UHCprovider.com**.
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*.
Member/Customer Care	**Online: myuhc.com** **Phone:** 877-842-3210
Mental Health and Substance Use Services	See member's health care ID card for carrier information and contact numbers.
Outpatient Injectable Chemotherapy, Colony Stimulating Factors and Denosumab	**Online: UHCprovider.com/priorauth** and select the specialty you need. **Phone:** 888-397-8129

Online Resources and How to Contact Us	Where to go
Pharmacy Services	**Online: UHCprovider.com/pharmacy** or **OptumRx.com** **Phone:** 800-711-4555 **Fax:** 800-527-0531
Provider Advocates: For participating hospitals, health care, and ancillary providers; Locate your physician or hospital advocate	**Online:** UHCprovider.com > **Contact Us** > Network Management Contacts
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 (IMRT, SRS, and SBRT)	**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
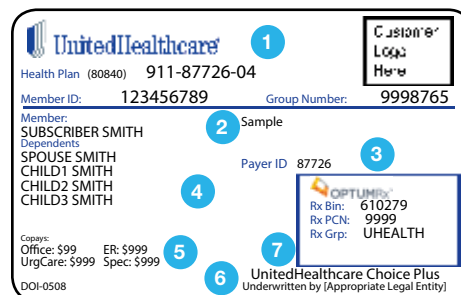
Back

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) 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. Select HMO benefit plans in SC and NC have tiered copayments. These plans have two copayments for PCPs and for specialists.

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 benefit plan. Examples of some MA benefit plans include, but are not limited to:

   • AARP Medicare Complete benefit plans

   • UnitedHealthcare Assisted Living Plans

   • UnitedHealthcare Dual Complete benefit plans

   • UnitedHealthcare MedicareComplete benefit plans

   • UnitedHealthcare Nursing Home Plans

8. **For Members:** Lists benefit plan contact information for the member.

9. **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 four weeks
Regular/Routine Care Appointment	Within 14 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 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.

Primary Care Physicians (PCP) Responsibilities

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.

Non-Discrimination

Do not discriminate against any patient on quality of service or accessibility of services. You must keep policies and procedures to show your compliance. This includes discrimination based on:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Disability
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of payment

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

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 network care provider 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 is defined as the PCP's practice is open to additional new members and transferring members.

- Closed status is defined as the PCP's practice is closed to all new members and transferring members.

- Existing only status is defined as 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 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 a line of business 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 phone, 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 hardcopy. 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 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 to the requirements listed in the *Information Required From the PCP* section, PCPs who wish to terminate their relationship with a Medicare Advantage 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 a 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, please 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 (31 U.S.C. §3729 et seq.), and the Anti-Kickback Statute (§1128B of the Social Security Act); 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 as defined in 42 CFR 422.310(a), and other MA program-related information as we may request, to us within the timeframes 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.

- In addition, you must comply with the Medicare Advantage Regulatory Requirements Appendix (MARRA).

Member Communication (CMS Approval Required)
Member communications require CMS approval. This includes:

- Anything with the MA and/or the AARP name or logo
- 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
- Mid-Year Network Changes
- Payments to Care Providers

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.

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 **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 members 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 assigned PCP and have electronic referrals submitted 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 does not. 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 assigned 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 does not. 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 assigned 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 does not. 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 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 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 provider or facility. Members with a tiered benefit plan have an identifier on the front of their health care ID card.

W500 Additional Network
Some benefit plans include Additional Network Benefits referred to as W500 Emergent Wrap. We contract with non-participating 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.

Remember, you can submit address corrections on **UHCprovider.com/mypracticeprofile** or call the phone number on the back of the member's health care ID card.

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 under the UnitedHealthcare or AARP brands: **HMO** • MedicareComplete • MedicareComplete Essential • MedicareComplete Access • MedicareComplete Focus • MedicareComplete Mosaic • MedicareComplete Premier • MedicareComplete Profile • MedicareComplete Value **HMO-POS** MedicareComplete Plus	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.*
Local PPO and Regional PPO (RPPO) benefit plans under the UnitedHealthcare or AARP brands: • MedicareComplete Choice • MedicareComplete Choice Essential • MedicareComplete Focus • MedicareComplete Headwaters • MedicareComplete Lakeshore • MedicareComplete Assure • MedicareComplete Open • UnitedHealthcare Sync	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. 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.*

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?
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 facilities 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 UnitedHealthcare Dual Complete HMO: UnitedHealthcare Dual Complete Focus 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. 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 (PPO and Regional PPO) PPO: UnitedHealthcare MedicareComplete 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.*	No, a referral is not needed.	Yes, see guidelines in *Chapter 6: Medical Management.*
Erickson Advantage Plans (HMO-POS)	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. Erickson Advantage provides out-of-network coverage for some covered benefits.*	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 meet 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 meet 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 meet 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

Members are required to select a Medicare network PCP. If not, we assign one automatically.

Changing PCP

Members may change their 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.

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 Guide, Medicare Managed Care Guide, Medicare Claims Processing Guide, 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 detailed policy update summaries 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 are 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 ($1,340 in 2018). 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
These Medicare plans reduce member expenses by covering:

- 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

- 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 Plan F 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. If you do not obtain a referral when required, we deny coverage or give the member a higher cost share.

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 members PCP). Referrals are valid for any care provider within the same TIN as the specialist listed.

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 their 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 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
You 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 a 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 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

Direct Access Services

Women's' Health Specialists
Females can receive obstetrical and gynecological (OB/GYN) services from a:

- OB/GYN

- Family practice physician

- Surgeon providing OB/GYN services

Flu Vaccine

Educate our members about:

- The annual flu vaccine

- How to get the vaccine

- The availability of the vaccine

Direct access services do not need a referral. However, the physician must be affiliated with their assigned care provider and participating with us.

Non-Participating Care Provider Referrals (All Commercial Plans)

When services are not available, the members network physician can submit a request for an out-of-network review. You can 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 apply the network benefits to the services done by the out-of-network care provider. We mail our decision to the requesting care provider and the member.

We send a written confirmation with the final decision to the requesting care provider and the member.

Before Submitting a Request for Network Benefit 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 (MA) Referral Required Plans

Some 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 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 assigned 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 observation
- Allergy immunotherapy
- Mental health/substance use services with behavioral health clinicians
- Any service from a pathologist or anesthesiologist (excludes office-based or pain management services), and any inpatient consulting physicians including hospitalists
- 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
- 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 benefits that may include a gym membership, or outpatient prescription drugs
- Services obtained under the UnitedHealth Passport® Program, which allows for services while traveling

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 may take up to two business days to update in the 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 network care providers in the area available, 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.

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

*** Delegated may follow different referral submission requirements.

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*
• UnitedHealthcare West
• 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 of which are addressed in separate sections later in this guide:

• *Outpatient Cardiology Notification/Prior Authorization Protocol*.

• *Outpatient Radiology Notification/Prior Authorization Protocol*.

• *Laboratory Services Protocol*.

• *Laboratory Benefit Management Program Administered by BeaconLBS™*.

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.

• 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 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.

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

- Could, in a short period of time, put their life or health at risk

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

- Could impact their ability to regain maximum function

- Causes severe, disabling pain (as confirmed by a physician)

Facilities: Standard Notification Requirements*

Confirming Coverage Approvals

Before providing a service that is 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:

- If we decide the service is not a covered benefit, we may deny the facility's 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.

- If a coverage review is in process on the date of the service and that review ultimately decides it is a covered benefit, we do not deny the facility's claim.

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*
- *UnitedHealthcare West*
- 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:

- Planned/elective admissions for 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.

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.

We need admission notification, even if advance notification was provided by the physician, and pre-service coverage approval is on file. 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 rendered were emergent. This determination is subject to appeal. You can find a definition of "emergency" in the *Glossary*.

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

Reimbursement Reductions for Lack of Timely Admission Notification

Facilities must provide timely admission notification as follows or claims payments are denied in full or in part:

Notification Timeframe	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.

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 Rehabiliatation 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, 2019, 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 be made to your notification/ prior authorization request, you must submit a new notification/ prior authorization request.

Updated requests must be submitted 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 Guide (MA members)

- Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Coverage Summaries

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 intended to be used in connection with the independent professional medical judgment of a qualified health care provider and are not equivalent to the practice of medicine or medical advice.

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 timeframe 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 Medical & Drug Policies and Coverage Determination Guidelines is available on UHCprovider.com/policies > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines**.

We develop Medical Policies, Medical Benefit Drug Policies, and Coverage Determination Guidelines to support the administration of medical benefits. 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 healthcare 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. A claim should be submitted 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 timeframe 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 related to 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, Clinical Trials 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. 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

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 (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.
- Possible request for authorization determinations include:
  - › 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 and considered 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.
- 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.
- Other — includes an error on the evidence in the files was misinterpreted or overlooked in making the decision.

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 reconsideration.

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

- An adverse decision has been issued, and
- The 60-calendar day timeframe 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 Medicare Advantage 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

Florida: AARP® MedicareComplete® (HMO) - Group 82958, 82960, 82963, 82969, 82977, 82978; AARP® MedicareComplete® Focus (HMO) - Group 82970, 82980; AARP® MedicareComplete® Plan 2 - Group 82962; UnitedHealthcare® The Villages® Medicare Complete® 1 (HMO) - Group 82940; UnitedHealthcare® The Villages® Medicare Complete® 2 (HMO-POS) - Group 82971; AARP® MedicareComplete® Choice (Regional PPO) - Group 82955, 82956; AARP® MedicareComplete® Choice (PPO) - Group 82957

Hawaii: AARP® MedicareComplete Choice Plan 1 - Group 77000 & 77007 and AARP MedicareComplete Choice Essential - Group 77003 & 77008

Illinois: AARP® MedicareComplete® - Group 17243, 17244; AARP® MedicareComplete® Plan 1 - Group 18027,18028; AARP® MedicareComplete® Plan 2 - Group 55860; AARP® MedicareComplete® Access Group 55306, 55307, 55430, 55431

Texas: UnitedHealthcare Dual Complete® (HMO SNP) – Group 00012; UnitedHealthcare Dual Complete Focus® (HMO SNP) – Group 00303, 00305, 00307, 00310; AARP® MedicareComplete Focus® (HMO) – Group 00300, 00304, 00306, 00309, 00315; AARP® MedicareComplete Focus Essential® (HMO) – Group 00308.

Utah: AARP® MedicareComplete Plan 1 - Group 42000; AARP® MedicareComplete Plan 2 - Group 42022; AARP® MedicareComplete Essential - Group 42004; UnitedHealthcare Group Medicare Advantage - Group 42020; UnitedHealthcare® MedicareComplete Choice - Group 42023

Medica HealthCare: Medica HealthCare Plans MedicareMax (HMO) – Group 77700, 77701; Medica HealthCare Plans MedicareMax Plus (HMO SNP) – Group 77702, 77703, 77704.

Preferred Care Partners: Preferred Choice Broward HMO – Group 78601; Preferred Choice Dade (HMO) – Group 78600;

Preferred Choice Palm Beach (HMO) – Group 78606; Preferred Medicare Assist (HMO SNP) – Group 78602, 78603, 78609; Preferred Medicare Assist Palm Beach (HMO SNP) – Group 78607, 78608, 78610; Preferred Special Care Miami-Dade (HMO SNP) – Group 78605; Preferred Choice Broward HMO – Group 99791; Preferred Choice Dade (HMO) – Group 99790; Preferred Choice Palm Beach (HMO) – Group 99797; Preferred Medicare Assist (HMO SNP) – Group 99792, 99793, 99796; Preferred Medicare Assist Palm Beach (HMO SNP) – Group 99798, 99799, 99800; Preferred Special Care Miami-Dade (HMO SNP) – Group 99795.

For the **Medica and Preferred Care Partners of Florida** groups above, please refer to the Medica Healthcare and Preferred Care Partners for 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 Nursing Home and UnitedHealthcare Assisted Living Plans (HMO SNP), (HMO-POS SNP), (PPO SNP)

Senior Dimensions Medicare Advantage Plans (Health Plan of Nevada)

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 notification of the procedure and if the member's benefit plan requires health services to be medically necessary to be covered, we conduct a clinical coverage review, pursuant to 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 and 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 can 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 health services to be medically necessary to be covered.

If the member's plan requires services to be medically necessary to be covered, 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 that 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 health services to be medically necessary to be covered.

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 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), 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 they 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 that health services be medically necessary to be covered, 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. They must verify that we have issued a coverage decision in accordance with 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 that are 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 that 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

Florida: AARP® MedicareComplete® (HMO) - Group 82958, 82960, 82963, 82969, 82977, 82978; AARP® MedicareComplete® Focus (HMO) - Group 82970, 82980; AARP® MedicareComplete® Plan 2 - Group 82962; UnitedHealthcare® The Villages® Medicare Complete® 1 (HMO) - Group 82940; UnitedHealthcare® The Villages® Medicare Complete® 2 (HMO-POS) - Group 82971; AARP® MedicareComplete® Choice (Regional PPO) - Group 82955, 82956; AARP® MedicareComplete® Choice (PPO) - Group 82957
Hawaii: AARP® MedicareComplete Choice Plan 1 - Group 77000 & 77007 and AARP MedicareComplete Choice Essential - Group 77003 & 77008
Illinois: AARP® MedicareComplete® - Group 17243, 17244; AARP® MedicareComplete® Plan 1 - Group 18027,18028; AARP® MedicareComplete® Plan 2 - Group 55860; AARP® MedicareComplete® Access Group 55306, 55307, 55430, 55431
Texas: UnitedHealthcare Dual Complete® (HMO SNP) – Group 00012; UnitedHealthcare Dual Complete Focus® (HMO SNP) – Group 00303, 00305, 00307, 00310; AARP® MedicareComplete Focus® (HMO) – Group 00300, 00304, 00306, 00309, 00315; AARP® MedicareComplete Focus Essential® (HMO) – Group 00308.
Utah: AARP® MedicareComplete Plan 1 - Group 42000; AARP® MedicareComplete Plan 2 - Group 42022; AARP® MedicareComplete Essential - Group 42004; UnitedHealthcare Group Medicare Advantage - Group 42020; UnitedHealthcare® MedicareComplete Choice - Group 42023

Medica HealthCare: Medica HealthCare Plans MedicareMax (HMO) – Group 77700, 77701; Medica HealthCare Plans MedicareMax Plus (HMO SNP) – Group 77702, 77703, 77704.

Preferred Care Partners: Preferred Choice Broward HMO – Group 78601; Preferred Choice Dade (HMO) – Group 78600; Preferred Choice Palm Beach (HMO) – Group 78606; Preferred Medicare Assist (HMO SNP) – Group 78602, 78603, 78609; Preferred Medicare Assist Palm Beach (HMO SNP) – Group 78607, 78608, 78610; Preferred Special Care Miami-Dade (HMO SNP) – Group 78605; Preferred Choice Broward HMO – Group 99791; Preferred Choice Dade (HMO) – Group 99790; Preferred Choice Palm Beach (HMO) – Group 99797; Preferred Medicare Assist (HMO SNP) – Group 99792, 99793, 99796; Preferred Medicare Assist Palm Beach (HMO SNP) – Group 99798, 99799, 99800; Preferred Special Care Miami-Dade (HMO SNP) – Group 99795.

For the **Medica and Preferred Care Partners of Florida** groups above, please refer to the Medica Healthcare and Preferred Care Partners for 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 Nursing Home and UnitedHealthcare Assisted Living Plans (HMO SNP), (HMO-POS SNP), (PPO SNP)

Senior Dimensions Medicare Advantage Plans (Health Plan of Nevada)

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 notification of the procedure and if the member's benefit plan requires health services to be medically necessary to be covered, we conduct a clinical coverage review, pursuant to 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 and 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 health services to be medically necessary to be covered.

If the member's plan requires services to be medically necessary to be covered, 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 that 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 health services to be medically necessary to be covered.

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.

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) 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 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 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, they 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, in accordance with the process described below:

- 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. They 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 that services be medically necessary to be covered 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 services to be medically necessary to be covered 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 that are 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 that 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 that an additional advanced outpatient imaging procedure should be delivered above and beyond the service(s) for which a notification/prior authorization number has already been obtained, the ordering care provider must request a new notification/prior authorization number before rendering the additional service, in accordance with 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.

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 that 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 shall no longer apply when, based on medical necessity, the member is determined to be 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.

Phone: 800-711-4555

For pharmacy notification and prior authorization:

Fax: 800-527-0531 (all medications)

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

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 necessary to treat diabetes or to medications that, due to their characteristics, as determined by UnitedHealthcare, 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** > Provider Vendor Assistance List- Specialty Pharmacy.

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 in our Clinical Services 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 (Includes UnitedHealthcare Dual Special Needs Plans [DSNP])

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 may be available to some members without network coverage.

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

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

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 drugs and 37% of the total cost of generic drugs in 2019. Coverage plans vary and the member may pay less if their plan offers additional coverage in the coverage gap.

- Catastrophic coverage level — Members who reach this level will have a significantly lower copayment/coinsurance for prescription drugs, until the end of the year.

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. 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

OptumRx follows the coverage determination timelines as established by CMS. We must complete standard coverage determinations within 72 hours. OptumRx must complete expedited coverage determinations within 24 hours. Turnaround time varies by case type, and may be extended beyond the initial 24 or 72 hours if there are incomplete service level Agreements (SLAs) as agreed upon by the specific benefit plan and CMS.

OptumRx will ask for more information from the physician, 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)
- 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.

MA 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, fill out and submit a prior authorization form available on professionals.optumrx.com > Prior Authorizations > **fax forms**.

More information about requirements is available at professionals.optumrx.com > Resources > **Formulary Lists** or by calling our Pharmacy department.

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; insulin when administered by pump. Some drugs covered under Part B are dispensed by outpatient pharmacies. For example, certain oral cancer drugs, immunosuppressants, and diabetes test strips.

Diabetes Monitoring Supplies

The Preferred Diabetic Supply program is 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®, OneTouch Verio® IQ , OneTouch Verio® Flex, ACCU-CHEK® Guide , ACCU-CHEK® Aviva, and ACCU-CHEK® Nano SmartView. Test strips: OneTouch Verio®, ACCU-CHEK® Guide, ACCU-CHEK® Aviva Plus, ACCU-CHEK® SmartView, and OneTouch Ultra®.

Other brands are not covered. There is a $0 copayment for Medicare-covered diabetes monitoring supplies.

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 800-711-4555.

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 800-711-4555.

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. To order injectable medications, complete and submit a prior authorization form. The forms are available at professionals.optumrx.com > prior authorizations > **fax forms**.

Call 800-711-4555 for details on the rules governing injectable medications.

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 per day, seven days per 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

- **Written request:** You can obtain a Commercial Prescription Prior Authorization Form – CA on OptumRx. com > **Health Care Professionals Portal** > Prior Authorizations.

  › Fax: 800-527-0531 for all medications

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 (MTM)

The 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 $4,044 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 gives temporary coverage to new 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:

- Only formulary changes that take effect at the beginning of the year are subject to the transition policy. There is a separate process for changes to the formulary that occur mid-year.

- Members subject to formulary changes in the middle of the year receive a 60 day notice before the change. During that time we will cover the prescribed drug while the member coordinates with the care provider to either switch to another drug or request an exception.

The following table summarizes the rules for receiving a transition supply of a drug:

	Current Member (>90days)	New Member (<90 days)
Retail Pharmacy (Not in a Long Term Care Facility)	Length of the prescription, with refills, up to a maximum of 30 or 31 days total, depending on the plan. During the first 90 days of plan calendar year only.	Length of the prescription, with refills, up to a maximum of 30 or 31 days total, depending on the plan. During the first 90 days of the plan calendar year only.
Long Term Care Facility Pharmacy	Length of the prescription, with refills, up to a maximum of 31 days total. During the first 90 days of the plan calendar year only.	Length of the prescription, with refills, up to a maximum of 31 days total. During the first 90 days of the plan calendar year only.

To request a formulary exception, call our Pharmacy Department at 800-711-4555 or fax us at 800-527-0531.

Chapter 8: Specific Protocols

Air Ambulance, Fixed-Wing Non-Emergency Transport

This protocol applies to all participating physicians and health care professionals. It applies to all non-emergency, fixed-wing air ambulance transports.

We have a network of air ambulance transportation providers. Members who get services from an out-of-network non-emergency air ambulance service typically pay more out-of-pocket.

Refer members to a participating air ambulance provider, unless we authorize a non-network one. We list these providers in our Physician Directory on **UHCprovider.com/ findprovider** > Search by 'Ambulance Services', then select 'Addtional Ambulance Services'. If you need help finding one, please call us.

Administrative Actions for Referral to Out-of-Network Fixed-Wing Air Ambulance Providers

If we find a pattern of referrals to out-of-network air ambulance providers without our approval, we will educate the referring provider. If the pattern of out-of-network referrals continues, we may take actions available in your Agreement.

Laboratory Benefit Management Program Administered by BeaconLBS™ (Florida Only)

This program applies to fully insured members who live in Florida. If you order laboratory services and your practice is outside of Florida, this program does not apply. This program provides physicians and laboratories with point of order support for test selection and laboratory selection. Certain laboratory services are subject to additional protocols, such as advance notification and Laboratory Point of Performance Requirements. Claims for laboratory services are subject to additional complete claim requirements.

For more information on requirements and implementation, please visit UHCprovider.com/policies > **Lab Benefit Management Program**.

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.

Please follow state and federal laws when giving us the clinical data. 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**.

Requirement to Use Participating Laboratories

The Laboratory Services Protocol applies to all participating physicians and health care professionals, and it applies to all lab services, clinical and anatomic, ordered by care providers, except this protocol does not apply:

- When the physician bears financial risk of lab services.
- When the physician provides laboratory services in their offices.

You are required to refer lab services to a participating lab provider. You can confirm whether a lab is in our network at **UHCprovider.com** or by contacting us directly.

We maintain a large network of regional and local labs. These labs provide a fast, comprehensive range of services. They also provide clinical data and related information to support:

- HEDIS reporting
- Care management
- UnitedHealth Premium Designation program
- Other clinical quality improvement activities

For an exception to this requirement you must have:

- Written consent from the member to use an out-of-network laboratory for that member's laboratory service for that date of service, and
- UnitedHealthcare approval to refer the member to use an out-of-network laboratory for that member's laboratory service for that date of service.

Administrative Actions for Out-of-Network Laboratory Services Referrals

If you refer a laboratory service to an out-of-network care provider, and have not responded to our request to confirm that the exceptions apply, you will be out of compliance with your Agreement. We may take administrative actions, which include:

- Loss of eligibility for the Practice Rewards programs;
- A decreased fee schedule;
- Financial responsibility for any costs or expenses collected from a member by a non-participating laboratory, including non-covered services and balance bills, if there is no written member consent authorizing the referral to the non-participating laboratory; or
- Termination of network participation, as provided in your Agreement.

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

If you do not follow this rule, we may:

- Decrease your fee schedule
- Terminate your network participation

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.

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 contact our Data Acquisition Technical Support (DATS) team by email at **dataacquisitiontechsupport@uhc.com**. Care providers have different data transfer capabilities, and we will work with you to find the best method of data transmission.

Non-Participating Providers Consent Form

Excluded Plans (benefit plans not subject to the following requirements)

- Neighborhood Health Partnership
- M.D.IPA, Optimum Choice, or OneNet
- Benefit plans subject to the *River Valley Entities Supplement*
- UnitedHealthcare West

Except in emergent situations, we require you to follow this protocol when directing members to use these types of non-participating care providers/services.

Impacted Care Provider/Service Types:

- Ambulatory Surgical Centers – free-standing and hospital outpatient non-emergent
- Surgical Assistant - a care provider or other health care provider who is assisting in or monitoring the care during

the performance of a surgical procedure, where the participating entity selects the Surgical Assistant

- Home Health
- Air Ambulance, fixed-wing non-emergency transport
- Laboratory Services – for specimens collected in the physician's office and sent out to a non-participating laboratory for processing
- Outpatient Dialysis
- Specialty Drug vendor
- For Oxford Members on New York Products – refer to the *Participating Provider Laboratory & Pathology Protocol (New York)* for specific requirements and instructions on non-participating laboratory and pathology services
- For UnitedHealthcare Members on Delaware, New York, Oklahoma, Pennsylvania and Texas Products – refer to UHCprovider.com/policies > **Protocols** > Participating Provider Laboratory and Pathology Protocol for specific requirements and instructions on non-participating laboratory and pathology services.

Before you provide services, you must:

1. Discuss options and costs with the member:
   - Review this policy and the Member Advance Notice Form
   - Provide participating care provider alternatives and explain the reason for using the non-participating care provider
   - Discuss the cost of using a non-participating care provider
     › If the member has out-of-network benefits, they can use those benefits to see a non-participating care provider. However, they may pay more when using them.
     › Members who do not have out-of-network benefits may have to pay all of the costs for the non-participating care provider.

2. Complete the UnitedHealthcare Member Advance Notice Form. Fill in the required information on the form and have the member sign it.
   - Participating care providers must keep a copy of the signed form on file to give to us upon request.
   - A separate form is required for each non-participating care provider/service.
   - A copy of the Form is on UHCprovider.com/policies > **Protocols** > Laboratory and Pathology Services Consent Form for Members.

This **protocol does not apply in emergent situations** or instances where the care provider or member has obtained a network exception to use a non-participating care provider.

We want to help members make informed decisions. We do not want to deter them from using out-of-network benefits. Members can use their out-of-network benefits at any time.

Administrative Actions for Non-Compliance

We monitor the involvement of the non-participating care provider types and services outlined above in our ER's care. We may request a copy of the completed Member Advance Notice Form. We will review your compliance with this protocol, in accordance with state and federal laws and regulations. If you do not comply with this protocol, we may take action as stated in your Agreement. Such actions may include, but are not limited to payment sanctions, ineligibility for performance based compensation, or termination of your Agreement.

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 to 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 a 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 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 Virtual Card Payments using the same method that your organization uses to process credit card payments. Your current credit card processing fees apply. You can confirm those rates with merchant processor directly.

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

Posting and Balancing with Virtual Card Payment:
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, Virtual Card Payments 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
- 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 dispute 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 can vary based on state requirements and contracts. Refer to your 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 utilizes 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 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 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 a 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 a 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. 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 our 'Labs of Choice' PDF on UHCprovider.com/policies > **Lab Benefit Management Program**.

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 in our Laboratory Benefit Management Program Administrative Protocol and or CMS.gov > Regulations & Guidance > Legislation > **Clinical Laboratory Improvement Amendments**.

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. 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. 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 dispute, 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 located on **UHCprovider.com/claims** in the Additional Resources section. Mail refunds for overpayments to the name and address indicated on 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.

Dispute

If you disagree with the claim adjustment, our request for an overpayment refund or recoupment, you may dispute.

Submit your dispute within 30 calendar days from the date you receive the overpayment notification letter. Your dispute must clearly state the items in dispute, with the relevant authority and supporting documentation for the disputed items. We respond to notifications of disputed audit findings in writing within 30 calendar days of receipt.

Direct Connect

Direct Connect is a no-cost web-based platform that helps payers and 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 provider and payer

• Avoid duplicate recoupment and returned checks

• Decrease resolution timeframes

• Real-time reporting to track statuses of inventories in resolution process

• Provide control over financial resolution method

• Manage and review overpayment disputes

• 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 COB 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 worker's 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, Appeals Process and Resolving Disputes

Claim reconsideration does not apply to some states based on applicable state law. Refer to *Care Provider Dispute Resolution (CA, 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.

Timeframe
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 that 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, Explanation of Benefits (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.

Timeframe

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 Timeframe

If medical records are requested to process an appeal, the following timeframes 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. Timeframes 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 877-847-2862 to obtain a status.

If you are disputing a refund request that you received from us, please reference the *Post-audit Procedures* section of this chapter.

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 Disputes – Concern or Complaint

If you disagree with the outcome of a claim appeal or other dispute, 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 dispute 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 below and in your Agreement. For disputes 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.

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 timeframe. 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 resulting 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 disputed health care service in your possession 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.

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 (EOC), 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.

Submit an advance notification request for a pre-service organization determination on **UHCprovider.com/paan**.

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.

Cost-sharing for Qualified Medicare Beneficiary (QMB)

QMBs are not responsible for Medicare cost sharing under CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copays 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**.

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 disputes 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. Should 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

We use nationally recognized billing/coding guidelines for our audits. These guidelines are from the American Association of Medical Audit Specialists in partnership with CMS located on: aamas.org > Resources > **National Audit Guidelines**. Facility audits help to identify billing and coding errors. They include a thorough review of critical

claim elements that are not on the UB-04, such as medical records and itemized bills. The audits could happen on a pre or post-payment basis. We conduct the audits onsite at your location or offsite with a designated representative. We may conduct other audits or make other record requests, in accordance with the National Hospital Billing Audit Guidelines.

Standard Percent of Charge Hospital Bill Audit

Our Standard Percent of Charge Hospital Bill Audit includes a review of medical records to support the billed charges. Inappropriate charges include:

- An individual charge that was unbundled from a more general charge in which it is commonly included
- A charge that is not supported by the records

Post-audit claim reconsideration reconciles overpayments or underpayments identified from the audit.

Hospital Requirements and Access

Our auditors notify the hospital of our intent to audit a claim by notifying the appropriate hospital representative. The hospital is responsible for:

- Sending a copy of the itemized bill within 30 calendar days of the request, and/or
- Sending a copy of the bill breakdown at the time of audit
  - › The hospital notifies the auditor if the breakdown will be provided within 30 calendar days after we notify them of the audit
- Cooperating in a timely manner
  - › The auditor needs to complete the audit scheduling process within 30 calendar days of the scheduling request
- Obtaining the member authorization to release their medical information
  - › In many cases, the member signs this authorization at the time of admission
- Waiving the fee associated with the audit or copying of records, unless specified in their Agreement
- Coordinating the audit location, if onsite
  - › Audits are conducted either offsite or at the hospital
- Providing the auditor with access to the medical records, department charge sheets, and any applicable hospital policy and procedure (if requested)
- Providing our audit vendors the same access as our employee auditors
  - › Vendors authorized by us are bound to our obligations under the Agreement
- Not imposing time limitations on our right or ability to audit, unless otherwise stated in the facility Agreement or by state/federal law

Audit Findings

When the audit is over, the auditor notifies the hospital of the findings. We provide the hospital representative with a copy of the audit findings, if requested. We provide a copy of the findings immediately if the audit is done at an offsite location.

Post-audit Procedures

- Refund Remittance – For an undisputed overpayment, 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.
- Disputed Audit Findings – If the hospital wants to dispute the findings, they submit notification of the dispute 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 dispute, with the relevant authority and relevant documentation for the disputed items.
- Dispute Resolution – We respond to notification of disputed audit findings in writing within 60 calendar days of receipt.
- Escalated Dispute Resolution – If the dispute remains unresolved, the hospital may request a conference call to include representatives of UnitedHealthcare and our Network Management staff. Escalated dispute resolution stops recovery efforts associated with the disputed audit findings during the discussion between parties.
- Unresolved Dispute – Either party may further pursue dispute resolution as outlined in this guide and in your Agreement.
- 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 dispute of 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 8: Our Claims Process follow the auto failure denial process.

In addition to the initial medical record request notification sent with all audited claims, audit failure denial claims asks

for additional information and notifies care providers of the audit failure denial process, overpayment, and future actions.

Notice of Medicare Non-Coverage (NOMNC)

You must deliver 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 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 that are 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 that 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 > **Clinical Guidelines** (in the left navigation pane). 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.

Special Needs Plans (SNP)

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 and Quality Measurement and Performance Improvement.

The MOC is a vital quality improvement tool. It helps ensure that 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 and Medicaid (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.

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

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.

Visit **uhcmedicaresolutions.com** for specific care management programs available to Medicare Advantage members.

Wellness and Behavioral Health Programs

We offer many care coordination programs for members. They focus on delivering skilled resources to help members understand their care provider's care plan and medication instructions. To access these programs, have the member call the phone number listed on the back of their health care ID card. Here is a partial list of our member wellness and behavioral health programs.

Tobacco Cessation: We offer a comprehensive tobacco cessation solution integrating industry and employer best practices.

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 takes an evidence-based approach to support weight loss. This program helps people make small changes necessary for larger long-term health results, 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

Consumer Transparency Tools

An online cost estimator tool is available in some markets to commercial members at myUHC.com. It is designed to assist them 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.

Behavioral Health Information

The U.S. Preventive Services Task Force (USPSTF) recommends that PCPs screen patients for depression 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**.

For more information on depression, alcohol use disorders, and other behavioral conditions, access the Optum website **providerexpress.com**. 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, Alcohol and Drug Use Disorder and Addiction & 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 dedicated section for physicians and other health care professionals with articles addressing aspects of each condition,
- Information about co-morbid conditions,
- Links to nationally recognized practice guidelines,
- A self-appraisal that you can print, use or refer our members to, and
- A listing of support resources for you, our members, and their families.

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 Regional Quality Director and Senior Medical Director are in charge of day-to-day QM operations.

Quality Management Committee Structure

The Medical Advisory Committee (MAC) oversees, reviews and provides recommendations on QM activities. These include:

- Clinical practice guidelines
- Medical policies
- Pharmacy updates
- Service standards
- Over-use and under-use of services by health care professionals

This committee suggests QM studies based on high-volume, high-risk and problem-prone areas 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 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:

- 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 studies 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. QM completes separate studies for special risk groups.
- 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.

- Through the RPRC and NPRCPC reviews and resolves member complaints about medical care and services. 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. Employers may choose to offer their employees a tiered benefit plan. Tiered benefit plans may offer an enhanced benefit of lower out-of-pocket costs for using Premium Care Physicians.

Some directories may display quality evaluation results only. On those, physicians with the Premium Care Physician or Quality Care Physician designation 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

An NCQA-certified vendor conducts our annual survey of member satisfaction using the 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, North Dakota, and South Dakota providers may submit applications to the Minnesota Credentialing Collaborative (MCC) also known as ApplySmart. Log **intocredentialsmart.net/mcc** to select UnitedHealthcare as a Preference, complete your application and submit to us.

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 providers in Maryland and New York.

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**.

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 disputes 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 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

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. The employees of FDRs working on MA and Part D programs, including contracted care providers, must complete the two requirements below within 90 days of employment and annually thereafter (by the end of the year). 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. 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**).

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.

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.

New 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 January 1, 2019. The Preclusion List applies to both Medicare Advantage plans as well as Part D plans.

The Preclusion 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.

Care providers receive notification from CMS of their placement on the Preclusion List, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with UnitedHealthcare. Once the preclusion date is effective, claims will no longer be paid, pharmacy claims will be rejected, and the network provider will be terminated from the UnitedHealthcare network until such time the care provider is removed from the preclusion status.

As contracted care providers of UnitedHealthcare, you must ensure that payments for healthcare 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.com**.

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 Web Sites:
  sam.gov/portal/SAM/#1

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 $10 and total less than $50 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 that 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: [Facebook] [YouTube] [Twitter]

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, you can also 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 2019, the Network Bulletin is available online and through email on the following dates:

Network Bulletin Edition	Publication Date
January	Jan 2
February	Feb 1
March	Mar 1
April	Apr 1
May	May 1
June	Jun 3
July	Jul 1
August	Aug 1
September	Sep 3
October	Oct 1
November	Nov 1
December	Dec 2

We offer Really Simple Syndication (RSS) feeds. You must have an RSS reader to check subscription data feeds and download new information. Free RSS readers, as well as instructions on how to use them, are available through many browsers, such as Google and Yahoo! To subscribe to our RSS feeds, copy and paste any or all of the following URLs into your RSS Reader:

- General News Updates: UHCprovider.com/rss/news.xml
- Administrative Guide Updates: UHCprovider.com/rss/adminGuide.xml
- Medical Policy Updates: UHCprovider.com/rss/medical.xml

Medical Policy Update Bulletin

We publish monthly editions of the *Medical Policy Update Bulletin*. This is a user-friendly online resource that 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 detailed policy update summaries 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*
Chemotherapy (outpatient injectable)	**Online: UHCprovider.com/priorauth** > Oncology **Phone:** 866-889-8054	Policies and instructions
Claims Submission	**Electronic Claims Submission:** Payer ID 81400 **Paper Claims Submission:** Mail to the address listed on the back of the ID Card.	
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 formation 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

Timeframe

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, Appeals Process and Resolving Disputes* 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

Does this supplement apply to me?

It applies if you are a:

- Capitated provider
- Delegated provider
- Delegated Accountable Care Organization (ACO)

Capitated Providers

What is a Capitated Provider?

Capitation is a payment arrangement for health care providers. If you have a capitation Agreement with us, you are a capitated provider. 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, e.g., per member, per month. In most instances, the capitated provider is either 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 the term "capitated providers".

This supplement is intended for participating physicians, health care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare products. This applies to all benefit plans for members who:

1. Have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare for that member, and

2. Are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare. Currently, there is a reference to "UHC" or 'WEST' on the back of the member's health care ID card. In the future, we will notify you if additional benefit plans in your area include other references.

Capitated 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 main guide.

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.

Delegated Providers and Accountable Care Organizations

What is a Delegated Provider/ACO?

Delegation is a process we use to give 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, or

5. Other clinical and administrative functions.

When we delegate any of these responsibilities to you, you are a Delegated Provider (referred to in this supplement as "delegated entity" or "delegate"). We remain responsible to external regulatory agencies and other entities for the performance of the delegated activities. To become a delegate, the provider/ACO must demonstrate compliance with our established standards and best practices. Additionally, to remain a delegate, the provider/ACO must continuously 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, you must 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*, located 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 containing eligibility changes. You must coordinate initiation of electronic eligibility files with your software vendor and us. Some of the advantages of receiving electronic eligibility are:

- An eligibility upload may reduce your costs by reducing the effort required to maintain eligibility manually.
- Eligibility updates may be loaded into your system in a timely manner.

Refer to the section titled *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. 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, are required to choose a primary care provider (PCP), as 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 dictates otherwise.

If the mother of the newborn is a dependent of the subscriber, but not the spouse, domestic partner or common law spouse of the subscriber, we will not cover any services provided to the newborn grandchild beginning upon delivery of the newborn unless coverage is specifically stated in the subscriber's benefit plan.

Medical or facility services for surrogate mothers who are not our members are not covered.

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 for the 30 day period 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 will remain 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.

In cases where both the mother's insurance plan and the father's insurance plan 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

Typically, 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 in advance of 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 who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.

Transfer of Members

A member may select a new medical group/IPA or PCP by calling Member Service or by accessing **myuhc.com**.

Members may change their PCP within the same medical group/IPA. The change is effective the first 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 of member's open enrollment period, will not be effective until the 1st day of the 2nd 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 3rd trimester of her pregnancy (defined as when the member reaches the 27th week of pregnancy); or
- Experiencing a high-risk pregnancy (not applicable to California members).

We do not recommend the member change PCPs while an inpatient in a facility, SNF, or other medical institution, or undergoing radiation therapy or chemotherapy, as a change may negatively affect the coordination of care.

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 will 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 (exception: 60 calendar days in California) to select another medical group/IPA, PCP, or facility within the member's current medical group/IPA. The member will receive 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 the member's PCP has terminated without proper notice, we will transfer the member to another PCP, within the same medical group/IPA with an effective date retroactive to the first of the current month.

Removal of Members
The medical group/IPA agrees we have the right to 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 the section 'Member Dismissals Initiated by a PCP (Medicare Advantage),' in Chapter 2: Provider Responsibilities and Standards.

Commercial Members
For commercial members, the medical group/IPA may regard certain actions as incompatible with the continuance of the care provider-member relationship and as obstructing the provision of proper medical care. For example, if the member refuses to accept the recommended treatment, counsel or procedures, and the medical group/IPA believes no professionally acceptable alternatives exist, other than dismissal from their panel.

The medical group/IPA may request a member change medical groups/IPAs if the care provider-member relationship is damaged by the member's refusal to accept recommended treatment, counsel or procedure. We evaluate requests based on the interest of the member and

accessibility of another medical group/IPA. If we approve the request for transfer, we request the member selects another medical group/IPA within 30 calendar days.

If the member fails to select another medical group/IPA, we designate another medical group/IPA on their behalf.

If no professionally acceptable alternatives exist, neither UnitedHealthcare nor the medical group/IPA shall be responsible to provide or arrange for the medical care or pay for the condition under treatment.

Potential 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); or
- Fraudulently applying for any UnitedHealthcare benefits.

After we receive of a completed "Incident Report for Removal of Members" and related documentation, we will respond to the member and 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 who is willing to formally document the incident in writing.
1st Occurrence:		
Medical group/IPA must counsel with and write to member in certified letter expressing such behavior is unacceptable; Discussions need documentation. Send copies to UnitedHealthcare, which will send warning letter outlining behavior and possible consequences.	Medical group/IPA must counsel with and write to member in certified letter expressing such behavior is unacceptable; Discussions will need documenting. 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 will send warning letter outlining continued behavior and possible consequences.	Send UnitedHealthcare a request to immediately remove subscriber/member from the medical group/IPA. UnitedHealthcare will review 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 will 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.

Medicare Advantage (MA) Enrollment, Eligibility and Transfers, and Disenrollment

For more information and instructions for confirming eligibility refer to to the section titled *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 names of the members and related member identification information, their enrollment date, and benefit plan information including, but not limited to, 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 and viewed on **UHCprovider.com**. We generally provide eligibility information once per month. We may provide it daily or weekly if needed.

Eligibility (MA)

Medicare beneficiaries who elect to become members of 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 utilizing the UnitedHealth Passport® benefit)

- Not have End Stage Renal Disease (ESRD).

MA plans include a Contract ID and Plan ID (also known as the plan benefit package or PBP) from CMS that corresponds to CMS filings, including CMS OD universe submissions. If you require assistance finding a Contract ID or Plan ID please email us at **odag_universe@uhc.com**.

Change of Membership Status (MA)

If a Medicare beneficiary is an inpatient at these facilities at the time the beneficiary's membership becomes effective with us, the previous carrier is financially responsible 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, or

- A rehabilitation facility.

The member's assigned medical group/IPA assumes financial responsibility for Part B services (medical care) on the member's 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 become 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 the facilities identified above, 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 or skilled nursing facility).

Refer to the Medicare Advantage 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, within the same state. The member must complete the form and return it within 30 calendar days. If they do not return the form within 30 calendar days, the member is considered out of the service area and is disenrolled on the 1st of the month following the 30 calendar days;

- Changes from one benefit plan to another. If the member does not return a completed form, they will remain on the existing plan. The member may only change benefit plans using their annual election period or during the MA Disenrollment Period defined by CMS.

If the member has exhausted these elections, and does not qualify for a Special Election Period, they are locked in to the current benefit plan for the remainder of the calendar year. They may not change benefit plans.

CMS requires us to treat a member who experiences a benefit plan change as a new member, rather than as an existing member. 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 for membership in a UnitedHealthcare MA plan.

Enrollment Periods

CMS has defined 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 different types of enrollment periods and the requirements of each type are outlined on the CMS website at **cms.hhs.gov**.

Enrollment periods for UnitedHealthcare Group MA members are dictated by the employer group's annual renewal date with us. A group retiree annual enrollment period will coincide 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.

Effective Date

Coverage begins at 12:01 a.m. on the effective date, provided 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 retroactive 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 will 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 the care provider, refer the member to our Member Service Department. Once the disenrollment is processed, we will send a letter with the effective date of disenrollment to the member. If the member submits a request for disenrollment during the month, the disenrollment is effective the 1st day of the following month.

Eligibility/Authorization Guarantee

Medical Group/IPA's Responsibility to Monitor Eligibility (CA Commercial Only)
We periodically send each medical group/IPA an eligibility list of assigned members. Current eligibility information is available through the Enterprise Voice website, care provider portal, and member service center. You and/or your network of care providers are responsible for checking eligibility within two business days prior to the date of service for individuals for who/whom services are provided or authorized. If the medical group/IPA checked and confirmed eligibility within two business days prior to the date of service, it is eligible for reimbursement under the Eligibility Guarantee and Authorization Guarantee programs. This program applies to services authorized by the medical group/IPA or UnitedHealthcare or provided by the medical group/IPA prior to the receipt of updated eligibility, showing an individual is no longer eligible.

Eligibility/Authorization Guarantee Procedure
Eligibility/Authorization Guarantee offers reimbursement to the medical group/IPA providing covered services to an individual:

1. We identified as eligible one or two business days before the date of service through our eligibility determination and verification processes and

2. Is later determined to be ineligible for benefits on the date of service, but had no authorization ("Eligibility Guarantee"); and

3. We provided an authorization to whom we confirmed as eligible one or two business days prior to the date of service, but later determined to have been ineligible on the date of service ("Authorization guarantee").

The Eligibility Guarantee and Authorization Guarantee procedures are designed to limit 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 the services are provided.

Eligibility Guarantee Billing Procedures (No Authorization Provided)
Medical group/IPA provides or arranges for health care services for an individual identified as an eligible member through our eligibility determination and verification processes. If no authorization is required or provided, and it is later determined the individual was not a member at the time the health care services were provided, medical group/IPA may seek reimbursement for such services:

- Submit the claim to the member or the responsible payer for fee-for-service reimbursement in two consecutive billing cycles, no less than 30 calendar days apart. The responsible payer may be another health plan or insurer or it may be a government payer, such as Medicare when determined as primary.

- If neither the member nor the responsible payer pays the claim within 30 business days following the submission of the second bill, 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;
  › Proof of eligibility verification within two business days prior to the date of service through the Enterprise Voice Portal, online care provider portal or toll-free phone number or care provider attestation letter;
  › Proof of billing the member or responsible payer twice — no less than 30 calendar days apart;
  › A record of any payment received from any other responsible payer; and
  › Amount due based on medical group/IPA's cost of care rate, less any payment received from any other responsible payer.

Eligibility Guarantee Reimbursement
The medical group/IPA must follow with the Eligibility 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, but no greater than 100% of the uncollected balance. The medical group/IPA is responsible for reimbursing the care provider.

Provider Responsibilities

Demographic Updates
To help ensure we have your most current provider directory information, submit any changes to:

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

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 are expecting any significant changes to your network, we strongly recommend you 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, and 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 of our product lines. Find information and help with EDI on UHCprovider.com/EDI, and in this guide under *EDI* section of Chapter 2: Provider Responsibilities, including 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. The ASC X12 Technical Report Type 3 publications are available for purchase from Washington Publishing via wpc-edi.com. We have developed guides to provide transaction specific information required by us for successful EDI submissions. UnitedHealthcare Companion Guides are available for viewing or 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 (*CA- please see below) written notice prior to any significant changes to the medical group/IPA or network care providers, which include:

- Inability of medical group/IPA to properly serve additional members due to lack of PCPs
- Closing or opening the PCP's practice to additional members
- Closure of any office or facility used by the medical group/IPA, PCPs or other network care provider and health care professional

The medical group/IPA, its care providers and other licensed independent health care professionals shall continue to accept members during the 90 day notice. We have developed specific definitions for open, closed or existing only practices to promote consistency throughout our 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.

California Requirements for Capacity Reporting
We require capitated providers to give us updates within five business days if capacity changes impact 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 is not intended to impede activities related to 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

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 the service you provide.

Inclusion of 'Notice of Availability of Language Assistance' in Non-Standard Vital Documents Issued by Delegated Care Provider Groups (CA Commercial Members Only)

The California Department of Managed Health Care's (DMHC) approved Notice of Availability of Language Assistance must be included with each vital document containing member specific information issued to UnitedHealthcare's Language Assistance Program (LAP) members by the delegated care provider group. The Notice must be included in UnitedHealthcare's threshold languages (English, Spanish and Chinese). Vital documents include, but are not limited to, 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 ensure the provision of auxiliary aides, including 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/auxiliary aide services, you must arrange these services promptly to avoid a delay in care and 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 surpluses and deficits based on an annual comparison of accumulated actual expenses in accordance with 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 replaced the Commercial Hospital Incentive Program effective Jan. 1, 2017. IHA 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) 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, and typically includes, but is not limited to, the following:

- Inpatient costs for facility services rendered to our members by network care providers valued at the actual costs incurred by us; plus,

- Other facility services given to our members by network care providers other than inpatient services, valued at actual costs incurred by us; plus,

- The actual amount paid for facility services, which are rendered by non-network care providers; plus,

- 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; and

- HIP financial report for the settlement period, the HIP financial 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 information stated above.

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 obtained by the medical group/IPA 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 needs to be signed by both parties to be valid. The medical group/IPA must submit the following required information, along with an original, signed letter stipulating the "care provider" has permission to 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; and

- 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; and

- Claims timely filing language.

Contract Entry

We will review the rider contract. Based upon the contract criteria and other considerations, we will determine if the rider contract qualifies for data entry into our claims payment system.

If the rider contract qualifies, we will 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.

Note: You must 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, you must 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 listing the actual costs incurred and denied during the previous month for services included in the HIP. The medical group/IPA should 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 in analyzing 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 of the fields in the Discrepancy report and submit it electronically to our Network Care Provider Management department. If all required fields are not completed, we will 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 — the rationale as to why the medical group/IPA is disputing the payment

Discrepancy Report Timely Filing

The medical group/IPA must submit Discrepancy Reports monthly. We will not pursue recoveries of overpayments you submit late, as dictated by 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) is protection to limit 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 is given the option to participate in the program each year.

The medical group/IPA may purchase ISL/reinsurance from us, or an outside carrier.

We determine our premium for ISL based on an analysis of our previous 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. Monthly, we subtract the result from the total capitation.

A medical group/IPA that purchases ISL through UnitedHealthcare is reimbursed 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.

A facility that purchases reinsurance through UnitedHealthcare is reimbursed 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 clearly identify all reinsurance claims prior to 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 acceptable to us 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 will provide 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

All ISL/reinsurance claims having met the ISL/reinsurance deductible must be submitted 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 email address **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. Combined submissions for an entire family or for more than one member are not acceptable.

• For capitated services rendered outside the medical group/IPA/facility, we will require copies of canceled checks showing actual amounts paid. Upon request, you may be required to 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). Lab results, X-ray results or records are not required.

• 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 will review the claim for completeness and will notify medical group/IPA/facility if any additional information is necessary. Supporting records for ISL/reinsurance claim verification may be required. After review, if the claim is accepted, a payment is made 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*. In addition to the requirements outlined in Chapter 14, delegated entities and capitated providers are subject to the requirements outlined in the following sections.

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 demonstrates compliance 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; and

• Review activities, including establishing and maintaining a Credentialing Committee.

Monitoring Sanction Activity

If a capitated provider is sanctioned and lost 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 compliance of the delegate with the established standards for delegation of credentialing. At least annually thereafter, we assess the delegate to monitor its compliance with established standards, including NCQA standards, and state and federal requirements. We may initiate a focused assessment review based on specific activity by the delegate that warrants such an assessment.

Improvement Action Plans

If delegates do not achieve compliance, we may require an improvement action plan to reach compliance. If compliance is not reached within a determined timeframe, we will continue oversight. We may revoke delegated functions if there is continued non-compliance 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, but not limited to, 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; and
  › TIN.
- Product participation (e.g., Commercial, Medicare Advantage); and
- Languages spoken and written by the care provider or clinical staff.

Reporting Changes
The delegate must provide to Credentialing Entity with current demographics for their care providers and/or changes to a status. Changes include:

- Address
- TIN
- Status of accepting patients: open, closed or existing only patients
- Product participation

All demographic changes, open/closed status, product participation or termination needs reporting via email to: **delprov@uhc.com** or until the My Practice Profile app on Link is available.

Delegate Reporting of Terminations
The delegate must notify us, in writing, of any terminations of care provider or other licensed independent health care professionals. We must receive such notice 90 calendar days in advance of the termination effective date.

Note: 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 prospectively as described in their benefit plan.

Negative Actions Reporting Requirements
The delegate is required immediately to 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, as applicable:

- 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; or
- 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 added a new benefit for Virtual Visits to some member benefit plans in January 2017. Members can use Virtual Visits for primary care services that include 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 (for example, from home or from work). When covered by a member's benefit plan, the Virtual Visit benefit has a separate defined copayment.

The Commercial HMO members with the new benefit 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 the Virtual Visit services, we will make a nationally contracted Virtual Visit care provider available. The network care provider groups intending to offer 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 will 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 chooses to develop 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 in accordance with state and federal laws.

Staff Orientation and Ongoing Training—The care provider group must participate in a written orientation plan with documented skill demonstrations as well as 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 will contact the member to either schedule or initiate a Virtual Visit.

Technology Security—The care provider group will conduct all member Virtual Visits via interactive audio and/or video telecommunications systems using a secure technology platform, which meets state and federal law requirements for security and confidentiality of electronic patient information. It will maintain member records in a secure medium, which meets state and federal law requirements for encryption and security of electronic patient information.

Professional Accreditation—The care provider group will pursue applicable accreditation by the American Telemedicine Association (or other mutually agreed upon accreditation body) with the objective of becoming 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 through data opportunities for real, 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 will log, by category and type, member complaints with specific improvement action plans for any patterns. There should be complaints registered on less than two percent of member cases.

Regulatory Assessment Results—If we ask, the care provider will have available and permit access to any applicable regulatory audit results.

Utilization—The care provider group will submit 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 will use existing eligibility validation methods to confirm Virtual Visit benefits.

Case Communication—The care provider group will support patient records management for Virtual Visits using existing EMR systems and standard forms. Its EMR records should contain required medical information including referrals and authorizations.

Joint Operating Committee—The care provider will meet with us up to quarterly at our request to review data reports, quality issues, and address any administration issues. Professional Environment — The care provider group will help 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) will not conduct member Virtual Visits in vehicles or public locations.

Medical Director—The care provider will employ or engage a licensed care provider as medical director. The medical director is responsible for clinical direction.

Referrals & Referral Contracting

Direct Access Services

Members may receive certain services without prior authorization or referrals. Please refer to *Chapter 5: Referrals* for specifics regarding direct access services.

Access to Participating Eye Care Providers (CA and CO Only)

If the medical group/IPA is delegated for vision services, they must allow the member direct access to any eye care provider participating and available under the plan. An eye care provider is defined as a network care provider who is an optometrist or ophthalmologist who is appropriately licensed. The medical group/IPA may subsequently 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 Provider Responsibilities

We assign each member a PCP at the time of enrollment if the member does not select one. The PCP has the primary responsibility for coordinating 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 the responsibilities of care providers.

Out-of-Network Provider Referrals (Commercial HMO and Medicare Advantage)

When medically necessary, the PCP is responsible for referring 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 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 (MA)

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 is responsible for ensuring all provisions of its Agreement with any care provider who provides services to MA members includes all provisions required under the delegate's Medicare Advantage Agreement and regulatory requirements and applicable accreditation standards.

- If a care provider has opted out of the Medicare program, the delegate will 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)

We are required by CMS 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 to 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 specific findings and expected time frame to reach compliance.

Referral Authorization Procedure

The delegated medical group/IPA may be responsible to initiate the referral authorization process when a request is made 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 is responsible for verifying eligibility and participating care provider listings on all referral authorization requests, to help 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 must submit the member's request to the delegate's Utilization Management Committee or its designee for a decision. The PCP or treating care provider should include appropriate medical information and referral notes about why the requested service is medically necessary. Information should include results of previous treatment efforts.

- If the request is not approved in whole, the medical group/IPA (or if not delegated, UnitedHealthcare) must issue a denial letter to the member, specific to the requested services, treatment or referral and which complies with the applicable state and federal requirements.

Standing Referral/Extended Referral for Care by a Specialist

The delegated entity is required to have specialty care referral procedures. They need to explain standing and

extended referrals for specialists and specialty care centers. A standing referral is needed 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, limit of time authorized and/or require the specialist to provide regular reports to the PCP.

For an extended specialty referral, the PCP and specialist need to determine which health care service each will be in charge of. Primary care should always be handled by the PCP. The PCP needs to 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 the expertise of an HIV/AIDS specialist. 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 there are no such care providers within the medical group/IPA, then 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 1376.16**.

Referral and/or Authorization Forms
The delegate may design its own request for referral and/or authorization forms, without our approval. When the forms are used to communicate approvals to the member, the font of the form must be at least 12-point. "Times New Roman" is the preferred style. If the referral or authorization form is not at least 12-point font, then the delegate needs to send a written notification that is. For Medicare Advantage members, we provide an approval template letter.

At a minimum, include all of 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 Initiated 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 responsible for 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 are responsible for the timely processing of all pre-service organization determination requests, including requests received by the delegate but are the responsibility of UnitedHealthcare. 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 the responsibility of UnitedHealthcare. 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. The request may have happened before the date and time the request reached the department that processes referrals and authorizations.
- 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. This should be done at least annually. Based on the data collected, the medical group/IPA must work with those 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 will 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 is also responsible for gauging members' experiences at least annually. This includes a member survey. Based on the survey results, the medical group/IPA identifies areas for improvement and implements 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, consult with us to determine if an authorization is required.

Clinical Delegation Oversight

We are responsible for the performance of delegated activities. We hold our delegates to those same requirements, including the requirements outlined in the Provider Administrative Guide, which is an extension of your contract with UnitedHealthcare. We perform clinical assessments of those activities prior to the approval of delegation to make sure the potential delegate meets those requirements. Once approved and the delegation is implemented, we assess to make sure there is continued compliance. We provide our delegates with the information they need to know 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 initiate an assessment process to confirm the entity's ability to perform those activities. Clinical reviewers request documented processes (programs, policies and procedures, work flows or protocols) and supporting evidence prior to an onsite visit. Supporting evidence may include materials (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 needed to take on delegation. Assessment results and delegation recommendations

are reported to the Delegation Oversight Governance Committee, which makes the decision 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. Subsequent 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 the required score and pass all critical elements, we require improvement action and remediation within 30 calendar days of the written notice of deficiencies, which 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) specifying how and when it will meet the requirements. The clinical reviewer follows up with the delegate at least weekly, working with the delegate to meet expectations. We expect the delegate to put controls into place to measure its adherence to expectations on an ongoing basis. A reassessment is performed at UnitedHealthcare's discretion to document the delegate's progress toward adherence.

If the delegate does not demonstrate adherence by the IAP completion date, we escalate the IAP to engage delegate leadership and within UnitedHealthcare to facilitate remediation. Continued non-adherence may result in the de-delegation process. This section 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 will review nationally recognized evidence-based criteria to determine medical necessity and appropriate level of care for services whenever possible. UnitedHealthcare and delegates will use multiple 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 criteria hierarchy appropriate to the benefit plan:

Commercial
1. Eligibility and benefits (Evidence of Coverage)

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. Plan eligibility and coverage (Plan Benefit Package or PBP)

2. CMS criteria

   a. National Coverage Determination (NCD)

   b. Local Coverage Determination (LCD) used only for the area specified in the LCD

   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, distribute a statement to all members, physicians and health care providers and employees who make utilization management (UM) decisions affirming the following:

- UM decision-making is based only on appropriateness of care and service, and existence of coverage

- Practitioners or other individuals are not specifically 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 will reimburse for the denied services. Medical directors are available to discuss their decisions and our criteria with you. Medical policies and guidelines are also available 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 care providers to use the most current service codes (i.e., ICD-10-CM, UB and CPT codes). We also require the care provider ensures the documented bill type is appropriate for the type of service provided.

Care Provider Responsibilities for Participation in Medical Management

Care providers are required to participate, cooperate and comply with our Medical Management policies. All care providers 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 established 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 retain responsibility 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 a prior authorization has not been requested, you must submit the request for prior authorization 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 will 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 timeframe, we may deny payment.

The delegated medical group/IPA sets its own policies regarding the responsibilities of care providers.

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 timeframes and conditions vary according to state regulations. In general, continuity of care is available to:

- New members who are experiencing an acute episode of care while making the transition to UnitedHealthcare; and

- Existing members who are experiencing an acute episode of care when:

  › A care provider participating with UnitedHealthcare terminates its Agreement; or

  › 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.

Typically, a condition that warrants a request for continuity of care requires prompt medical attention and is of short duration. 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, payment for services performed by a non-network care provider is the member's responsibility.

We (or the medical group/IPA delegated for continuity of care) review all requests for continuity of care on a case-by-case basis. Reasonable consideration must be given to 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, including, but not limited to: credentialing, facility privileging, utilization review, peer review and quality assurance requirements.

- Agrees, in writing, to compensation rates and methods of payment similar to those used by us 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 which 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. Incomplete or incorrect forms, or submissions with incomplete medical records are not accepted. 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 the required regulatory timeframes. 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 have an opportunity to speak with a medical director to discuss the case.

- The authorized care provider delivers care to the member. They 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 provider for a delegated medical group/IPA, then you must 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

The facility must 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/day, seven days/week at:

Phone: 800-799-5252

Fax: 800-274-0569

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 with 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 30 miles or less from medical group/IPA site

based on the shortest route using public streets and highways for Commercial members, and based on CMS Health Service Delivery (HSD) tables from the member's residence for Medicare members.Refer to your Agreement for your specific service area definition, as well as 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 those emergency or urgently needed services to treat an unforeseen illness or injury while a member is outside of the medical group/IPA's contracted service area. These OOA services would have been the financial responsibility of the medical group/IPA if they had been provided within the medical group/IPA service area.

- UnitedHealthcare retains the ultimate accountability for the management of OOA cases, unless otherwise contractually defined. Refer to the Division of Financial Responsibility (DOFR) section of your Agreement to determine risk (financial accountability) for OOA medical services.

- Medical services provided outside of the delegated medical group/IPA defined service area that are arranged and/or authorized or could be anticipated by the member's medical group/IPA are the delegate's responsibility, and 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, it remains the responsibility of the delegated medical group/IPA to perform 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 found at the time of the consult evaluation to require medically necessary inpatient care will be the responsibility of the referring medical group/IPA and will not meet the criteria of an OOA case.

- The delegated medical group/IPA remains responsible to issue appropriate denials for member-initiated non-urgent, non-emergency medical services provided outside of 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 1st business day after receiving member notification of an OOA admission, procedure and/or treatment.

- Failure to notify us within this timeframe 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 out-of-area 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 obtain any required authorization

  › Determines the appropriate level of care or facility for the member's care and obtain 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 work actively and collaboratively with us 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 network care provider by making sure the following process occurs in a timely fashion:

  › If the medical group/IPA delays the transfer of a member considered medically stable for transfer, we may hold the medical group/IPA financially responsible for any additional out-of-area charges incurred in 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 will not be considered as out-of-area services and will be 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 out-of-area medical service unless contractually defined. It is the responsibility of the medical group/IPA.

Injectable Medication Utilized in a Patient's Home
In all cases, 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 is responsible for authorizing and paying for all injectable medications; whether self-injected or given with the aid of a health professional in the home.

Trauma Services
Trauma services are defined as 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 care and 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 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 via:

- **Phone:** 866-300-7736

- **Fax:** 888-361-0502

The transplant case manager works with the member's transplant team, PCP, and other clinicians to complete an assessment of the member's healthcare needs, develop, implement and monitor a care plan, coordinate services and re-evaluate the care plan for the member.

- All care providers must 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 is responsible for the authorization and management for all transplant-related care and services. This includes the evaluation, transplant procedure, and through one year post-transplant, unless dictated by the member's benefit or federal/state law.

- Optum is responsible for 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 is responsible for 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) remain the responsibility of the delegated medical group/IPA. 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 at our sole discretion, 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, authorized for:

- VAD/MCSD and admitted 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 will provide 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, 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 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 regarding the diagnosis or continuance of the treatment; or

• The member has attempted to follow the treatment plan or has 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 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 will notify the member in writing and provide 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 will be financially responsible for the cost of the opinion.

When the PCP is not affiliated with any participating medical group/IPA, but is instead 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 will document the second medical opinion in a consultation report, which they will make available to the member and the treating participating provider. The second opinion care provider will include in the report 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 the recommendation is medically necessary, then the delegate or UnitedHealthcare will 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 is a covered service. 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 will consider authorizing 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 providers. The delegate sends to UnitedHealthcare all requests for second and third opinions from providers not participating in the delegate's network.

• If the healthcare professional is participating with the member's assigned medical group/IPA, the medical group/IPA is responsible for authorization for the second opinion consultation. The medical group/IPA is also responsible to pay claims if it is delegated for claims.

• If approved, we are responsible for claims payment of the second opinion consultation by the non-participating health care professional.

• 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 will notify the member in writing and provide 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 there is an imminent and serious threat to the member's health, 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 lack of timeliness 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. Call us at 877-842-3210 for a clinical coverage review.

> **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 currently 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 groups (medical group/IPA) fails to obtain this review and receive prior authorization from us prior to the start of IMRT services 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 utilizing 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 will communicate with the medical group/IPA regarding the decision once they receive all the necessary and/or requested information. They make a decision within the applicable timeframe.

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?** Additional information and requirements can be found on:
> 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. You may want to 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 the 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 receive all the information requested and make a determination we will communicate the decision to you within the correct timeframe. We will not make a decision on a request that is incomplete or requires additional information.

We make authorizations following benefit design, provided the member does not exceed benefit restrictions (applied to the requested agent(s)/therapeutic class, and the prior authorization process).

We will fax a written communication of case resolution to you. For denials, we send a letter to the member and care provider stating why the requested medication is denied. 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, then this policy will apply to those medications listed in your Agreement.

UnitedHealthcare has a "prior authorization" process in place to provide for review of 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 to the medical group/IPA. If the medical group/IPA does not get this review and receive prior authorization from us prior to administration of these drugs we will deny reimbursement for the drug. This policy does not apply to bevacizumab (Avastin) used for non-oncological indications.

Prescription Drug Appeals Process
Care providers should be aware that members may initiate an appeal for coverage of a prescription drug if the initial determination is adverse to the member. An appeal may be initiated 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, or
- 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, you must 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, separate notification is required immediately when a newborn is admitted to the NICU.

The delegate must have a clearly defined process with the facility whereby the facility information on all admissions, updates in member status, and discharge dates are provided to the medical group/IPA and UnitedHealthcare daily.

UnitedHealthcare and the medical group/IPA require timely notification of admission to give us adequate time to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning.

For emergency admissions, you must 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)
You must 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** or by fax at 866-383-1740.

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 include all cases worked between the previous submission and current submission:

- Cases generated upon admission;
- Length of stay changes/extensions;
- Discharged cases; and
- Completed outpatient prior authorization cases.
  › 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 type for the applicable reporting time.

Logs must include:
- Member ID
- Member name
- Member date of birth
- Requesting care provider (name and address, with TIN if available or NPI)
- Attending/servicing care provider (name and address, with TIN if available or NPI)

- Facility care provider (name and address, with TIN if available or NPI)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Actual admission date
- Actual discharge date
- Service start date
- Service end date
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Planned admission date
- Planned discharge date
- Service type
- Authorization number (if available)

The medical group/IPA must have a clearly defined process for determining medical necessity and authorizing outpatient services, which were 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
- Out of 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.

If UnitedHealthcare or the delegated entity does not respond within one hour, care is considered authorized until:

- Member is discharged,
- A network care provider assumes responsibility for the member's care either at the treating facility or through transfer, or
- Treating care provider and the organization, defined as the plan or its delegate, agree to another arrangement.

Based on the Agreement, the delegate is financially responsible for:

- ER and post-stabilization services in area, and
- OOA services if responsible for OOA per the Agreement.

Medical Observation

Typically, observation status is used to rule 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, when:

1. It receives notification of the admission;
2. It receives a post-service request for admission authorization prior to claims submission and 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; or,

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 level of care 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 level of care within the same facility
- Delay in facility discharge

The delegated medical group/IPA must comply with our protocols, policies and procedures for denials, including turn-around times for issuing, delivering and submitting facility denial letters to UnitedHealthcare.

When UnitedHealthcare has the responsibility to pay 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, facility disputes will be managed by the UnitedHealthcare Provider Dispute Resolution process.

If the delegated medical group/IPA has the responsibility for payment of 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 level of care and/or services. Under these circumstances, any care provider facility disputes are managed by the delegated medical group/IPA's care provider dispute resolution process.

A facility denial letter is available if requested by the member.

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, Local Coverage Decision and UnitedHealthcare medical policies and guidelines to determine eligibility of coverage. Authorization is required prior to the start of therapy and each time a patient 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. Once we receive all the necessary information requested, we make a decision within the applicable timeframe.

Note: For Medicare Advantage plans, the timeframe to review and render a decision begins upon receipt of the initial request.

We authorize therapeutic radiation services following the member's benefit design provided the member does not exceed their benefit restrictions.

eviCore is our nationally contracted vendor for utilization management to administer the prior authorization program for Therapeutic Radiation Services (IMRT, SRS and SBRT). eviCore uses the NCDs, LCDs and the UnitedHealthcare Medicare Advantage Coverage Summaries for managing the program.

We will fax a written communication of case resolution to the medical group/IPA for each case serviced. Denials require a letter sent to both member and care provider stating the reason why the requested service denied and outlining 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 outlined 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 on-boarding process, training after on-boarding, 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
There are 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 will provide 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 service(s)

- 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 of 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
In February 2017, CMS published a memo, "Updated Guidance on Outreach for Information to Support Coverage Decisions," relating to the job aid about "What's 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 US 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 forth standards for including non-discrimination notices on significant communications sent to health plan members. This includes, but is not limited to member facing letters (example: 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 is required to 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 federal regulatory requirements.

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 federal regulatory requirements.

Complete Claims Requirements

Care providers submit a clean claim by providing the required data elements, along with any attachments and additional elements, or revisions to data elements, of which the care provider 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 level of care are appropriate;
- Eligibility was verified;
- Follow-up for utilization, quality and risk issues was needed and initiated;
- Billing is correct; and
- 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; and
- Claims with level of service (LOS) or level of care (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; and

Medical group/IPA monitors appeals and overturn rates for emergency department claims, and develops and executes 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.

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 will be required to provide a remediation plan describing how the deficiencies will be corrected. The remediation plan should include a timeframe the deficiencies will be corrected. Delegated

entities who do not correct deficiencies may be subject to additional oversight, sanction and potential de-delegation.

If the delegated entity is non-compliant, we will require them to develop an Improvement Action Plan (IAP) to correct any deficiency, such as:

- 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 timeframe we give to 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. We conduct frequent reviews during the cure period. We may sanction delegated entities who do not achieve compliance within the established cure period. Sanctions may consist of additional/enhanced assessments, onsite claims management, revocation of delegated status, and/or enrollment freeze. Sanctions may result in costs to the delegated entity.

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 state regulatory standards.

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 to a member. Send the denial letter within the appropriate regulatory timeframes.

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.

The delegated entity remains responsible to issue appropriate denials for member-initiated, non-urgent/emergent medical services outside of 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. The care provider 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, EOB, 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 member of their right to dispute the decision or discuss it with a care provider reviewer.

Time Limits for Filing Claims

All care providers need to submit clean claims per the timeframe listed in their Agreement or per applicable laws. We, or our capitated provider, will allow at least 90 days for participating providers and 180 days for non-participating providers from the date of service to submit claims. If we, or our capitated provider,are not the primary payer, we will 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 timeframes outlined above, 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 defined as 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

Refer to the official CMS 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 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:

(A) For outpatient services and all emergency services and care: the date the provider delivered separately billable health care services to the member.

(B) 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 federal regulations. We send the care provider of service a notice that we have 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 (either manually or systematically). Tracking must include:

1. The name of the entity of where the claim was sent, and

2. The date mailed.

The delegated entity must then immediately forward the claims to the appropriate payer, and follow state and federal regulatory timeframes. If they determine the member was assigned to another medical group/IPA on the date of service, the care provider should forward the claim to the appropriate delegated entity following state and federal regulatory timeframes for processing.

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.

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 of 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 are required automatically to pay applicable interest on claims according to state and 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.

ERISA Claims Processing
For claims falling under the Department of Labor's ERISA regulations, you must make a decision to pay or 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 and 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 is responsible to pay the claim and submit it to UnitedHealthcare per this process 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, but are not limited to, 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 in accordance with the agreed upon contract rates and within applicable federal regulatory requirements. Claims are to be adjudicated within 60 calendar days of receipt.

MA non-contracted care provider claims should be reimbursed in accordance with the current established locality-specific Medicare Physician Fee Schedule, DRG,

APC, and other applicable pricing published in the Federal Register. Non-contracted, clean claims must be adjudicated within 30 calendar days of receipt. Non-clean claims are to be adjudicated within 60 calendar days of receipt.

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. Information on this requirement is found on **CMS.gov**.

Claims Disputes and Appeals

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 federal regulations must:

- Provide a clear, accurate, written explanation
- Be issued within 365 calendar days from the last date of payment for the claim
- 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 Payment Dispute Resolution (PDR) process for any decision where they contend the amount paid by the organization, (in this instance the delegated entity), for a covered service is less than the amount which would have been paid under Original Medicare. This 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 a Medicare 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; and
  - › 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 days from the date the PDR claim is received;

- 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, 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;

- Ensure the care provider Remittance Advice (PRA) or Explanation of Payment (EOP), and Uphold PDR Determination Letter contains appropriate information and meets requirements;

- Include information on how to contract the organization in notices of upheld or overturned payment disputes if the non-contracted care provider has additional questions;

- Include information in the notices of upheld or overturned payment disputes on how to contract the organization if the non-contracted care provider has additional questions;

- If the root-cause of overturned PDRs is system-related, a process in place to update their claims system, if needed, so future claims will reimburse appropriately;

- Process in place to identify trends that contract year for any non-contracted care provider who submitted a payment dispute to help ensure they may be paid correctly;

- Ongoing training program in place for any piece of the internal claim PDR process to include educating all areas of the organization, such as customer service, claims, appeals;

- Consistent monitoring of internal compliance to help ensure CMS requirements are met; and

- End-to-end quality review process, from the time a dispute is received from the non-contracted care provider to the time when 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 has filed an appeal and you have 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: Utilize the most updated Medicare Advantage and Commercial Monthly Timeliness Report (MTR) you received from the Claims Delegation Oversight Department. The MTR forms are similar to the Industry Collaboration Efforts (ICE) versions that is based in California.

The most current forms must be used at all times. This applies to both Commercial and Medicare Advantage products.

All Delegated Entities must upload their Medicare Advantage CMS Universe Reports (Claims, DMRs and Dismissals) and MTR forms to the **ECG Connect Portal**.

Monthly MTR forms must be uploaded to the ECG Connect Portal by the 15th of each month and Medicare Advantage CMS Universes must be uploaded to the ECG Connect Portal by the 10th of each month.

CA: In accordance with 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, prepared in accordance with generally accepted accounting principles within 45 calendar days of the end of each calendar quarter.

Copies of assessed annual financial statements together with copies of all auditors' letters to management in connection with such reviewed annual financial statements submissions are due within 150 calendar days of the end of each fiscal year. If the quarterly/annual financial statement submissions include deficiencies in financial solvency grading criteria defined by state regulations, a self-initiated Improvement Action Plan (IAP) proposal shall be submitted 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, quarterly progress reports need submission to UnitedHealthcare within 45 calendar days of the end of each subsequent reporting period until compliance with all financial grading criteria achievement.

The Delegated Entity must submit financial statements and IAPs via email to UnitedHealthcare at **financialstatementsubmission@uhc.com**.

Both UnitedHealthcare and the delegated entity are responsible to provide compliance oversight of the Delegated Entities 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 healthcare services, including a 24/7 telephonic triage or screening requirement. Health plans are required to 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 claim(s) to the appropriate entity that holds financial responsibility to process each claim.

UnitedHealthcare will research the issue to identify who holds financial risk of the services and will abide by federal and state legislation on appropriate timelines for resolution. We will 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 and adjudicate claims or approve or deny referrals for service shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted care provider disputes in accordance with 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 is accountable for submitting all required information to us and the appropriate state agency in accordance with the guidelines established by state and federal regulations. All delegated claims processing entities are required to report PDR processing compliance results quarterly in accordance with state and federal regulations. Submission of quarterly reports, are due 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 reviewing. 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 found to be non-compliant with UnitedHealthcare state or federal requirements, we expect the delegated entities to develop an improvement action plan designed to bring them back into compliance.

We sanction care providers who do not achieve compliance within the established timeframes until they reach compliance. PDR processing is a delegated function that is 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 a care provider continues to have a commercial claims dispute with the delegated entity related to medical necessity and utilization management, the care provider must forward all claim information and correspondence between the delegated entity and the care provider to UnitedHealthcare for review. We do not begin the review until we receive the supporting documentation.

Commercial care provider claims must be processed in accordance with the 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 timeframes 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 that they are required to comply with certain laws applicable to entities and individuals 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; and
- 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 will be 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

In the following instances, when a member needs one of the following forms, for 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; and
- Member cannot pay office visit copayment at the time of visit, for basic healthcare services. In this instance, 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; or
- Nurse practitioner.

Do not collect copayments when there is no actual office visit. For example:

- Injections administered by a nurse or medical assistant; or
- 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 in monitoring the member's individual out-of-pocket/deductible maximum. For additional information on the reporting available from UnitedHealthcare, see *Chapter 10: Compensation* of this guide. When a member meets their annual individual out-of-pocket/deductible maximum, UnitedHealthcare will notify the member's capitated care provider in writing that the member has met their annual individual out-of-pocket/deductible maximum. Capitated care providers are responsible for updating their claims systems within two business days of receiving the notification from UnitedHealthcare that a member has met their maximum out of pocket. They must help ensure members are not charged for copayments or coinsurance/deductibles once the annual maximum out-of-pocket expense 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 will be required to:

- 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 to the member any cost share amounts collected in excess of the member's annual individual out-of-pocket and deductible maximums
- Verify the member has received all appropriate reimbursements

UnitedHealthcare will monitor the capitated care provider's compliance with this annual individual out-of-pocket deductible maximum policy to help ensure all requests for claims reprocessing and member reimbursement are completed timely.

If necessary, we will 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 via 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**.

- 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

- We notify capitated care providers and members when members meet their annual out-of-pocket copayment/ deductible maximums. Delegated entities can view members who have met the annual copayment/ deductible maximum on the EL917.

- The EL918 report is a daily Member Cost Share report that shows the cost share information for all active members belonging to a care provider. This report is available in both CSV and data formats.

- Delegated entities are responsible for updating their systems within two business days of receiving the notification from UnitedHealthcare that a member has met their maximum out of pocket. 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 and

  › 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 co-payments, 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 and

  › Five business days on standard issues.

- When UnitedHealth care 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, and

  › 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 than weekly (e.g., twice a week, or daily). Frequent encounter submissions, allows us to support various state and federal regulatory requirement 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 monthly. As you are processing claims on our behalf, we expect all encounter submissions to be an accurate reflection of the original claim received without exception. 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 risk adjustment reporting, Essential Health Benefits (EHB), and with 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; and

• Report member out-of-pocket maximums.

We require capitated medical group/IPAs and capitated facilities to submit timely and compliant encounter data. The member cost share amount should be included on the encounter data submissions and 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 of submissions for risk adjustment. 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.

The Encounter Data Collection Team is your point of contact for additional questions 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 their MA claims and encounters in the same manner as their Medicare fee-for-service bills, and 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 submitted by you. 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 are able to make our submission 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.

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 which is based on the member's benefit plan, 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 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 be required 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 Standard 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 file(s) from a zipped file format.

- **All** —Download image reports and flat file(s) 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, you need to 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, 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 via ASM, you will first need to contact the Optum ASM Operations team at **cas_ops@ingenix.com** to start the onboarding process.

Provider reports can be accessed 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 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 purposes of capitation payments, we add members on the first day of the month, or terminated on the last day of the month, with the exception of newborns who 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.

Capitation payments are delivered via check or electronic funds transfer on the date listed in the Agreement. If the due date falls on a non-banking day, the capitation payment is delivered the next banking day.

Electronic Funds Transfer (EFT)

To receive capitation payments via EFT, we require a signed EFT Payments form, detailing the bank account and bank routing information. It takes three weeks for the EFT initial set-up, or a change in banking information, to take effect.

We deposit capitation payments via 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 electronic funds transfers.

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, there are 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 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: (1) flat base rate; (2) age/gender factor; and (3) benefit factor.

• Flat base rate detailed in the Agreement;

• 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;

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 above under 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, there are 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 — is detailed in the Agreement

2. Risk Adjusted Factor (RAF) — the score for each Medicare Advantage plan member taken directly from the Monthly Membership Report (MMR) provided by CMS. 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 and 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 Physician Advocate with specific information for that member so 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 reported by CMS 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 SCC is updated by the CMS system, 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 3-tier approach: (1) dialysis status, (2) receiving a transplant, and (3) 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 aid the medical group/IPA with identifying their ESRD patient who is our member. The risk-adjusted factor type code is not reported on the image reports. Additional information on the Risk-Adjusted ESRD model, go to the CMS website.

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 determined by CMS. 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). You can find specifics on the CMS Working Aged Program on the CMS website.

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 by CMS 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 healthcare professionals and impacts care provider, facility, ancillary care provider and other healthcare 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 will reflect the premium received from CMS and 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 will 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, foot 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 (1) the amount from the core transaction processing system, plus (2) 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 code 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 will 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, they are typically reversed 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 (1) core transaction processing system (NICE) or (2) 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 timeframe 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. The Premium capitation calculation methodology is applicable. 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, taking into account 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.

Performance Domains

Performance measurement supports practice improvement and provides delegates with access to information regarding how their group compares to peers benchmarks for specific measures. This information provides a starting point for an ongoing dialog regarding how we may best support your efforts in providing high quality, cost-effective care to our members.

Delegate performance domains include, but are not limited to, these areas:

- 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 peers benchmarks, and communicated to the delegate in the form of 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 timeframes may require continued oversight until they achieve compliance.

Continued non-compliance or failure to perform may result in removing the delegate from the service(s).

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. Timeframes 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 and 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 health of the member, 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 which in turn 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 complaints by care provider 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 timeframe. For expedited appeals, care providers must submit the requested within two hours. For standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Timeframes 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 including 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. Care providers must 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). Timeframes 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 timeframes on reversals of adverse determinations. Care providers must 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). Timeframes 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 to 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, MI, PR, 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, 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 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 **Fax:** 855-307-8531 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.-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

Resources	Where to Go		What you can do there
Claims	**Online:**	UHCprovider.com/claims	• Submit or review claims, encounters, inquiries, status, or review requests
	Phone:	800-348-5548	• Check claims, eligibility, benefits
		Monday through Friday, 8 a.m. to 5 p.m. ET	
	Fax:	866-725-9337	
Claims (WellMed)	**Online:**	eprg.wellmed.net	• Use payer ID #WELM2.
	Phone:	800-550-7691	
	Mail:	WellMed Claims P.O. Box 400066 San Antonio, TX 78229	
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	• Ask questions related to overpayments
	Online:	Connect.werally.com	
Chiropractic, Physical Therapy, Occupational Therapy and Speech Therapy Providers	**Phone:**	877-670-8432 Monday through Friday, 9 a.m. to 5 p.m.	• Access list of participating Physical Therapist providers in our directory
	Fax:	888-659-0619	
	Email:	pcp-NetworkManagementServices@ uhcsouthflorida.com	
Credentialing	**Phone:**	800-963-6495 Monday through Friday, 9 a.m. to 5 p.m.	• Update or complete credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility
	Fax:	866-567-0144	
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	• Information and registration for electronic payment services
	Online:	changehealthcare.com	
Fraud, Waste, and Abuse (FWA) Hotline	**Online:**	medicaplans.com	• Report concerns related to fraud, waste or abuse
	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	
Grievances & Appeals	**Phone:**	Call the provider number listed on the back of the member's identification card.	• Obtain information about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms
	Mail:	Medica Healthcare Grievances & Appeals Department P.O. Box 30997 Salt Lake City, UT 84130	

Resources	Where to Go		What you can do there
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:** **TTY:** **Fax:**	800-407-9069 Everyday, 8 a.m. to 8 p.m. ET 711 800-517-6924	• Assist our members with any questions, help locate specialists, and perform other related functions • Also printed on the member's Plan ID card
Network Management Services—Medica Provider Relations and Contracting	**Phone:** **Fax:** **Email:**	877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. 888-659-0619 **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:** **Fax:**	800-711-4555 800-527-0531	• Verify pharmacy benefits and eligibility, adjudications, or authorizations
Risk Management	**Phone:**	952-406-4806	• 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 them to their primary care physician
United Behavioral Health	**Online:** **Phone:**	**providerexpress.com** Licensed clinicians available 24 hours. Member Services – 24 hours. 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:** **Phone:**	**SolsticeBenefits.com** 855-351-8163	• Access a list of Solstice dental providers in the provider directory
Fitness (Renew Active)	**Online:** **Phone:**	**Medica.myrenewactive.com** 800-407-9069	
Hearing (Hear-X/HearUSA)	**Phone:**	877-670-8432 Monday through Friday, 9 a.m. to 5 p.m.	
Laboratory LabCorp	**Online:** **Phone:** **Phone:**	**labcorp.com** 855-277-8669 Automated Line 800-877-7831 Live Scheduling	• Find information on locations, to make an appointment, and to order lab tests and view results
QUEST	**Online:** **Phone:**	**Questdiagnostics.com/home/ patients.html** 866-697-8378	
Mail Order Pharmacy (OptumRx)	**Online:** **Phone:**	**optumrx.com** 877-889-6358	• Obtain mail-order medications

Resources	Where to Go		What you can do there
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, 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 952-406-4806.

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 healthcare 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 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 that 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 needed for referrals to specialists.

• Submit all requests for referrals through our online provider portal on **UHCprovider.com/referral**.

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* Contact Network Management Services for a complete list of specialty types that need referrals.

- 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.

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: Do not request an expedited (72 hours) review unless it is determined that 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:

- 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.
- **Fax:** For manual prior authorizations, the requesting care provider must complete and sign the Prior Authorization Form, and fax it to 855-307-8531.

Required Information for Prior Authorization Prior authorizations must have:
- 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.

Timeframes 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 of the 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 provider, you must return calls from our UM staff or Medical Director. You must provide complete clinical information as required within the timeframe 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 utilized 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) utilize 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 based clinical 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 timeframes, 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 healthcare 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 is 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 the filing deadlines and the address to use to submit the appeal. In the event a member designates a healthcare 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 the 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 healthcare 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 regulation 45 CFR § 164.512 (d) allows 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 healthcare 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 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, provider organizations and facility management.

An adverse event is defined as an event over which healthcare 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 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 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 healthcare 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 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 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 on 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 authorizations 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**.
- **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 United Healthcare 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 via 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 has been 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.

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 has been 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 the 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**.

Prior authorization requests may be submitted online at **UHCprovider.com/paan** or via phone. Please include clinical notes and the name of the specialty pharmacy vendor. We will call you within three business days if conditions aren't met for prior authorization of the drug. If authorized, Pharmacy Services provides a written authorization number and coverage dates.

This authorization must be submitted to the specialty pharmacy vendor along with the medication order.

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. Any 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

This 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** • Medical policies, medical benefit drug policies and coverage determination guidelines • Provider news and updates, such as the Medical Policy Update Bulletins **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 Standard Preservice Appeals	**Urgent Appeals Fax** Medical: 801-994-1083 Pharmacy: 801-994-1058 **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:** 866-889-8054
Chemotherapy (outpatient injectable)	**Online: UHCprovider.com/oncology** **Phone:** 866-889-8054
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** Roche Insulin Delivery Systems: 800-280-7801 **accu-check.com**
Intensity Modulated Radiation Therapy (IMRT)	**Online: UHCprovider.com/oncology** > Commercial Intensity Modulated Radiation Therapy Program **Phone:** 877-842-3210 **Fax:** 866-756-9733

Resource	Where to go	
Medical Supply Providers (Disposable supplies, ostomy, urological, incontinence supplies)	Byram Medical: 877-902-9726 Edgepark Medical: 888-394-5375 Liberty Medical: 800-615-0714 Medline: 800-633-5463 McKesson: 855-404-6727	**byramhealthcare.com** **edgepark.com** **libertymedical.com** **medline.com** **mckesson.com**/providers/home-care/mckesson-patient-care-solutions/
Mental Health Services Prior Authorization Optum Behavioral Health	**Phone:** 800-817-4705	
Pharmacy (OptumRx)	**Online: professionals.optumrx.com** > Prior Authorizations **Prior Authorization:** 800-711-4555 **Specialty Pharmacy Customer Service:** 888-739-5820 **Fax:** 800-837-0959	
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:** 786-300-4331 **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 "drop off" of drawn specimens at 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 that the services 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 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.

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* 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 a 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 a 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.

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 of **UHCprovider.com/priorauth/oncology**.

Pharmacy Drug PA Requests
OptumRx
Phone: 800-711-4555

OptumRx Fax
(non-specialty meds): 800-527-0531

OptumRx Fax
(specialty meds): 800-853-3844

NHP Medical Drug PA Requests
Online: 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

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* 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.

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, Appeals Process and Resolving Disputes* 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".

OneNet health care providers are physicians, health care practitioners, hospitals and facilities whose Agreement with UnitedHealthcare includes participation in the Workers' Compensation network offered by 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 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.

The OneNet PPO Workers' Compensation Network is the only OneNet network product currently accessed. Access to the OneNet PPO Workers' Compensation Network is limited to employers and administrators contracted with Procura Management, Inc. (Procura), an Optum Company.

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. 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 appropriate chapter in the main guide.

Terms Used in the OneNet Supplement

OneNet Client: OneNet Clients include insurance carriers, third-party administrators (TPA) and others. OneNet Clients may be a OneNet Payer or any entity that provides administrative services to a OneNet Payer (e.g., a TPA).

OneNet Customer, Primary Participant or Participant: A OneNet Customer is 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 supplement. OneNet Customers, Primary Participants or Participants include the qualifying injured worker, subscriber, employee, insured, policyholder or other person who through their direct or indirect Agreement with OneNet is eligible to access network health care providers.

OneNet Payer: A OneNet Payer is a person or entity obligated to pay for services rendered by a OneNet participating health care provider to a OneNet Customer. OneNet Payers may include insurance carriers, workers' compensation carriers, self-funded health plans and others. OneNet Payers may use the services of a TPA or other entity to provide administrative services, including verifying eligibility and adjudicating and issuing claims payment on behalf of OneNet Payers. References in the health care provider Agreement to "participating entity" or "Payer" also apply to OneNet Payers. Neither OneNet, Procura, nor UnitedHealthcare and its affiliates are OneNet Payers.

Claim Pricing or Repricing: The process of applying the OneNet contracted rates to claims submitted by participating health care providers to OneNet or to third party payers or other entities who have contractually based authority to access OneNet networks for themselves or their clients. This process includes 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 pricing" and "repricing" are used interchangeably.

About OneNet PPO

This is a network of physicians, health care practitioners, hospitals and ancillary facilities used for work-related illness and injury. It serves workers' compensation programs administered by employers and TPAs contracted with Procura, an Optum Company.

Procura's clients are responsible for the administration of workers' compensation programs accessing the OneNet PPO Workers' Compensation Network. These responsibilities include determining claim eligibility, providing explanation of benefit (EOB) statements or remittance advice, and paying claims.

How to Contact OneNet PPO

Resource	Where to go
Customer Care	For OneNet PPO Workers' Compensation Network inquiries, contact Procura: **Phone:** 877-461-3750 **Fax:** 484-804-6034 **Email: proppo@procura-inc.com** The Procura name appears on the EOB/remittance advice of Procura clients.
Website:	OneNet workers' compensation claim pricing sheets for Procura are available on **UHCprovider.com** > Link > United Healthcare OneNet PPO pricing.
Claim Submission	**Workers' Compensation Claims** Submit workers' compensation claims to the injured workers' employer, workers' compensation carrier or third-party administrator (TPA). Do not submit workers' compensation claims directly to OneNet or to Procura.
Claim Pricing Appeals	Send pricing appeals for OneNet PPO Workers' Compensation claims to: **Email: proppo@procura-inc.com** **Phone:** 877-461-3750
Claim Payment Appeals	Direct Procura workers' compensation payment appeals to: **Email: proppo@procura-inc.com** **Note: OneNet and Procura are not payers and are not the entities responsible for claims payment.**
Questions About Your UnitedHealthcare Contract	Please contact your UnitedHealthcare Provider Representative.
OneNet Information and Updates	**UHCprovider.com/news**

OneNet General Provider Administrative Requirements

OneNet care providers follow *Chapter 2: Provider Responsibilities and Standards* described in the UnitedHealthcare guide 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 Workers' Compensation 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.

Participant Eligibility

Contact the injured worker's employer or workers' compensation carrier or administrator to verify acceptance of workers' compensation injury for purposes of coverage. ID cards are not usually issued or used for workers' compensation programs. Injured workers accessing you through the OneNet PPO Workers' Compensation Network will not present an ID card. Workers' compensation insurers, administrators and employers of the injured worker 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 injured worker's employer, carrier or administrator is contracted with Procura to provide workers' compensation network access.

Online Services on UHCprovider.com

View workers' compensation claim pricing sheets by using the UHCprovider.com > **Link** > United Healthcare OneNet PPO Pricing tool. Pricing sheets show the allowed amount of your claims after the application of OneNet claim pricing. Pricing sheets do not show the final claim adjudication by the payer. It may include billed charges that are non-payable. The workers' compensation EOB or remittance advice shows these charges.

Because workers' compensation 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 utilize 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 Workers' Compensation Network. Do not use the Referral Submission system online. However, in some states, the injured worker may be required to use certain care providers to receive workers' compensation benefits. Please contact the injured workers' case manager or 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 may not receive workers' compensation benefits unless an authorized care provider is used. Please contact the injured worker's case manager or adjuster to determine where to refer the injured worker for authorized care.

Laboratory Services

UnitedHealthcare's requirement that participating laboratory providers must be used does not apply. The injured worker may not receive workers' compensation benefits unless an authorized laboratory is used. Please contact the injured worker's case manager or adjuster for guidance. Use your best efforts to refer to a laboratory based on the information provided. The OneNet PPO Workers' Compensation 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 network does not include a pharmacy network. Contact the insured worker's case manager or adjuster to determine where to refer the injured worker 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 Workers' Compensation Network. Please contact the injured worker's case manager or adjuster for the name of a specialty pharmacy provider, as the injured worker may be required to use certain care providers to receive benefits.

Behavioral Health Services

If you believe an injured worker would benefit from mental health/substance use services due to their job-related injury and based on ODG guidelines and requirements or other evidenced based requirements as defined by each state, contact the injured worker's case manager or adjuster. The network includes behavioral health care providers.

Utilization Review Components for Workers' Compensation

Procura clients may use case management services for injured workers. You are required to comply with the case management programs used by Procura and its clients. Individual states may also have specific regulations related to case management for workers' compensation and injured workers.

Workers' Compensation Claims Process

Claims Submission

All workers' compensation claims, whether submitted electronically or by paper, should be sent directly to the applicable employer, worker's compensation insurance carrier or administrator. Do not submit workers' compensation claims directly to OneNet or Procura, except for pricing appeals.

When submitting workers' compensation claims, it is important to submit complete claims 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.

Claims must be submitted within the time-frame identified in your contract and in accordance with any applicable laws. Failure to submit claims correctly will result in the rejection and return of claims. You will receive a notice from the workers' compensation carrier or administrator in the event your claims are being withheld from claim pricing and payment while compensability is being determined.

If you have questions about submitting claims to us, please call the employer or workers' compensation carrier or administrator.

Complete Claims Requirements

Your workers' compensation claims 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 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 UB-04.

• Bill all outpatient surgeries with the appropriate revenue and CPT codes if reimbursed according to ambulatory surgery groupings.

Submit all claims 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.

Claim Review Procedures

Our claim review procedures identify coding errors and coding irregularities. This helps provide better consistency during our claims pricing.

Tips to Expedite Claim Processing:

• Submit claims 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 claims on original forms, not photocopies.

• Complete all required fields on standard claim 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.

• Sign and date all necessary forms; an electronic signature is acceptable.

Pricing of OneNet PPO Workers' Compensation Claims

OneNet workers' compensation claims pricing includes claim completeness and accuracy review, and application of claim pricing per your contracted rate.

Payment for covered services is the least of:

• The OneNet PPO Workers' Compensation 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.

Workers' Compensation Claims Subject to Claim Edits

For workers' compensation 837P and CMS 1500 (formerly HCFA-1500) claims subject to code edits or line bundling and unbundling, the claim pricing resulting from these edits is allocated back to the original submitted claim lines and codes. Priced claims do not display the lines or codes added or deleted by these claim edits. This is intended to assist physicians and OneNet's workers' compensation clients in claims reconciliation by having priced claims match originally submitted claims.

Allocation of Global Pricing to the Claim Line Level

Certain claims 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 claim.

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 claim-level rate separately.

Claim Inquiries

OneNet may only verify the receipt, pricing and mail date of a claim from participating care providers. Make other claims inquires directly to the applicable employer, workers' compensation insurance carrier or administrator.

The fastest way to check for a claim pricing sheet for a Participant accessing the OneNet PPO Workers' Compensation Network through Procura is through UHCprovider.com > **Link** > United Healthcare OneNet PPO pricing. Pricing sheets show the allowed amount of your claims after the application of OneNet claim pricing. They do not show the final claim adjudication by the payer. They may include charges identified as non-payable, ineligible or the participant's responsibility. The EOB or remit shows these charges.

If you do not have internet access, or if you cannot find the claim information for the Procura client you need on our website, please call 877-461-3750.

Workers' Compensation Claim Payment
OneNet and Procura do not pay claims and do not have an obligation to pay for services rendered by a OneNet provider to an injured worker authorized to access the OneNet PPO Workers' Compensation Network.
The priced claim is sent 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 claim forms or submitting additional information. If OneNet rejects or denies a claim because a health care provider failed to follow policies and procedures, the participant may not be billed.

OneNet Clients are required to adjudicate and pay clean claims within 30 days of claim pricing, or within applicable state or federal guidelines. If the OneNet Client fails to adjudicate and pay a claim within this time period, the care provider may, at their discretion, request the least of the full charges, or applicable state or federal maximums applying to workers' compensation. In these instances, the OneNet Payer will pay the claim 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 claim payment. Exceptions to the right to request full billed charges for failing to offer timely payment is as follows:

- When OneNet notifies the care provider after receipt of the claim but prior to the expiration of the applicable claim payment time limit that the claim is denied, missing required information or is deficient in some way.

- When a OneNet Client notifies the care provider after receipt of the claim but prior to the expiration of the applicable claim payment time limit that the claim is denied, deficient or being held to determine workers' compensation compensability.

The OneNet Client must send you an EOB or remittance advice indicating that the OneNet PPO Network was accessed and showing itemized explanations of reimbursement amounts for 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, and

- Services found to be non-payable

Submit claims with non-payable services to the injured worker's health plan. Do not assume that UnitedHealthcare is the worker's health insurer. You may obtain the patient's medical insurance information by calling their employer or from the worker directly.

Claims Appeals (Post Service)

OneNet claim appeals may not be submitted for reconsideration using the Claim Reconsideration tool on **UHCprovider.com**.

Email direct pricing appeals for Procura claims to **proppo@procura-inc.com**, or call 877-461-3750.

Claim pricing appeals must be submitted within 12 months of the date of the EOB, or within applicable state and federal time frames. Follow the procedure below for payment appeals on OneNet PPO Workers' Compensation claims:

Payment Appeal Procedures

Email your payment appeals to Procura at **proppo@procura-inc.com**.

When resubmitting information, include all applicable documentation, including any additional information requested, with a copy of the claim and EOB.

Overpayments

Direct all questions or refunds of overpayments to the applicable OneNet payer at the phone number listed on the injured worker's EOB or remittance advice.

If you find a claim where you were overpaid or if we inform you of an overpaid claim 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 participant'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 OneNet Payer in writing as to why you do not believe overpayment occurred and why you dispute the refund.

If the OneNet Payer still believes a refund should be provided, the OneNet Payer forwards the information to OneNet for further review. OneNet works with you and the OneNet Payer to resolve the issue.

Claim Pricing Adjustments of $5.00 or Less

We strive to accurately re-price all claims and make adjustments when an incorrectly priced claim results in significant underpayment or overpayment for services.

Claim pricing that results in either an overpayment or underpayment of $5.00 or less is not adjusted.

Resolving Disputes

If you have a concern or complaint about a OneNet Client, please use your best efforts to resolve the issue directly with the client.

If the issue is not resolved to your satisfaction, please follow the resolution processes outlined in *Resolving Disputes - Concern or Complaint* section of the UnitedHealthcare guide.

Compensation

Follow UnitedHealthcare's protocols on compensation for care provided to OneNet Participants with these exceptions:

- In regards for charging members for non-covered services when you know services may not be covered, the injured worker's written consent needs to have a statement that the payer determined services are not compensable for workers' compensation and the injured worker agrees to be responsible for them.

- The workers' compensation carrier or administrator determines compensability.

- The online Claim Estimator available on **UHCprovider.com** may not be used to estimate claims. OneNet claims may not be submitted for real time processing through UHCprovider.com.

- For Hospital Audit Services, OneNet or OneNet Clients may conduct their own audits of hospital claims. 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 Payers must pay the claims first before requesting an audit.

- 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 claims 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.

Medical Records Standards and Requirements

Standards and requirements described in *Chapter 11: Medical Records Standards and Requirements* extend to OneNet and OneNet Clients.

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.

- 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 Network. If you believe a Participant would benefit from mental health/substance use services due to their job-related injury, please contact the workers' compensation case manager or adjuster for guidance. ODG guidelines and requirements or other evidence-based requirements as defined by each state must be followed.

Participant Rights and Responsibilities

Get a copy of current OneNet Workers' Compensation 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 Workers' Compensation Network, if applicable. OneNet does not produce workers' compensation benefit materials for injured workers. We cannot inform OneNet Participants of state laws on advance directives. This is the responsibility of the employer, workers' compensation carrier or administrator.

Participant Appeals, Grievances or Complaints

OneNet participants should 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.

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.

Care providers 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 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.

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 PO 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** • Claim(s) 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** • Claim(s) 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:** evicore.com 24 hours a day Policies: **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index.** **Phone:** 877-PREAUTH / 877-773-2884 (Monday through Friday, 7 a.m. to 7 p.m. ET)
Chemotherapy Prior Authorization Injectable Outpatient Chemotherapy Colony Stimulating Factors , Denosumab	**Online:** UHCprovider.com/priorauth > **Oncology** **Phone:** 877-773-2884 (Monday through Friday, 7 a.m. to 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 & 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:** **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index**.
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/protocols** > UnitedHealthcare's Credentialing & Recredentialing Plan. **Phone:** United Voice Portal at 877-842-3210 **New Jersey only** **Online: State of New Jersey Department of Health** or **CAQH** **Phone:** Provider Services at 800-666-1353 or CAQH Support at 888-599-1771
Electronic Payments & 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
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

Commercial Products	
RESOURCE	**WHERE TO GO**
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:** **UHCprovider.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 information: 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
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

Commercial Products	
RESOURCE	**WHERE TO GO**
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: evicore.com** 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:** 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
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, intensivist 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

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, and 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 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

Participating care providers must have practice policies showing they accept for treatment 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 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 information from you:

- A description of accessibility to your office or facility

- A description of the methods you or your staff uses to communicate with members who have visual or hearing impairments

- A description of 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 a violation of the ADA. 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.

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* 28 CFR Sect. 36.....303(c)
** 28 CFR Sect. 36.....303(b)(1)

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. It is important you 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.

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, the following:

- Quality assurance, such as onsite case management of members, intensivist 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 the member 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.

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 emergency room 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 utilized 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.

- 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 care providers 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, it is your responsibility to 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 which employees are authorized to access such information

- Maintain and secure records, including records which are stored electronically, and make sure 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.

  › Expectant mothers must be advised of the counseling and services offered when results are positive, including 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 the following:

- 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, but 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 that supports 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 the Member Service department 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 the Member Service department 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 the Member Service department 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 the Member Service department 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** > Referrals.

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. Cases of emergency, 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.

Care providers have the option to update their referral fax number or decline the auto-fax notification feature on our website in the My Account section.

Member Self-Referrals

We have a number of programs to improve outcomes for members and help us better manage the use of medical services. Care providers 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, emergency room 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 on OxfordHealth. com > Providers (or Facilities) > Tools and Resources > Medical Information > **Radiology & Radiation Therapy Information** > Radiology & Radiation Therapy

Information > Radiology & Radiation Therapy Information > Oxford's Outpatient Imaging Self-Referral Policy.

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 care providers, 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 Prior Authorization List located on **OxfordHealth.com** > Providers (or Facilities) > **Tools & Resources** > Medical Information > Medical and Administrative Policies > **Services Requiring Prior Authorization**).

- 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 local business hours

Medically Necessary Services

Medically necessary services are services or supplies provided by a hospital, skilled nursing facility, 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 list of services requiring prior authorization is on **OxfordHealth.com** > Providers (or Facilities) > **Tools & Resources** > Medical Information > Medical and Administrative Policies > **Medical and Administrative Policies Index** > Services Requiring Prior Authorization.

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 at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Policy Update Bulletin** (published monthly).

- 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 the care provider before applying prior authorization rules.

eviCore Healthcare Prior Authorizations Online

eviCore Healthcare 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, care providers 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, the care provider's office and the member are notified in writing of the denial. Log into **evicore.com** 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 Healthcare 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, etc.).

- 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 utilize 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. They may obtain required prior authorizations 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, and 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, on **OxfordHealth. com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index**. 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)

• New York Participating Provider Laboratory & Pathology Protocol

Hospital Services, Admissions and Inpatient and Outpatient Procedures

Facilities are responsible for providing admission notification for all of the following types of inpatient admissions:

• Planned/elective admissions for acute care

• Unplanned admissions for acute care (admission notification only)

• Skilled Nursing Facility (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. ETthe 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. Regulations for home nursing visits 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 will 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 prior to discharge).
- Any member who changes level of care. The member must be enrolled and effective with us on the date the service(s) are rendered. But, if CMS or an employer or group retroactively disenrolls the member up to 90 days following the date 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. It is the responsibility of all care providers to deliver letters of non-coverage to the member before discharge. This includes hospitals, acute rehabilitation, skilled nursing facilities, and home care.

We will 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 be deny the day for medical necessity. We will 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 also 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 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 will facilitate certification and management at a contracted facility with a partial hospitalization program. The case manager will continue 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 including:

- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Crisis intervention

We will 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
It is important that you 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 will 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 complete policy at **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Medical & Administrative Policy Index > **New York Participating Provider Laboratory & Pathology Protocol**.

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: **OxfordHealth. com** > Providers > Tools & Resources > Medical Information > **Medical and Administrative Policies** > In-Office Laboratory Testing and Procedures List. 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

A care provider's 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 will reimburse the specimen handling and venipuncture codes per our fee schedule.

Radiology, Cardiology and Radiation Therapy Procedures

Oxford has engaged eviCore healthcare to perform initial reviews of requests for pre-certification.

eviCore healthcare 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 healthcare website. In addition, eviCore established coding and billing guidelines to help ensure appropriate billing of radiation oncology codes.

eviCore healthcare handles all pre-certification requests. To pre-certify a radiology, cardiology or radiation therapy procedure, please contact eviCore healthcare 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 on **OxfordHealth.com** > Providers (or Facilities) > Tools and Resources > Medical Information > Radiology & Radiation Therapy Information > Radiology Procedures Requiring Precertification for eviCore healthcare Arrangement.

- **Online: evicore.com**; or
- **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 healthcare 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

It is the imaging facility's responsibility to 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 healthcare offices are unavailable, you may perform the services, and may 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 healthcare 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.

> To 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 engaged eviCore healthcare 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 healthcare 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 healthcare 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 will 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 will communicate 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 healthcare's hours of operation and rendered on an urgent basis. eviCore will make retrospective review decisions within 30 business days of receiving all necessary information. If your request is not authorized, they will 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 healthcare 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 complete list of procedures requiring precertification through eviCore please visit:

UHCprovider.com >Policies and Protocols > Commercial Policies > **UnitedHealthCare Oxford Clinical, Administrative and Reimbursement Policies**.

Radiation Therapy Procedures
Oxford engaged eviCore healthcare 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.

eviCore handles all pre-certification requests.

Oxford Municipality and School Board Members
Radiology, Radiation Therapy, Cardiology, Cardiac Catheterization, Echocardiogram and Stress Echocardiogram Procedures
eviCore healthcare will perform 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, tax identification number and information such as:

- Reason for the procedure performed;
- Member's signs and symptoms;
- Treatment, including type and duration;
- Previous studies for the specific medical issue; and

- 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 ensure you 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 will be required to obtain a referral before seeing you for an initial visit.

Claims Processing
We will continue to process claims from participating care providers for radiation therapy services. You will 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 rights of appeal for any service that is not approved for payment.

When cardiology procedures are provided in the emergency room, observation unit, urgent care facility, or during an inpatient stay, prior authorization is not required.

A list of Current Procedural Terminology (CPT®) codes requiring medical necessity review is available on: UHCprovider.com >Policies and Protocols > Commercial Policies > UnitedHealth care Oxford Clinical, Administrative and Reimbursement Policies.

The clinical criteria consistent with existing UnitedHealthcare and Oxford policy are available on **eviCore.com**.

See a list of codes that require prior authorization online at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > **Medical & Administrative Policy Index** > Services Requiring Prior Authorization. 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. On **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 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:

- Online, after logging onto **myoptumhealthcomplexmedical.com**, or
- Calling OptumHealth at 877-512-9340 or
- 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 will perform utilization management review of requested services to ensure they meet approved clinical guidelines for medical necessity.

OrthoNet will conduct the review by determining medical necessity and medical appropriateness, and to initiate 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
- Skilled Nursing Facility

For a complete list of orthopedic diagnosis codes, or for more information on Oxford's arrangement with OrthoNet, refer to **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > **Medical & Administrative Policy Index** > Orthopedic Services.

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 work-up.

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 will review the services requested for medical necessity, and make 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 Committee (P&T) 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 quarterly 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.

Our care providers and other prescribers receive quarterly, 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, select high-risk or high-cost medications may require advance notification (PA) 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, will make the final coverage determination. We will notify you and the member of the decision.

Step Therapy (Subject to Plan Design)
Certain medications may be subject to step therapy (ST), 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 there is a Step 1 medication in the claims history. The medication may automatically process. If not, request a coverage review. If we do not approve the medication, a pharmacist or medical director, in keeping with state regulations, will make the final coverage determination and we will notify you and the member of the decision.

Supply Limits (Subject to Plan Design)
Some medications are subject to supply limits (SL). 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. A subset of medications has coverage criteria available to obtain quantities beyond the established limit. For these medications, the pharmacist receives a message that includes the toll-free number to call for coverage review.

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 and does not otherwise fall under the definition of emergency care as defined below.

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 emergency room services for medical emergencies. The member is responsible for paying their copayment. Follow-up emergency room 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.

- Emergency room 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 emergency room 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 emergency room treatment and subsequent release. However, all emergency inpatient admissions and emergency outpatient admissions (i.e., for emergent ambulatory surgery, etc.) 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 emergency room (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 defined above), we will 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 will provide limited coverage for members outside of the United States, Mexico, Canada, or the U.S. Territories.

New York (NY) and Connecticut (CT) Products
Out-of-Country 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
Out-of-Country 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 healthcare diagnosis and/or treatment, and the travel is for a period of six months or less; or

- Business assignment, provided the covered member is temporarily outside of the United States for a period of six months or less; or

- 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 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 our website at **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, in its discretion.

The process of selecting services for review, requests for clinical information concerning such services, review

of clinical information, and action based on clinical information will comply with all relevant federal and state regulations, laws, and provisions in a specific care provider's 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) will be made by a clinical peer reviewer, while 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 under the following circumstances:

1. Relevant medical information presented to us or utilization review agent during retrospective review is materially different from the information presented during the preauthorization review; and

2. The information existed at the time of the preauthorization review but was withheld or not made available; and

3. UnitedHealthcare or the UR agent was not aware of the existence of the information at the time of the preauthorization review; and

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 shall have the opportunity to request reconsideration of the adverse determination. Except in cases of retrospective reviews, the medical director or other health care professional will conduct 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 above 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 will include 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, and

3. Clinical review criteria relied upon to make our decision will be 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 shall request the missing information, in writing, within five (5) business days of receipt of partial information. If a determination is not made within 15 day of the filing of the appeal, we will 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 will 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 will immediately notify the member and their health care provider by telephone or facsimile 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 will 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 utilization review 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 (2) business days of receipt of necessary information for an expedited appeal, we will 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 will not agree to this. In those rare situations where we are willing to waive the internal UR appeal, we will inform the appeal requester and/or member verbally and/or in writing. If the member agrees to waive the internal UR appeal process, we will 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 will 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 will 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 timeframe will not be handled through this process. If your appeal is still submitted within the contractual deadlines for an appeal, we will 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 services requested 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 will make 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 that are not submitted within the contractual timeframes will be denied.

Connecticut Members
Utilization Review (UR) Appeals
UR will occur whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. The utilization review 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).

Please 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 timeframes 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 will use our best efforts to provide written acknowledgement of the receipt of your appeal within 5 business days, but in no event later than 15 calendar days. Our decision to either uphold or reverse the adverse determination will be 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 will be made within 3 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 will be continued without liability while your appeal is being reviewed. However, if additional information is requested, a determination will be made within 1 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 will be 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 and 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 section below, "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 timeframes 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 timeframes 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 timeframes 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 facsimile. We will provide reasonable access to our clinical peer reviewer within one business day of receiving notice of an expedited UR appeal.

A decision will be rendered and communicated for an internal expedited UR appeal within the following timeframes:

- 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 24/72 hours of receipt of the necessary information, the adverse determination will be reversed.

The notice of an appeal determination will include 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 will also include a notice of your right to initiate an external

appeal. A description of each process and associated timeframes will be included.

If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process and may then file a request for an external review (see below), 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 timeframe 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

• You, or your care provider acting on your behalf with your consent, filed a request for expedited internal review.

If you choose this option, you must submit the appeal by contacting the Connecticut Insurance Department at P.O. Box 816, Hartford, CT 06142-0816 (telephone number: 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 final adverse determination vary based on the state in which the member's certificate of coverage was issued. Each notice of final adverse determination will be in writing, dated and include 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 Internet web site.

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 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 utilized, 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 requirements for rendering decisions (above) the following rules apply to members enrolled on CT and NJ 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 will have the opportunity to resubmit their appeal.

Member's Rights to External Appeal
The member has a right to an external appeal of a final adverse determination (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, healthcare 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 will 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, or 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 listed below. 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 will 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 dis-enrolls 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 and 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 will determine 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 will 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 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 33 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 will 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, we will, upon request, 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 following for complete details on **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** > Global Days Policy.

Hospital reimbursement: We will 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 **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index** > Modifier Reference Policy.

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. The requested information must be submitted promptly as outlined in the request. If it is not submitted within 45 days an appeal must be submitted with the information.

Reimbursement Address, phone or TIN changes: An accurate billing address is necessary for all claims logging and payment, and mailings that may be sent. It is critical that you 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. The care provider's or other health care professional's obligation is to:

- Understand their 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 and 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 listed below. (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:

- 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); or
- A benefit limit is exceeded/exhausted; or
- Oxford denied a request for precertification, before the service was rendered, and the member proceeded to receive the service anyway; or
- 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, and acknowledging they would be responsible for the cost of the service, before delivering the service; or
- 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 a care provider inappropriately balance-bills a member, Oxford will hold the member harmless and pursue the matter directly with the care provider.

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, Appeals Process and Resolving Disputes* 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.

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); or

- 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 will initiate discussions and take action during the following one year period.

We will 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 prior to 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 utilize 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 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, Appeals Process and Resolving Disputes* found in *Chapter 9: Our Claims Process* for general reconsideration requirements and submission steps. Continue below for Oxford specific requirements.

I. **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 will reprocess the claim and remit the additional payment.

II. **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 **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > **Medical & Administrative Policy Index**.

III. **Timeframe 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 will uphold the denial.

Exceptions: There are separate processes for New Jersey (NJ) 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 will include 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, as stated above. 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 will be conducted and results 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 at the address listed above.

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 timeframes (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 timeframe.

If Oxford fails to provide the additional reimbursement within the 45 day review timeframe, 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.

IV. **Method for Submitting a Reconsideration or Appeal**
Appeals – 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 (above).

- The appeal of unilateral coding adjustments made to New York Hospital claims (above)

V. **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 will be issued by means of a letter or updated Remittance Advice (RA) statement at the time of determination of the appeal. This decision will constitute 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 **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > **Medical & Administrative Policy Index** > Timeframe Standards for Benefit Administrative Initial Decisions.

VI. **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 NY, NJ and CT should refer to the AAA web site (**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 American Arbitration Association (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 utilize 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 New York State.

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 and 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 will determine 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 will be 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 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 CT 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
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

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*In New York, a second-level appeal is not required by us to be eligible for an external appeal.

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 will immediately remove any health care provider from the network who is unable to provide health care services due to a final disciplinary action.

A health care provider may not be prohibited from, nor may the UnitedHealthcare terminate or refuse to renew a contract 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, or
- 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 will be provided within 30 calendar days after the adverse action is taken that will include 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 right 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 the receipt of request for appeal, or within the timeframe required by state law. The fair hearing or review will take place within 60 calendar days of the date we receive the request for appeal, or within the timeframe 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; or

2. Provisional reinstatement with conditions set forth by us, or

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 found here: **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Network Information > **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" and be sure no part of the record is visible during transmission.

Electronic Medical Records (EMR)
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, to 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 will tell 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 will 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 will be given the opportunity to discuss the unique nature of your patient population which may have bearing on your profile and we will 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. Care providers 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 (HEDIS) 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 (Center for Medicare and Medicaid Services), 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 the 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

An acute hospital day (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 will determine that an inpatient ALC applies in any of the following scenarios:

- An acute clinical situation has stabilized.
- 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 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; and
  › 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 to 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

A potentially avoidable day (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 will be 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.

Re-Admissions

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.

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*ALC only applies if the facility has a contracted rate.

**Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria may result in denial of coverage.

- 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 the situations noted above, 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 will 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 will consider this to be notification only; first day approval will not be granted to hospitals with a DRG contract. When we receive notification of an admission to a hospital with a DRG contract, our case manager will review the admission for appropriateness. If the case manager cannot make a determination based on the admitting diagnosis, the case manager will request 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 will be 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 will be paid only with the validated codes.

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, and helps eliminate certain areas of contention among participating parties and allow 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 prior to 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 defined as 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 defined as 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 any code.

Medical and Administrative Policy Updates

We change or 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**. 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 user-friendly 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**. A supplemental reminder to the detailed policy update summaries 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	**Online:** UHCprovider.com/priorauth **Phone:** 800-995-0480 **Fax:** 866-567-0144	• 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:** **Fax:**	800-963-6495 Monday through Friday, 9 a.m. to 5 p.m. (ET) 866-567-0144	• 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:** **Phone:**	**ChangeHealthcare.com** 800-845-6592	• Get information and register for electronic payment services.
Eligibility and Benefits Verification	**Online:** **Phone:**	**UHCprovider.com/eligibility** 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:** **Fax:** **Email:** **Mail:**	866-678-8822 Monday through Friday, 9 a.m. to 5 p.m. (ET) 888-659-0617 **ReportFraud@UHCsouthflorida.com** 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:** **Mail:**	Call the provider number listed on the back of the member's identification card. 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:** **Phone:** **TTY:** **Fax:**	**mypreferredcare.com** > Member Resources 866-231-7201 Monday through Friday, 8 a.m. to 5 p.m. (ET) 711 866-567-0144	• 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:** **Fax:** **Email:**	877-670-8432 Monday through Friday, 9 a.m. to 5 p.m. (ET) 888-659-0619 **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.

Resources	Where to Go	What you can do there
Pharmacy **(OptumRx)**	**Phone:** 800-711-4555 **Fax:** 800-527-0531	• 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.

Ancillary and Enhanced Benefit Providers		
Optum Behavioral Health	**Online:** providerexpress.com **Phone:** 800-985-2596 No DSNP 800-496-5841 DSNP & 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** **QUEST**	**Online:** labcorp.com **Phone:** 855-277-8669 Automated Line **Phone:** 800-877-7831 Live Scheduling **Online:** questdiagnostics.com **Phone:** 866-697-8378	• Find information on locations, make an appointment, order lab tests and view results.
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**.

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*Contact Network Management Services for a complete list of specialty types that need referrals.

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.

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.

- Use Medcare, our Home Health Care (HHC) and DME capitated care provider.
  Note: Do not request an expedited (72 hours) review unless waiting for a standard (14 calendar days) review could place the member's life, health, or ability to regain maximum function in serious jeopardy. Once you determine the situation meets this definition, request that a prior authorization be expedited by placing "STAT/urgent" on the Prior Authorization Form.

- 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 or fax 866-567-0144.

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 timeframe 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 healthcare 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, call us at 800-995-0480 or reach us by fax at 866-567-0144.

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 regulation 45 CFR § 164.512 (d) allows 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: **Fax:** 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, Appeals Process and Resolving Disputes* 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)	**Phone:** 877-842-3210 **Fax:** 866-756-9733 **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive Moline, IL 61265
Inpatient Admissions (Notifications)	**Phone:** 877-842-3210 **Fax:** 866-756-9733
Mental Health/Substance Use **Vision** **Transplant Services**	**Phone:** 877-842-3210
Pharmacy Services/Prescription Drugs Requiring Preauthorization	**Online:** **UHCprovider.com/pharmacy**, or **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 **Appeals (Urgent)**	**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 **Fax:** 866-756-9733
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	**Phone:** 877-842-3210 **Fax:** 866-756-9733
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 Policies, 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.

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. Fax requests for end-of-life care to 866-756-9733.

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
320	Radiology-Diagnostic (General Classification)
321	Angiocardiography
322	Arthrography
323	Arteriography

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Revenue Codes Requiring CPT® and HCPCS Codes

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
419	Other Respiratory Services
460	Pulmonary Function(General Classification)
469	Other-Pulmonary Function
470	Audiology (General Classification)

Revenue Codes Requiring CPT® and HCPCS Codes

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)
750	Gastro-Intestinal (GI) Services (General Classification)
790	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
921	Peripheral Vascular Lab
922	Electromyogram

Revenue Codes Requiring CPT® and HCPCS Codes	
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, Appeals Process and Resolving Disputes* 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 MedicareComplete® • 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 MedicareComplete® SecureHorizons® • Sharp® SecureHorizons® Plan by UnitedHealthcare® • UnitedHealthcare® Group Medicare Advantage • UnitedHealthcare MedicareComplete Assure
California	Commercial	UnitedHealthcare Core^{SM}* and Core Essential^{SM} *This UnitedHealthcare West Capitated Supplement does not apply to this benefit plan. Please refer to the main guide for regulations, processes and contact information
Colorado	MA	• AARP MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage

State	Products Offered	Benefits Plans
Nevada	MA	• AARP MedicareComplete® • UnitedHealthcare® Group Medicare Advantage • Premier Plan (H0609-31) • UnitedHealthcare® Medicare Focus (H0609-32) • MedicareComplete (H0609-33)
Oklahoma	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
Oregon	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP MedicareComplete® • UnitedHealthcare® Group Medicare Advantage
Texas	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP MedicareComplete® • AARP MedicareComplete® SecureHorizons® • UnitedHealthcare® Chronic Complete • UnitedHealthcare Dual Complete® • UnitedHealthcare® Group Medicare Advantage
Washington	Commercial and MA	**Commercial:** • UnitedHealthcare® SignatureValue® **Medicare:** • AARP MedicareComplete® • 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. These SNPs are currently only available in specific counties in the state of Texas.

UnitedHealthcare West Information Regarding our Care Provider Website

The UHCWest.com website was retired on Nov. 30, 2017 and redirects to **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 Echocardiogram Clinical Trials	**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.	**Phone:** 800-799-5252 **Fax:** 800-274-0569 Mental health Medicare Advantage: 800-508-0088 Transplant: 866-300-7736 **Fax:** 888-361-0502

Resource	Where to go
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**.
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

Resource	Where to go
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 **Fax:** 800-527-0531
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**.
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 in fact 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.

California Prohibition Against Care Provider Rescission

California law requires that if:

1. You contacted us immediately before or during the providing treatment, and

2. You relied upon the member's eligibility to treat, and

3. The member is later retro-cancelled, you may submit an appeal showing proof that eligibility was obtained and relied upon at the time services were provided. If you do not verify eligibility immediately before each service date, the service is not subject to this provision. You should not rely on another care provider's eligibility verification, (as an example the facility's verification). Each care provider must contact us to confirm eligibility.

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 timeframe. 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 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.

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* As an "authorization representative" of UnitedHealthcare, physicians are responsible to notify the member about the prior authorization determination, unless State regulation requires otherwise.

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 detailed policy update summaries 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 authorized by UnitedHealthcare West or the member's assigned network care provider. 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 in January 2017. 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 delivered by the care provider groups covered under professional capitation. 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 89*.

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. Monday through Friday WT.

Provide after-hours and weekend emergency services as clinically appropriate; enter the notification online or fax to us at 800-274-0569 on the next business day.

Urgently Needed Services

Please check the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, 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., Monday through Friday WT.

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. 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 their 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.

5. Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician's office that do not require prior authorization may be performed.

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**:

- 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.

Hospitals, rehabilitation facilities and skilled nursing facilities (SNFs) are required to notify us daily of all admissions, changes in inpatient status and discharge dates.

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, as well as 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 SignatureValue 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: OptumRx.com > **Healthcare Professionals** > Prior Authorizations.

This online service enables physicians and health care professionals to submit a real- time prior authorization request 24 hours per day, seven days per week. After logging on at **OptumRx.com** with your unique National Provider Identifier (NPI) number and password, you may submit member details securely online, enter a diagnosis and medical justification for the requested medication, and, in many cases, receive authorization instantly. Otherwise, you may obtain prior authorization by any of the following methods:

- **Phone:** 800-711-4555
- **Written request:** Obtain a Commercial Prescription Prior Authorization Form – CA on OptumRx.com > **Health Care Professionals Portal** > Prior Authorizations.
- **Fax:** 800-527-0531 for medications

California Commercial HMO and PPO 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.

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 utilize 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 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, 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 dictate 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
> Spanish: 800-730-7270; 800-855-3000 TDHI
> Chinese: 800-938-2300

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 senior medical director 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:** • **Phone:** 800-711-4555 • **Fax** for non-specialty meds: 800-527-0531 • **Fax** for specialty meds: 800-853-3844 **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:** • **Phone:** 800-711-4555 • **Fax** for non-specialty meds: 800-527-0531 • **Fax** for specialty meds: 800-853-3844 **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).

Be sure to check the member's health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to 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 that you want to be paid promptly for the services you provide. This is what you can do to help promote prompt payment:

1. Notify us, in accordance with the notification requirements set forth 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)
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 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

Revenue codes requiring CPT® and HCPCS codes
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
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

Revenue codes requiring CPT® and HCPCS codes
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
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)

Revenue codes requiring CPT® and HCPCS codes
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 or our staff identifies a claim where you were overpaid or if we notify you of an overpayment, send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our notification.

Claim Reconsideration, Appeals and Disputes

If you disagree with a claim payment determination or adjustment, you may make an 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 orally, by fax or in writing at:

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, Appeals Process and Resolving Disputes* 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 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 that the service or supply is:
  › Not medically necessary;
  › Experimental or investigational;
  › Cosmetic;
  › Dental rather than medical; or
  › Treatment of a pre-existing condition.

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 situation:

- 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 between 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 is erroneous or that the amount we have 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:
A written request for appeal must be submitted using the Health Care Provider Application to Appeal a Claims Determination Form created by the New Jersey Department of Banking and Insurance. This request must be submitted 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

The review will be conducted, and a decision will be communicated to you in writing within 30 calendar days of receipt of the form.

If you are not satisfied with the results of the internal dispute, 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

Internal UM appeals must be initiated by the member or their designee 180 calendar days from receipt of the initial adverse UM determination. 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 orally, by 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

Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis. Expedited UM appeals are determined within 72 hours of receipt of the appeal. For expedited requests involving continued inpatient care in a network facility for a substance use disorder, the determination will be made within 24 hours of receipt of the request for review. Standard UM appeals are determined within 10 calendar days of receipt of the appeal.

All UM appeals are done by clinical peer reviewers other than the clinical peer reviewer who rendered the initial UM determination.

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 deadlines of the appeals process, 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 and must include a specific description of the basis for which it was determined the delay should not cause the internal appeals process to be exhausted. 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.

Administrative appeals must be initiated by the member or their designee 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 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 eligibility for coverage 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 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.

Durable Medical Equipment: 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.

Refer to **UHCprovider.com/policies** for more information about DME.

Durable Medical Equipment (DME): Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a physician.

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 **durable medical equipment, prosthetics, orthotics and supplies (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 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 healthcare 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.

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.

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 such term is 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.