

CASE NO. 85525; *Combined with* CASE NO. 85656

IN THE SUPREME COURT OF NEVADA

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC. D/B/A UNITEDHEALTHCARE; UMR, INC. D/B/A UNITED MEDICAL RESOURCES; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; AND HEALTH PLAN OF NEVADA, INC.,

Appellants/Petitioners,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD., D/B/A RUBY CREST EMERGENCY MEDICINE.

Respondents/Real Parties in Interest.

Appeal from the Eighth Judicial District Court, Clark County
District Court Case No. A-19-792978
Hon. Nancy L. Allf, District Judge

APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF

VOLUME 9 OF 13

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APPENDIX OF EXHIBITS TO RESPONDENTS' ANSWERING BRIEF

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CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY ❖ KENNEDY and that on the 28th day of August, 2023, service of the foregoing **Appendix of Exhibits to Respondents' Answering Brief – Volume 9 of 13** was made by electronic service through Nevada Supreme Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

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EXHIBIT 38

PART
2 OF 2

EXHIBIT 38

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich



LETTER TO MY REPRESENTATIVE(S)
About Powers of Attorney Forms and Responsibilities

To My Representative:

Name: _____
Address: _____

To My Alternate Representative:

Name: _____
Address: _____

A. What I Ask You to Do For Me: Arizona law allows me to make certain medical and financial decisions as to what I want in the future if I become unable or incapable of making certain decisions for myself. I have completed the following document(s), and I want you to be my representative or alternate representative for the following purposes, (Initial or check one or more of the following):

- ☐ 1. Durable Health Care Power of Attorney
☐ 2. Durable Mental Health Care Power of Attorney

B. Why I Named an Alternate Representative: I chose two representatives in case one of you is unable to act for me when the time arises. I ask that you accept my selection of you as my representative or alternate. If you do not return the Power of Attorney form(s) and this letter to me or inform me differently, I will assume that you have agreed to be my representative.

C. Your Responsibilities as My Representative: By selecting you, I want you to make some very important decisions for me about my future health care needs if I become unable to make these decisions for myself. I might need you to carry out my medical choices as indicated in the enclosed Powers of Attorney, even if you do not agree with them. Please read the copies of the Powers of Attorney I am giving you. You will be my voice and will make medical decisions on my behalf. Other than what I have indicated in the Powers of Attorney as to my specific directions on certain issues, I am trusting your judgment to make decisions that you believe to be in my best interests. If at any time you do not feel that you can undertake this responsibility for any reason, please let me know. If you are unsure about any of my directions, please discuss them with me. If you are not willing to serve as my representative, please tell me so I can choose someone else to help me.

As to Health Care: You are not financially responsible for paying my health care costs merely by accepting this responsibility. Under Arizona law, you are not liable for complying with my decisions as stated in the Powers of Attorney or in making other health care decisions for me if you act in good faith.

D. What Else You Should Do: Please keep a copy of my Powers of Attorney and other documents in a safe place. Please read these documents carefully and discuss my choices with me at any time. I will give copies of my health care Powers of Attorney to my physician, and I will give copies of any or all of these Powers of Attorney to my family and any other representative I may choose. I authorize you to discuss with them the Powers of Attorney, including, as applicable, my medical situation, or any medical concerns about me. Please work with them and help them to act in accordance with my desires and in my best interests. I appreciate your support, and I thank you for your willingness to help me in this way.

Signature: _____ Date: _____

Printed Name: _____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)
(IMPORTANT—THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT:** Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this form.

1. My Directive and My Signature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient Signature: _____ Date: _____

PROVIDE THE FOLLOWING INFORMATION:

OR

ATTACH RECENT PHOTOGRAPH HERE:

My Date of Birth _____
 My Sex _____
 My Race _____
 My Eye Color _____
 My Hair Color _____



2. Information About My Doctor and Hospice (if I am in Hospice):

Physician: _____ Telephone: _____

Hospice Program, if applicable (name): _____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE) (Last Page)

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider: _____ Date: _____

4. Signature of Witness to My Directive:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature: _____ Date: _____

**HEALTH PLAN OF NEVADA
PROVIDER SUMMARY
GUIDE**

SECTION 23

FRAUD WASTE AND ABUSE COMPLIANCE POLICY

23 – Fraud, Waste and Abuse Compliance Policy

Activities that are considered fraud, waste and abuse by members, practitioners or care providers hurts everyone – HPN, taxpayers, members and providers. Combating fraud, waste and abuse is the responsibility of members, healthcare providers and insurers alike. It is your responsibility to report members or other providers you suspect are committing fraud or abuse. Your assistance in notifying us and cooperating with any potential fraud or abuse occurrence is vital and appreciated in conjunction with our mutual ongoing efforts to coordinate the most effective health outcomes possible for our members.

Definitions of Fraud, Waste and Abuse

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. 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.

Examples of Fraud, Waste and Abuse include:

Administrative or Financial

- Kickbacks.
- Falsifying credentials.
- Fraudulent credentials.
- Fraudulent enrollment practices.
- Fraudulent third party liability reporting.
- Fraudulent recoupment practices.

Falsifying Claims/Encounters

- Alteration of a claim.
- Incorrect coding.
- Double billing.
- False data submitted

Falsifying Services

- Billing for services or supplies not provided.
- Misrepresentation of services/supplies.
- Substitution of services.

Member issues

- Resource misrepresentation (transfer and/or hiding).
- Residency.
- Household composition.
- Citizenship status.
- Unreported income.

- Misrepresentation of medical condition.
- Failure to report third party liability.

If you identify potential fraud, waste or abuse, please report it to us immediately so that we can investigate and respond appropriately. There are multiple reporting methods including:

HPN Provider Services - 702-242-7088

The Compliance & Ethics Help Center

–Phone: 1-800-455-4521 (US)

–Online: www.uhghelpcenter.ethicspoint.com

–The Help Center is available 24 hours a day, 7 days a week.

Health Care Fraud Tip Line – 1-866-242-7727

UnitedHealth Group Compliance & Ethics Office

–Phone: 1-952-936-7463

–Email: ethicsoffice@uhg.com

Integrity of Claims, Reports and Representation to Government Entities

The Deficit Reduction Act of 2005 (DRA) was signed into law in early 2006. The DRA encourages states to have in place false claims legislation. It further requires that any entity receiving annual Medicaid payments of \$5 million or more to provide written policies available to all employees, contractors and agents (including providers), detailed information about the False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements, and the whistleblower protection under such laws, including the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

A number of federal and state regulations govern information provided to the government, including the Federal False Claims Act, State False Claims Acts and other regulations and protections. HPN requires compliance with the requirements of federal and state laws that prohibit the submission of false claims in connection with federal health care programs, including Medicare and Medicaid. Federal and state governments have adopted a number of statutes to deter and punish misrepresentations with regard to health care programs. Failure to comply with these laws could result in civil and criminal sanctions imposed by government entities and HPN.

Required Training

As part of an effective Compliance Program, CMS requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including HPN, to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their employees, including the CEO, senior administrators or managers, and for governing body members, and for first tier, downstream, and related entities" (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties.

The required education, training, and screening requirements to which we – and you – are subject include the following:

Standards of Conduct Awareness:

FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide a copy of their own or the UnitedHealth Group's (UHG's) Code of Conduct (found at <http://www.unitedhealthgroup.com/~media/UHG/PDF/About/UNH-Code-of-Conduct.ashx>)

to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services within 90 days of hire and annually thereafter (by the end of the year).

What You Need to Do for Standards of Conduct Awareness: Provide your own or the UHG's Code of Conduct as outlined above and maintain records of distribution standards (i.e. in an email, website portal or contract, etc.) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Fraud, Waste, and Abuse and General Compliance Training: FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide Fraud, Waste, and Abuse (FWA) and General Compliance training within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

Effective January 1, 2016, CMS has amended the regulations to mandate only the use of CMS published training materials by FDRs of a contracted Medicare plan sponsor. FDRs cannot alter the published CMS training material content; however, CMS will allow FDRs to download CMS training material and add content and topics specifics to your organization. The CMS standardized FWA training and education module is available through the CMS Medicare Learning Network (MLN) at cms.gov.

FDRs meeting the FWA certification requirements through enrollment in the fee-for-service (Parts A or B) Medicare program or accreditation as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Provider are deemed by CMS rules to have met the training and education requirements.

It is our responsibility to make sure that your organization has access to appropriate training. To facilitate that, we are providing you information on the CMS Parts C and D FWA and General Compliance training module. This module is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>.

What You Need to Do for FWA and Compliance Training: Administer FWA and General Compliance training as outlined above and maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), employee attestations or electronic certifications from employees that include the date of the training) for 10 years. Documentation may be requested by UnitedHealthcare or CMS to verify compliance with this requirement.

Exclusion Checks: FDRs must review federal exclusion lists (HHS-OIG and GSA) and state exclusion lists, as applicable, prior to hiring/contracting with employees (including temporary workers, volunteers, and consultants), the CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA and Part D benefits or services to make sure that none are excluded or become excluded from participating in Federal health care programs. FDRs must continue to review the federal and state exclusion lists on a monthly basis thereafter. For more information or access to the publicly accessible excluded party online databases, please see the following links:

Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at <http://oig.hhs.gov/exclusions/index.asp>

General Services Administration (GSA) Excluded Parties Lists System
at <https://www.sam.gov/portal/public/SAM>

What You Need to Do for Exclusion Checks: Review applicable exclusion lists as outlined above and maintains a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by UnitedHealthcare or CMS to verify that checks were completed.

**HEALTH PLAN OF NEVADA
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SECTION 24

MEDICAL RECORD RETENTION

24- Medical Record Retention

It is HPN's policy that enrollees have a right to access their medical records, as allowed by law. Providers are required to remain compliant with CMS guidelines. Members who contact HPN requesting access to their medical records will be instructed to contact their providers of care, and when necessary, HPN will assist the member in obtaining records.

HPN requires its contracted practitioners and institutional providers to have policies and procedures that describe how and under what circumstances medical records are made available to their patients.

Providers are expected to remain in compliance with CMS guidelines and retain patients' medical records in compliance with the Centers for Medicare and Medicaid Services (CMS) medical record retention requirement. As of January 2009 the CMS medical record retention requirement is ten (10) years. Please understand that this medical record retention requirement is subject to change at the discretion of CMS and it is each provider offices responsibility to ensure compliance with any future modified medical record retention requirements mandated by CMS.

**HEALTH PLAN OF NEVADA
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SECTION 25

FREQUENTLY USED FORMS

25-Frequently Used Forms

- 25.1 Request for Allowables Form
- 25.2 @YourService Forms
 - A. Request Form
 - B. Terms of Use Acknowledgement Form
 - C. Penalties for Violations of Terms of Use
- 25.3 Provider Add Request Form
- 25.4 Health Plan of Nevada Complaint Form
- 25.5 Health Plan of Nevada Medicaid and Nevada Check Up Member Grievance Form
- 25.6 Medicaid Maternity Risk Screen Form
- 25.7 Claim Reconsideration Request Form
- 25.8 Nevada Universal Prior Authorization and Referral Form

Additional forms applicable to Southern Nevada providers only:

- 25.9 SMA Imaging Services Expectation Sheet
- 25.10 SMA Routine Imaging Services Order Form
- 25.11 SMA Screening Mammography Imaging Services
- 25.12 SMA Diagnostic Mammography Imaging Services
- 25.13 SMA Imaging Order Form for Bone Density (DEXA Scan)
- 25.14 SMA Imaging Services Expectation Sheet – Bone Density (DEXA Scan)
- 25.15 SMA Imaging Order Form for Cat Scan
- 25.16 SMA Imaging Services Expectation Sheet – Cat Scan
- 25.17 SMA Imaging Order Form for FLOURO
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- 25.19 SMA Imaging Services Expectation Sheet – HSG
- 25.20 SMA Imaging Services Expectation Sheet – IVP
- 25.21 SMA Imaging Services Expectation Sheet – Myelogram
- 25.22 SMA Ordering Form for Ultrasound
- 25.23 SMA Imaging Services Expectation Sheet - Ultrasound



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

REQUEST FOR ALLOWABLES
(Fax Request to 702-266-8809)

Date: _____

Tax ID#: _____

Provider/Group Name: _____

Specialty: _____

Contact Name: _____ Phone#: _____ Fax#: _____

E-Mail: _____

Contact is from which of the following? ☐ Billing Service ☐ Provider's office ☐ Other

Type of Code(s): ☐ CPT ☐ HCPCS ☐ ASA

Please put a check mark next to each contracted line of business you are requesting.

- ☐ Health Plan of Nevada (HPN)
- ☐ Senior Dimensions; Medicare
- ☐ Sierra Health & Life (SHL)
- ☐ Sierra Healthcare Options (SHO)
- ☐ Medicaid and Nevada Check-up
- ☐ Prime Health
- ☐ Worker's Compensation; Sierra at Work (SAW)
- ☐ Northern Nevada Health Network (NNHN)

Requests are limited to a maximum of 40 codes. Requests submitted with more than 40 codes will only be processed up to the 40th code. Please maintain and use your EOPs for reference.

1.	2.	3.	4.	5.
6.	7.	8.	9.	10.
11.	12.	13.	14.	15.
16.	17.	18.	19.	20.
21.	22.	23.	24.	25.
26.	27.	28.	29.	30.
31.	32.	33.	34.	35.
36.	37.	38.	39.	40.

Please note: Allowable quotes do not guarantee payment. Claim processing is subject to member eligibility, benefits, claim processing guidelines, and contract limitations.

Network Development & Contracts/ Provider Services
P.O. Box 15645, Las Vegas, NV 89114-5645
Phone: (702) 242-7088 or (800) 745-7065

Please allow 30 days for processing



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

@YourService Administrator Account Request Form

Please complete this form with the information for the individual your office has designated to be an Account Administrator.

- The Account Administrator will be responsible for creating profiles, editing profiles, and password reset of the individual accounts associated with their provider TIN.
- The Account Administrator will be responsible for ensuring that every employee ("individual account holder") has his/her own username and password for HPN/SHL @YourService and signs the Acknowledgement to Comply with HPN and/or SHL's @YourService Terms of Use. The signed Acknowledgements must be retained by the Account Administrator and produced to HPN/SHL upon request.
- The Account Administrator will be responsible for notifying HPN/SHL Provider Services at 702-242-7088 within 24 hours of designation of a new Account Administrator, an individual account holder's termination of employment and if termination of an individual's account is necessary for any other reason.

Billing offices must go through their physician office for access. NO EXCEPTIONS

Please complete and fax to (702) 242-9124 Attn: Provider Services

ALL REQUESTED INFORMATION IS REQUIRED

First & Last Name:	
Requestor DOB:	
Requestor Job Title:	
Office Name:	
Office Address:	
TIN:	
E-Mail:	
Phone Number:	
Fax Number:	

As an authorized user of the HPN/SHL @YourService application, the above named organization will be given access to private and confidential patient and health plan member data for the exclusive purpose of performing their professional responsibilities. The following rules will govern usage of the system named above at all times:

- Usernames and passwords are to be safeguarded. Disclosing the username and password information to anyone for any reason with the exception of authorized personnel of the entity providing access to the HPN/SHL @YourService application is **STRICTLY PROHIBITED**.
- The private and confidential data within the HPN/SHL @YourService application is to be safeguarded at all times. The HPN/SHL @YourService application contains information that is confidential and protected from disclosure by law (except for specific legal exception or with the individual's authorization). The Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Federal Privacy Rule all protect the confidentiality of all individually identifiable health information.
- Use of the HPN/SHL @YourService application is monitored and subject to audit review. Access to private and confidential data within the HPN/SHL @YourService application is to be limited to only such data as is required to carry out professional responsibilities. Improper disclosure or access to private and confidential information (obtained through the computer or otherwise) may result in immediate termination of system access privileges and possible legal action.

HPN/SHL expressly reserves the right to make any and all determinations concerning violation of the rules stated herein. Any determination made by us will be final and not subject to any formal review or appeal process.

Note: Please allow up to 10 business days for account set-up. The information will be sent to the above listed requestor(s).

HPN 2018 Section 25 Frequently Used Forms

25.2B



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company



SIERRA HEALTH AND LIFE
A UnitedHealthcare Company

**Acknowledgement to Comply with Health Plan of Nevada, Inc.'s ("HPN")
and/or Sierra Health and Life Insurance Company, Inc.'s ("SHL")
@YourService Terms of Use**

- I acknowledge that I am responsible for my unique @YourService User ID ("User ID") and must not share or disclose my User ID. I acknowledge that I am responsible for my use of @YourService and that I may only access @YourService for job-related purposes.
- I hereby agree, as a condition of access to @YourService, that I will not access my own Protected Health Information ("PHI") or that of a family member or co-worker and will not ask a co-worker to do so either. I agree that I will not access the PHI of any individual without a job-related purpose.
- I understand that use of the HPN/SHL @YourService application is monitored and subject to audit review. Access to private and confidential data within the HPN/SHL @YourService application is to be limited to only such data as is required to carry out professional responsibilities. Improper disclosure or access to private and confidential information (obtained through the computer or otherwise) may result in immediate termination of system access privileges and possible legal action.
- I understand that access to @YourService is a privilege, which may be revoked at any time at the sole discretion of HPN or SHL.
- I also agree to promptly report all violations or suspected violations of these Terms of Use to HPN/SHL at 702-242-7186.

I have read and agree to comply with the above.

Signature of User: _____ Date: _____

Name of User (please print): _____

Network Contract Provider: _____

Administrator Name (please print): _____

Administrator's Signature: _____ Date: _____

25.2C



Penalties for Violations of Health Plan of Nevada, Inc.'s ("HPN") and Sierra Health and Life Insurance Company, Inc.'s ("SHL") @YourService Terms of Use

1. As stated in the @YourService Terms of Use Acknowledgement Form, @YourService Users (collectively "Users" and individually a "User") are prohibited from accessing @YourService for any purpose that is not job-related. Users are also prohibited from sharing and/or disclosing their unique @YourService User ID ("User ID"). A violation of the Terms of Use will result in temporary suspension or termination of system access privileges as outlined below.
 - (a) Users are prohibited from using @YourService to access their own Protected Health Information ("PHI") or that of a family member, co-worker or any other individual other than for job purposes and must not ask a co-worker to do so either. A violation of this Term will result in immediate termination of some or all of the User's system access privileges. If more than one User was involved, each User's system access privileges will be terminated.
 - (b) An initial violation of the Terms of Use by an individual User which upon investigation is found to have resulted from an honest error made in good faith and that does not constitute a violation described in (a) above will not result in deactivation of the User's ID or termination of the User's system access privileges. A second violation by the same User will result in temporary deactivation of the User's ID, which may not be reactivated* for a period of at least one (1) month. A third violation will result in termination of the User's system access privileges.
 - (c) Each User is required to have his/her own unique @YourService User ID and password. Users are prohibited from sharing and/or disclosing their User ID. If a User is found to have shared or disclosed his/her User ID or used another User's ID, the involved Users' system access privileges will be terminated.
2. If an Account Administrator is found to have created an additional User ID or re-activates a User ID for any User whose system access privileges were temporarily suspended or terminated, the Account Administrator's access privileges for creating and editing account profiles will be revoked and the provider will be required to designate another Account Administrator.
3. If any single User has had more than one violation of the Terms of Use in a calendar year or more than one User from the same provider office is found to have violated the Terms of Use in a single quarterly audit period, the provider will be required to submit a Corrective Action Plan ("CAP") to HPN/SHL Provider Services which should include, at a minimum, training for all employees on the @YourService Terms of Use. The provider will be required to submit a brief description of the training along with a list of all individuals in attendance to Provider Services.
4. If the Account Administrator fails to respond to an audit request within 14 days from the date of the initial request, the User ID under investigation will be de-activated until a response is received and a determination is made as to whether or not a violation occurred.

* The Account Administrator is solely responsible for requesting reactivation of a User ID from HPN/SHL Provider Services

**PROVIDER ADD REQUEST**

This form must be completed in full before the Credentialing Department can start the credentialing process on the following provider. The provider must hold a valid license in the State of their primary location. (Please write legibly.)

Provider Name

Last Name

First

Middle

Title (please check appropriate box)☐ MD☐ DO☐ DC☐ DPM☐ CRNA☐ PAC☐ APN

-- Preceptor's Name

Social Security #: _____**NPI #:** _____**Billing Tax ID Number:** _____**Medicaid #:** _____**Effective Date with Group:** _____**Medicare #:** _____**Primary Group/Practice**

Name of Group/Practice

Provider Will Be (please check appropriate box)☐ Full Time☐ Part Time☐ Per Diem**Primary Specialty****Additional Specialty** _____**Primary Address**

Street

Suite

City

State

Zip

Phone

Additional Sites to Primary Location

Street

Suite

City

State

Zip

Phone

Street

Suite

City

State

Zip

Phone

Credentialing Contact (please print name): _____ **E-mail:** _____**Phone Number:** _____ **Fax Number:** _____**Mailing Address for Credentialing Application** (Will be sent to Primary Address listed above if not specified here)

Street

Suite

City

State

Zip

Phone

THANK YOU!**Please return via fax to (702) 266-8809**

HEALTH PLAN OF NEVADA

COMPLAINT FORM

Member/Insured Name: _____

Member Number: _____ **Date of Birth:** _____

Description of the issue/concern (please include date(s), any known names of individuals involved; name of facility, if applicable):

Signature

Date

(If signed, a written response will be submitted to the member/insured)

WHEN COMPLETED, THIS FORM SHOULD BE SUBMITTED TO:

COMPANY NAME: Health Plan of Nevada
DEPARTMENT: Customer Response and Resolution Department
MAILING ADDRESS: P.O. Box 14865
 Las Vegas, NV 89114-4865

As always, the Member Services Department can be contacted directly by telephone at the following numbers:

HEALTH PLAN OF NEVADA:	(800) 777-1840
SENIOR DIMENSIONS:	(800) 650-6232
MEDICAID AND NEVADA CHECK UP	(800) 962-8074
TTY	711

MEDICAID AND NEVADA CHECK UP**MEMBER GRIEVANCE FORM**

Member/Insured Name: _____

Member Number: _____ Date of Birth: _____

Description of the issue/concern (please include date(s), any known names of individuals involved; name of facility, if applicable):

*Signature**Date*

(If signed, a written response will be submitted to the member/insured)

WHEN COMPLETED, THIS FORM SHOULD BE SUBMITTED TO:

COMPANY NAME: Health Plan of Nevada
DEPARTMENT: Customer Response and Resolution Department
MAILING ADDRESS: PO Box 14865
Las Vegas, NV 89114-4865

As always, the Member Services Department can be contacted directly at 1-800-962-8074.

MEDICAID MATERNITY RISK SCREEN

The *risk screen* is designed to identify pregnant women at risk for preterm birth or poor pregnancy outcome. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ Medicaid # _____ EDC _____

A. MEDICAL

	Substance Abuse	# Days/Week Used	# Times/Day Used
1. _____ Hypertension, chronic or preg. Induced	10. Alcohol	_____	_____
2. _____ Gestational diabetes/diabetes	11. Cocaine/crack	_____	_____
3. _____ Multiple gestation (twins, triplets)	12. Narcotics/Heroin	_____	_____
4. _____ Previous preterm birth < 5 ½ lbs.	13. Marijuana/ Hashish	_____	_____
5. _____ Advanced maternal age, > 35 yrs.	14. Sedatives/ Tranquilizers	_____	_____
6. _____ Medical condition, the severity of which affects pregnancy, document below diet pills	15. Amphetamines	_____	_____
7. _____ Previous fetal death	16. Inhalants/Glue	_____	_____
8. _____ Vision Impairments	17. Tobacco/Cigarettes	_____	_____
9. _____ Hearing Impairments	18. Other, Please Specify	_____	_____

B. SOCIAL

1. _____ Teenager 18 yrs. or younger	*4. _____ Abuse/neglect during pregnancy
2. _____ Non-compliant with medical directions or appointments	*5. _____ Shelter, homeless or migrant
3. _____ Mental retardation or history of emotional/mental problems	*6. _____ Lack of food

C. NUTRITION

1. _____ Teenager 18 years or younger	3. _____ Poor diet or pica
2. _____ Prepregnancy underweight/overweight inadequate or excessive wt gain	4. _____ Obstetrical/Medical condition requiring diet modification; document condition below

REFERRALS AND/OR SERVICE PLAN

1. _____ Care Coordination	5. _____ Glucose Monitor w/nutrition counseling
2. _____ Smoking Cessation	6. _____ Parenting/Childbirth Classes
3. _____ Homemaker	7. _____ Substance Abuse TX
4. _____ Nutritional Counseling	8. _____ No Care Coordination

PHYSICIANS COMMENTS OR SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PHYSICIAN # _____

Once the form has been completed, please fax it to HPN's Obstetrical Case Management Team, at (702) 804-3732.

Assist Recipient in contacting Appropriate Agencies for Care Coordination of Non-Covered/Carved –Out Plan Services or Community Health Information



Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

- Please submit a separate claim reconsideration request form for each request
- No new claims should be submitted with this form.

Member Information (Required Information)			
Line of Business: (circle one) HPN SHL Senior Dimensions Medicaid			
Member ID and Date of Birth:	Claim #:	Date of Service:	Billed Amount:
Member Last Name	First Name	MI	Expected amount owed:

Physician/Health Care Professional Information			
Tax Identification Number (TIN):	Physician Name/Facility or other health care professional (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):	Email Address:	Contact Name and Telephone Number:

Reason for request: (please circle applicable reason)

- Exceeds Timely Filing
- Additional Information
- Coordination of Benefits
- Resubmission of a corrected claim
- Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
- Prior Authorization/Referral denial
- Resubmission of "Bundled/Incidental" services
- Carve-Outs

(Explain below)

Please include what you are expecting from HPN/SHL regarding this Claim Reconsideration

Comments:

Required attachments:

- Copy of EOP - Claim Form is **ONLY** required for Corrected Claims Submissions
- Other required attachments as outlined in the Claims Reconsideration Reference Guide

NEVADA UNIVERSAL
PRIOR AUTHORIZATION AND REFERRAL FORM

25.8

HEALTH PLAN NAME & MEMBER HEALTH PLAN I.D. #:	Primary Care Provider Name / Address / Phone & Fax #:
Health Plan Phone/Fax #:	
Date of Request:	Requesting Provider Name:
Member Name & SS#:	Requesting Provider's Address & Phone #:
Member's Address & Phone #:	Requesting Provider's Fax #:
	Requesting Provider's Tax ID #:
Member DOB:	HIPAA Provider Identification #:
Employer Group's Name & Phone #:	Contact Person (Name, Phone & Fax #):
Other Insurance (s):	Requesting Provider's Signature or Stamped Signature:
Diagnosis (inc. ICD code):	Procedure / Treatment Request (inc. CPT code):
	Number of Treatments Requested: _____ Inpatient / Outpatient Service Requested by Patient Yes No
Service Provider / Address / Phone #:	Place of Service / Facility and Address:
	Requested Procedure Date / Start Treatment Date:
Current Clinical Findings and Management All procedures/treatment requested require clinical information (may use this space - also see requirements below and attach to this form):	
<u>Pertinent Attachments</u> = Information to support the proposed diagnosis, treatment / procedure; i.e. current clinical findings (progress reports), results of laboratory testing, imaging studies (x-rays, etc.) must be submitted to prevent processing delays.	

Area for internal health plan use only	Authorization: Yes No	Date of Authorization:	Pended / Denied: (Reason):
Health plan contact name & phone #		Authorization Number:	

***All sections of this form must be completed.**

****On adverse determinations a reconsideration / expedited appeal may be requested.**

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is privileged & confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Revised 12/11/00

Imaging Services

To better serve you and your patients, Radiology asks you to please follow these guidelines when ordering procedures.

All Referral/Orders must be filled out completely to include Date, Patients Name, DOB, Exam type and Diagnosis.

If a Referral has been written for a Cat Scan, Ultrasound, IVP or Fluoro: Some radiology services over \$200.00 may require prior authorization. Exceptions are HPN, SD, and POS. After calling for prior authorization, documentation must be included on referral of Authorization # or "none required."

The referral can then be created in AR or fax **(304-7403)** to Imaging/Demand Management Department and patients should be instructed to call **877-5390** to schedule their appointment. **Failure to follow the requirements of this referral process will result in a higher out-of-pocket cost to the patient.**

FOR THE FOLLOWING EXAMS:

If you're Provider has given you a handwritten order. Please bring with you at time of exam.

**** FAILURE TO BRING WRITTEN DOCTOR'S ORDERS AT TIME OF EXAM MAY RESULT IN YOUR EXAM BEING RESCHEDULED.**

If an Order has been written for a Mammogram or Breast Ultrasound: Patients can be referred to call Demand Management Department at 877-5390 to schedule their appointment.

If an Order has been written for a Bone Density (DEXA): Patients can be referred to call Demand Management Department at 877-5390 to schedule their appointment.

If an Order has been written for a General X-ray: These can be done at all SMA Imaging clinics.
(No appointments needed)

Please provide patients with appropriate Imaging Expectation sheets according to exam being requested.

Listed below are the SMA locations and hours of operation.

SMA Location	Address	Telephone Number
Rancho	888 S. Rancho	(702) 877-5125 24hrs
South Eastern	4475 S. Eastern	(702) 737-1880 7am - 8pm
North Tenaya	2704 N. Tenaya Way	(702) 243-8500 7am - 7pm
Siena	2845 Siena Heights Dr.	(702) 617-1227 8am - 8pm
Montecito	7061 Grand Montecito Park Way	(702) 750-3900 8am - 8pm
West Tropicana	4835 S. Durango Dr.	(702) 984-5200 8am - 5pm
Nellis	540 N. Nellis	(702) 459-7424 8am - 5pm
Summerlin	10105 Banburry Cross Dr.	(702) 854-3221 8am - 4:30pm
West Oakey	4750 W Oakey Blvd	(702) 877-5199 8am - 5pm
Henderson	270 W. Lake Mead	(702) 677-3720 Days and Hours vary
Pahrump	2210 E. Calvada	(775) 727-6400 Days and Hours vary

1. Have patients call Member Services or their Insurance Company to assess if they will have a co-pay, for Imaging procedure.
2. For release of Southwest Medical Mammo CD/Films, please call 877-5125 option 5, M-F, 8am - 4:30pm. Mammograms done prior to 2012, please allow 3-5 business days for processing. Mammo films to be picked up at 888 S. Rancho ONLY
3. CD of digital images will be burned upon arrival at any SMA Imaging Clinic. Hard copy images will be printed per Providers written request. Please allow 30 minutes for processing.
5. We need a letter & copy of ID from Patient giving permission to family or friend to release films or CD.

PD-0815 (04/16)

ROUTINE Imaging Services Order

All orders must be filled out completely to include PATIENT'S NAME, DOB, EXAM TYPE and DIAGNOSIS.

PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____

PATIENT'S PHONE #: _____ PATIENT'S MEMBER #: _____

SMA MRN: _____

REQUESTING PROVIDER: _____

REQUESTING PROVIDER'S ADDRESS: _____

REQUESTING PROVIDER'S PHONE: _____ CC PROVIDER: _____

CONTACT PHONE: _____ CONTACT PERSON: _____

DIAGNOSIS AND CLINICAL INFORMATION

____ REPORT ONLY

____ CALL STAT REPORT – PH# _____

____ FAX STAT REPORT – FAX# _____

ICD10 CODE(S): _____

____ SEND CD OF IMAGES WITH PATIENT

Please Circle:

LEFT

RIGHT

BILATERAL

Abdomen 1V _____	Chest _____	Finger _____	Hip _____	Ribs _____
Abdomen 3V _____	Clavicle _____	Foot _____	Humerus _____	Shoulder _____
Ankle _____	Elbow _____	Forearm _____	Knee _____	T-Spine _____
C-Spine _____	Femur _____	Hand _____	L-Spine _____	Tib/Fib _____
			Pelvis _____	Wrist _____

Other/Special Instructions _____

**** PLEASE BRING THIS WRITTEN DOCTOR'S ORDERS AT TIME OF EXAM. ****

SMA Location	Address	Telephone Number
Rancho	888 S. Rancho	(702) 877-5125 24hrs
South Eastern	4475 S. Eastern	(702) 737-1880 7am - 8pm
North Tenaya	2704 N. Tenaya Way	(702) 243-8434 7am - 7pm
Siena	2845 Siena Heights Dr.	(702) 617-1227 8am - 8pm
Montecito	7061 Grand Montecito Pkwy.	(702) 750-3900 8am - 8pm
West Tropicana	4835 S. Durango Dr.	(702) 984-5200 8am - 5pm
Nellis	540 N. Nellis	(702) 459-7424 8am - 5pm
Summerlin	10105 Banbury Cross Dr.	(702) 854-3221 8am - 5pm
West Oakey	4750 W Oakey Blvd.	(702) 877-5199 8am - 5pm
Henderson	270 W. Lake Mead	(702) 677-3720 Days and Hours vary
Pahrump	2210 E. Calvada Blvd.	(775) 727-6400 Days and Hours vary

Physician Signature: _____ **Date** _____

CD-7459 (04/16)

Imaging Services – MAMMOGRAM

Appointment Date: _____ Appointment Time: _____

Your provider has submitted an order for a mammogram. To schedule or reschedule your exam, please call, **702-877-5390** Monday through Friday between the hours of 8:00am and 5:00pm. Listed below are the SMA mammogram locations.

If you're Provider has given you a handwritten order. Please bring with you at time of exam.

**** FAILURE TO BRING WRITTEN DOCTOR'S ORDERS AT TIME OF EXAM MAY RESULT IN YOUR EXAM BEING RESCHEDULED.**

Screening Mammograms

<i>Location of Appointment</i>	<i>SMA Location</i>	<i>Address</i>
	South Eastern	4475 S. Eastern
	West Tropicana	4835 S. Durango Dr.
	North Tenaya	2704 N. Tenaya Way
	Siena	2845 Siena Heights Dr.
	Nellis	540 N. Nellis
	Summerlin	10105 Banburry Cross Dr.
	West Oakey	4750 W Oakey Blvd

Diagnostic Mammograms / Breast Ultrasound

<i>Location of Appointment</i>	<i>SMA Location</i>	<i>Address</i>
	Rancho	888 S. Rancho Lower Level

To better serve you, Imaging Services asks that you:

1. Arrive 10 minutes prior to your appointment time for paperwork. If you are late for your appointment, you may be rescheduled.
2. You may have a co-pay for your procedure, please call your insurance company to verify the amount.
3. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
4. If you have questions about the exam that is being ordered for you please contact your provider directly.

Listed below is the preparation for this exam.

1. **Do not** use powder, creams, perfumes, deodorant or oils around the breast area or under the arms the day of the examination.
2. **If your last mammogram was digital please bring a CD in place of film.**
3. MAMMOGRAM CD/films done out-of-state or at another facility other than SOUTHWEST MEDICAL ASSOCIATES, must be hand carried the day of your appointment or arrangements made ahead of time for the CD/films to be mailed to:
 Southwest Medical Associates, Inc.
 Attn: Rancho Radiology Dept.
 P.O Box 15645
 Las Vegas, NV 89114-5645
4. For release of Southwest Medical Mammo CD/Films, please call 877-5125 option 5, M–F, 8am – 4:30pm. Mammograms done prior to 2012, please allow 3-5 business days for processing.
 Mammo films to be picked up at 888 S. Rancho ONLY



MAMMOGRAM & BREAST ULTRASOUND Imaging Services Order

All orders must be filled out completely to include PATIENT'S NAME, DOB, EXAM TYPE and DIAGNOSIS.

PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____

PATIENT'S PHONE #: _____ PATIENT'S MEMBER #: _____

SMA MRN: _____

REQUESTING PROVIDER: _____

REQUESTING PROVIDER'S ADDRESS: _____

REQUESTING PROVIDER'S PHONE: _____ CC PROVIDER: _____

CONTACT PHONE: _____ CONTACT PERSON: _____

DIAGNOSIS AND CLINICAL INFORMATION

____ REPORT ONLY

____ CALL REPORT – PH# _____

ICD10 CODE(S): _____ FAX REPORT – FAX# _____

Patients need to call Demand Management Department at 877-5390 to schedule their appointment.

Please Circle: **LEFT** **RIGHT** **BILATERAL**

MAMMOGRAM, SCREENING _____

MAMMOGRAM,DIAGNOSTIC _____

MAMMOGRAM,SCREENING W IMPLANTS _____

MAMMOGRAM,DIAGNOSTIC W IMPLANTS _____

____ US BREAST

Other/Special Instructions _____

**** PLEASE BRING THIS WRITTEN DOCTOR'S ORDERS AT TIME OF EXAM. ****

Screening Mammograms

SMA Location	Address
South Eastern	4475 S. Eastern
North Tenaya	2704 N. Tenaya Way
Siena	2845 Siena Heights Dr.
West Tropicana	4835 S. Durango Dr.
Nellis	540 N. Nellis
Summerlin	10105 Banbury Cross Dr.
West Oakey	4750 W Oakey Blvd.

Diagnostic Mammograms / Breast Ultrasound

SMA Location	Address
Rancho	888 S. Rancho

Physician Signature: _____ **Date** _____

CD-7458 (04/16)



25.13

BONE DENSITY (DEXA) Imaging Services Order

All orders must be filled out completely to include PATIENT'S NAME, DOB, EXAM TYPE and DIAGNOSIS

PATIENTS NAME: _____ DATE OF BIRTH: ____/____/____

PATIENT'S PHONE #: _____ PATIENT'S MEMBER #: _____

SMA MRN: _____

REQUESTING PROVIDER: _____

REQUESTING PROVIDER'S ADDRESS: _____

REQUESTING PROVIDER'S PHONE: _____ CC PROVIDER: _____

CONTACT PHONE: _____ CONTACT PERSON: _____

DIAGNOSIS AND CLINICAL INFORMATION

ICD10 CODE(S): _____

REPORT ONLY

CALL REPORT - PH#

FAX REPORT - FAX#

Patients need to call Demand Management Department at 877-5390 to schedule their appointment.

BONE DENSITY (DEXA)

Other/Special Instructions _____

**** PLEASE BRING THIS WRITTEN DOCTOR'S ORDERS AT TIME OF EXAM. ****

SMA Location	Address
South Eastern	4475 S. Eastern
Rancho	888 S. Rancho

Physician Signature: _____ **Date** _____

CD-7456 (11-15)



Imaging Services – DEXA SCAN – BONE DENSITY

Appointment Date: _____ Appointment Time: _____

Your provider has written you an order for a Bone Density exam. To schedule or reschedule your exam, please call, **702-877-5390** Monday through Friday between the hours of 8:00am and 5:00pm. Listed below are the SMA locations.

**** FAILURE TO BRING WRITTEN DOCTOR'S ORDERS AT TIME OF EXAM MAY RESULT IN YOUR EXAM BEING RESCHEDULED OR CANCELLED.**

Location of Appointment	SMA Location	Address
	Rancho	888 S. Rancho (300 lbs and under)
	South Eastern	4475 S. Eastern Ave (350 lbs and under)

To better serve you, Imaging Services asks that you:

1. Arrive 10 minutes prior to your appointment time for paperwork. If you are late for your appointment, you may be rescheduled.
2. You may have a co-pay for your procedure, please call your insurance company to verify the amount.
3. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
4. If you have questions about the exam that is being ordered for you please contact your provider directly.

Listed below is the preparation for this exam.

1. Please wear clothing that does not have METAL, ZIPPERS, and BRAS or they will need to be removed prior to exam.
2. **NO MULTIVITAMINS OR ANTACIDS CONTAINING CALCIUM** on THE SAME DAY of EXAM.
3. Take all your other medications as usual.
4. If you have had any x-rays within the past 30 days involving Barium, please make sure this is scheduled 30 days after any barium study.
5. **FEMALE PATIENTS ONLY** – If you are still menstruating please schedule your appointment within 2 weeks of your last period.

CAT SCAN Imaging Services

All orders must be filled out completely to include PATIENT'S NAME, DOB, EXAM TYPE and DIAGNOSIS.

PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____

PATIENT'S PHONE #: _____ PATIENT'S MEMBER #: _____

SMA MRN: _____

REQUESTING PROVIDER: _____

REQUESTING PROVIDER'S ADDRESS: _____

REQUESTING PROVIDER'S PHONE: _____ CC PROVIDER: _____

CONTACT PHONE: _____ CONTACT PERSON: _____

IS THIS A TRANSPLANT PATIENT? _____

DIAGNOSIS AND CLINICAL INFORMATION

____ STAT (24hrs.)

____ Expedited (72hrs)

____ REPORT ONLY

____ CALL STAT REPORT – PH# _____

____ AT RISK (14 days)

____ Routine (30 days)

____ FAX STAT REPORT – FAX# _____

ICD10 CODE(S): _____

____ SEND CD OF IMAGES WITH PATIENT

PLEASE INDICATE WHAT EXAM:

EXTREMITY ONLY PLEASE CIRCLE:

LEFT

RIGHT

BILATERAL

CT ABDOMEN _____

CT HEAD/BRAIN _____

CT SOFT TISSUE NECK _____

CT ABD/PELVIS _____

CT FACIAL _____

CT C-SPINE _____

CT CHEST _____

CT MANDIBLE _____

CT L-SPINE _____

CT CHEST/ABDOMEN _____

CT ORBITS _____

CT T-SPINE _____

CT CHEST/ABD/PELVIS _____

CT IAC/SELLA _____

CT EXTREMITY LOWER _____

CT PELVIS _____

CT SINUS. _____

CT EXTREMITY UPPER _____

PLEASE CIRCLE:

WITHOUT CONTRAST

WITH CONTRAST

Other/Special Instructions _____

SMA Location	Address
Rancho	888 S. Rancho
South Eastern	4475 S. Eastern
North Tenaya	2704 N. Tenaya Way

Physician Signature: _____ Date _____



Imaging Services – CT Scan

Exam: _____ Appointment Date: _____ Appointment Time: _____

Location for Exam: _____ 888 S. Rancho Dr. _____ 4475 S. Eastern _____ 2704 N. Tenaya Way

Your provider will send your referral to the Southwest Medical Associates (SMA) Scheduling department. Please allow two to three business days for your referral to be processed. To schedule, reschedule or cancel your exam, please call, **877-5390** Monday through Friday between the hours of 8:00am and 5:00pm.

Bring your most recent films, related to the current problem, which were done at a facility other than Southwest Medical Associates. They must be hand carried the day of your appointment.

To better serve you, Imaging Services asks that you:

1. Arrive 10 minutes prior to your appointment time for paperwork and check in at the reception desk. If you are late for your appointment, you may be rescheduled.
2. You may have a co-pay for your procedure, please call your insurance company to verify the cost.
3. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
4. If you have questions about the exam that is being ordered for you please contact your provider directly.

If you are a diabetic taking a medication that includes Glucophage/metformin, please contact your provider regarding your medication, lab work will need to be done 48hrs after your exam. If your exam is being ordered with IV contrast and you are allergic to iodine, you must contact your provider for specific instructions regarding your exam.

If you are having an exam that will use IV contrast, you *may* be required to have a blood test that must be completed a minimum of 3 days prior to your exam date. This blood test is a BUN and Creatinine and should be ordered by your provider. Reasons patients must have the blood test:

1. You are 60 years of age or older
2. You have known or potential renal disease.
3. You are a diabetic.

For best results some examinations require the administration of a preparation. Listed below are the preparations required for these exam types. All oral CT prep solutions can be picked up at any SMA facility. Failure to prepare may result in rescheduling your appointment. **Exams not listed will not require any preparation.**

***CT Scan of the brain, soft tissue of the neck, or the chest (with IV contrast)**

1. Nothing to eat for four (4) hours prior to the exam.
2. You may have clear liquids up to two (2) hours prior to the exam.
3. Take prescribed medication (unless instructed otherwise)
4. Blood work as needed

***CT Scan of the abdomen:**

1. Nothing to eat for four (4) hours prior to the exam.
2. You may have clear liquids up to two (2) hours prior to the exam.
3. Take prescribed medication (unless instructed otherwise)
4. One hour prior to your exam, drink the 1 bottle of CT oral prep.

***CT Scan of the pelvis, or both the abdomen and pelvis:**

1. Nothing to eat four (4) hours prior to the exam.
2. You may have clear liquids until two (2) hours prior to the exam.
3. Take prescribed medications (unless instructed otherwise)
4. Drink one (1) bottle of the CT oral prep, three hours prior to your exam.
5. Finish drinking the 2nd bottle of the CT oral prep one-hour prior to your exam.

*These exams usually require an intravenous injection of a substance known as, iodine contrast media, which helps visualize blood vessels and organs

FLUORO Imaging Services

All orders must be filled out completely to include PATIENT'S NAME, DOB, EXAM TYPE and DIAGNOSIS.

PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____

PATIENT'S PHONE #: _____ PATIENT'S MEMBER #: _____

SMA MRN: _____

REQUESTING PROVIDER: _____

REQUESTING PROVIDER'S ADDRESS: _____

REQUESTING PROVIDER'S PHONE: _____ CC PROVIDER: _____

CONTACT PHONE: _____ CONTACT PERSON: _____

IS THIS A TRANSPLANT PATIENT? _____

DIAGNOSIS AND CLINICAL INFORMATION

____ STAT (24hrs.)

____ Expedited (72hrs)

____ REPORT ONLY

____ CALL STAT REPORT – PH# _____

____ AT RISK (14 days)

____ Routine (30 days)

____ FAX STAT REPORT – FAX# _____

ICD10 CODE(S): _____

____ SEND CD OF IMAGES WITH PATIENT

PLEASE INDICATE WHAT EXAM:

BARIUM ENEMA _____

BARIUM ENEMA, AIR CONTRAST _____

CYSTOGRAM _____

CYSTOGRAM, VOIDING _____

ESOPHAGRAM _____

HYSTEROSALPINGOGRAM _____

IVP _____

____ MYELOGRAM, CERVICAL

____ MYELOGRAM, LUMBAR

____ MYELOGRAM, THORACIC

____ SMALL BOWEL FOLLOW THROUGH

____ UPPER GI

____ UPPER GI AND ESOPHAGRAM

____ UPPER GI AND SMALL BOWEL STUDY

Other/Special Instructions _____

<i>SMA Location</i>	<i>Address</i>
Rancho	888 S. Rancho

Physician Signature: _____ **Date** _____

Imaging Services – Fluoroscopy Exam

Exam: _____ Appointment Date: _____ Appointment Time: _____

Location for Exam: 888 S. Rancho Dr.

Your provider will send your referral to the Southwest Medical Associates (SMA) Scheduling department. Please allow two to three business days for your referral to be processed. To schedule or reschedule your exam, please call, **877-5390** Monday through Friday between the hours of 8:00am and 5:00pm.

Bring your most recent films, related to the current problem, which were done at a facility other than Southwest Medical Associates. They must be hand carried the day of your appointment.

To better serve you, Imaging Services asks that you:

1. Please check in at the reception desk located in the lobby.
2. Arrive 10 minutes prior to your appointment time for paperwork. If you are late for your appointment, you may be rescheduled.
3. You may have a co-pay for your procedure, please call your insurance company to verify the cost.
4. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
5. If you have questions about the exam that is being ordered for you please contact your provider directly.

For best results some examinations require the administration of a preparation. Listed below are the preparations required for these exam types. Failure to prepare may result in rescheduling your appointment.

These exams should not be scheduled after 9:00am if you are Diabetic.**Barium Enema (BE)**

Your ordering provider will prescribe moviprep for you to pick up from the pharmacy. Moviprep is a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements

Once your appointment is scheduled pick up your prep

Please take this prep as directed by your ordering provider.

Please complete the entire bowel prep regimen unless otherwise directed by your provider.

Upper GI (UGI), Barium Swallow, Esophogram, Small Bowel Follow Through

Nothing to eat, drink, or smoke after midnight. No breakfast until after the examination is completed. Small Bowel follow-through exams may take 4 hours or more to complete. Please wear comfortable shoes.

Imaging Services – Hysterosalpingogram (HSG) Exam

Exam: _____ Appointment Date: _____ Appointment Time: _____

Location for Exam: 888 S. Rancho Dr.

Your provider will send your referral to the Southwest Medical Associates (SMA) Scheduling department. Please allow two to three business days for your referral to be processed.

To schedule or reschedule your exam, please call, **877-5390** Monday through Friday between the hours of 8:00am and 5:00pm, **on the first day of your menstrual cycle. Essure patients must be scheduled 8 weeks after Essure procedure.**

Bring your most recent films, related to the current problem, which were done at a facility other than Southwest Medical Associates. They must be hand carried the day of your appointment.

To better serve you, Imaging Services asks that you:

1. Please check in at the reception desk located in the lobby.
2. Arrive 10 minutes prior to your appointment time for paperwork. If you are late for your appointment, you may be rescheduled.
3. You may have a co-pay for your procedure, please call your insurance company to verify the amount.
4. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
5. If you have questions about the exam that is being ordered for you, please contact your provider directly.

Listed below is the preparation required for this exam. Failure to prepare will result in rescheduling your appointment.

HSG Appointment: (IF you are still on your menstrual cycle exam cannot be done)**Regular Menstrual cycle:**

1. The exam will be scheduled for 7-10 days, from the 1st day of your menstrual cycle.
2. Patient must be accompanied by an individual to drive the patient home after the examination is complete.
3. No sexual intercourse from the 1st day of your menstrual cycle until 24 hours after the exam.

Irregular or No Menstrual cycle: Complete lab work ordered by requesting provider/PCP (Pregnancy test) 2 days prior to appointment.

1. No sexual intercourse for 17 consecutive days, day 15 get blood drawn, schedule your exam on day 16 or 17.
Refrain from sexual intercourse from day 1 until 24 hours after the scheduled exam.
2. Obtain an order from your provider for a serum blood pregnancy test to be done on day 15 depending on the day of the exam (1 or 2 days prior to scheduled exam).
3. Exam must be done on day 16 or 17 ***No sexual intercourse from day 1 until 24 hours after scheduled exam. ****

Essure HSG Appointment:

1. Please refer to Regular or Irregular Menstrual cycle protocol above.

Please be aware the Exam may take about 1 hour unless Radiologist needs additional Images which may require additional time.

PD-0798 (01/16)

Imaging Services – IVP Exam

Location: **888 S. Rancho Dr.** Appointment Date: _____ Appointment Time: _____

Your provider will send your referral to the Southwest Medical Associates (SMA) Scheduling department. Please allow two to three business days for your referral to be processed. To schedule or reschedule your exam, please call, **877-5390** Monday through Friday between the hours of 8:00am and 5:00pm.

Bring your most recent films, related to your current problem, which were done at a facility other than Southwest Medical Associates. They must be hand carried on the day of your appointment.

To better serve you, Imaging Services asks that you:

1. Please check in at the reception desk located in the lobby.
2. Arrive 10 minutes prior to your appointment time for paperwork. If you are late for your appointment, you may be rescheduled.
3. You may have a co-pay for your procedure, please call your insurance company to verify the cost.
4. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
5. If you have questions about the exam that is being ordered for you please contact your provider directly.

Your ordering provider will prescribe Moviprep for you to pick up from the pharmacy.

Moviprep is a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements

Once your appointment is scheduled pick up your prep

Please take this prep as directed by your ordering provider.

Please complete the entire bowel prep regimen unless otherwise directed by your provider.

You are having an exam that will use IV contrast, you *may* be required to have a blood test that must be completed a minimum of 3 days prior to your exam date. This blood test required is a BUN and Creatinine and should be ordered by your provider. Reasons patients must have the blood test:

1. You are 60 years of age or older
2. You have known or potential renal disease
3. You are a diabetic

Failure to complete lab work may result in your appointment being rescheduled

If you are a diabetic taking a medication that includes Glucophage, and/or you are allergic to iodine, you must contact your provider for specific instructions regarding your exam.

Imaging Services – Myelogram & Post Myelogram CT Scan

Exam: _____ Appointment Date: _____ Appointment Time: _____

Location for Exam: _____ 888 S. Rancho Dr.

Your provider will send your referral to the Southwest Medical Associates (SMA) Scheduling department. Please allow two to three business days for your referral to be processed.

To schedule or reschedule your exam, please call, **877-5390** Monday through Friday between the hours of 8:00am and 5:00pm.

To better serve you, Imaging Services asks that you:

1. Please check in at the cubicles located in the lobby.
2. Arrive 10 minutes prior to your appointment time for paperwork. If you are late for your appointment, you may be rescheduled.
3. You may have a co-pay for your procedure, please call your insurance company to verify the amount.
4. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
5. If you have questions about the exam that is being ordered for you, please contact your provider directly.

If you are a diabetic taking a medication that includes glucophage, please contact your provider regarding your medication. Your exam is being ordered with contrast. If you are allergic to iodine, you must contact your provider for specific instructions regarding your exam.

Listed below is the preparation required for this exam. Failure to prepare may result in rescheduling your appointment.

Prior to Appointment:

1. Patient to complete lab work ordered by requesting provider/PCP (PT/PTT/INR/ PLATELETS) **14** days prior to appointment.
2. Patient to bring Non-SMA images related to the exam on the day of the appointment.
3. No Blood Thinners (i.e. Aspirin(ASA), Plavix, Coumadin) **7** days prior to appointment.

Day of Appointment:

1. Patient must have a regular breakfast and drink plenty of fluids prior to appointment. Nothing to eat or drink after 9:00 a.m. unless diabetic, If diabetic limit intake to clear liquids.
2. Patient must be accompanied by an individual to drive the patient home after the examination is complete.
3. Please be aware the Myelogram and post Myelogram CT may take 2 to 3 hours to complete.

ULTRASOUND Imaging Services

All orders must be filled out completely to include PATIENT'S NAME, DOB, EXAM TYPE and DIAGNOSIS.

PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____

PATIENT'S PHONE #: _____ PATIENT'S MEMBER #: _____

SMA MRN: _____

REQUESTING PROVIDER: _____

REQUESTING PROVIDER'S ADDRESS: _____

REQUESTING PROVIDER'S PHONE: _____ CC PROVIDER: _____

CONTACT PHONE: _____ CONTACT PERSON: _____

IS THIS A TRANSPLANT PATIENT? _____

DIAGNOSIS AND CLINICAL INFORMATION

_____ STAT (24hrs.)	_____ Expedited (72hrs)	_____ REPORT ONLY
_____ AT RISK (14 days)	_____ Routine (30 days)	_____ CALL STAT REPORT – PH# _____
ICD10 CODE(S): _____	_____ SEND CD OF IMAGES WITH PATIENT	_____ FAX STAT REPORT – FAX# _____

PLEASE INDICATE WHAT EXAM

_____ US ABDOMEN, COMPLETE	_____ US PELVIC & TVAG, COMPLETE
_____ US AORTA, COMPLETE	_____ US TRANSVAGINAL
_____ US GALL BLADDER	_____ US PELVIC TRANSABDOMINAL
_____ US LIVER, COMPLETE	_____ US CAROTID, COMPLETE BILATERAL
_____ US LIVER, VASCULAR ONLY	_____ US THYROID
_____ US RENAL/BLADDER	_____ US SOFT TISSUE NECK/HEAD
_____ US RENAL, VASCULAR ONLY	_____ US MISC for LUMP-VARIOUS BODY PART
_____ US RETROPERITONEAL, BLADDER	_____ US LOWER VENOUS
_____ US TESTICULAR	_____ US UPPER VENOUS

EXTREMITY/VENOUS ONLY Please Circle: **LEFT** **RIGHT** **BILATERAL**

Other/Special Instructions _____

<i>SMA Location</i>	<i>Address</i>
Rancho	888 S. Rancho
South Eastern	4475 S. Eastern
North Tenaya	2704 N. Tenaya Way
Siena	2845 Siena Heights Dr.
Montecito	7061 Grand Montecito Park Way
Summerlin	10105 Banburry Cross Dr.
West Oakey	4750 W Oakey Blvd.

Physician Signature: _____ **Date** _____

CD-7461 (04/16)

Imaging Services – ULTRASOUND

Exam: _____ Appointment Date: _____ Appointment Time: _____

Your provider will send your referral to the Southwest Medical Associates (SMA) Scheduling department. Please allow two to three business days for your referral to be processed.

To schedule or reschedule your exam, please call, **877-5390** Monday through Friday between the hours of 8:00am and 5:00pm.

Location of Appointment	SMA Location	Address
	Rancho	888 S. Rancho, Lower Level
	South Eastern	4475 S. Eastern
	North Tenaya	2704 N. Tenaya Way
	Siena	2845 Siena Heights Dr.
	Montecito	7061 Grand Montecito Park Way
	Summerlin	10105 Banbury Cross Dr.
	West Oakey	4750 W Oakey Blvd

To better serve you, Imaging Services asks that you:

1. Arrive 10 minutes prior to your appointment time for paperwork. If you are late for your appointment, you may be rescheduled.
2. You may have a co-pay for your procedure, please call your insurance company to verify the cost.
3. **DO NOT** bring children with you to your appointment. We do not have the facilities or the personnel to provide for their care while your exam is being done.
4. If you have questions about the exam that is being ordered for you please contact your provider directly.

Listed below are the preparations required for the identified exams. Failure to prepare may result in rescheduling your appointment.

Abdominal, aorta, gallbladder, bile ducts, liver, and pancreas Ultrasounds

1. Nothing to eat, drink or smoke for 8 hours prior to exam.
2. You may take your medications with a small amount of water on the day of your exam.

Renal (kidney) Bladder Ultrasound **THE BLADDER MUST BE FULL TO HAVE THIS EXAM DONE**

1. Drink **16 oz** of water starting 45 mins. Before the exam and finishing ½ hour before the exam.
2. Your bladder will fill during the ½ hour before the exam.
3. **DO NOT EMPTY YOUR BLADDER BEFORE THE EXAM.**

Pelvic Ultrasound **THE BLADDER MUST BE FULL TO HAVE THIS EXAM DONE**

1. Drink **32 oz** of water and finishing 1 hour before the exam.
2. Your bladder will fill during the 1 hour before the exam.
3. **DO NOT EMPTY YOUR BLADDER BEFORE THE EXAM.**

OB (OBSTETRICAL) Ultrasound **THE BLADDER MUST BE FULL TO HAVE THIS EXAM DONE**

1. Drink **26 oz** of water starting one hour before the exam and finishing 20-30 mins. before the exam.
2. Your bladder will fill during the ½ hour before the exam.
3. Family members are not allowed in the exam room.
4. **DO NOT EMPTY YOUR BLADDER BEFORE THE EXAM.**

Breast, popliteal, testicular, soft tissue, venous, thyroid, transvaginal and carotid Ultrasounds

1. No preparation is needed for these exams.
2. All breast ultrasound patients: please pick up your CD or mammogram films and bring them with you to your appointment if they were done at a facility other than SMA or you have signed them out.



HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

P.O. Box 15645 • Las Vegas, Nevada 89114-5645

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EXHIBIT 39

PART 1 OF 2

EXHIBIT 39

1 DEF320246



2018 UnitedHealthcare Care Provider Administrative Guide



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 UHCCommunityPlan.com > Health Care Professionals, and select the correct state.
- If you are looking for a UnitedHealthcare Dual Complete manual in Arizona, Massachusetts, New Jersey, New York or Tennessee, go to UHCCommunityPlan.com. All other UnitedHealthcare Dual Complete plans follow this Provider Administrative Guide.

You may easily find information in this guide using the following 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 2018 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, 2018 for physicians, health care professionals, facilities and ancillary providers currently participating in our commercial and Medicare networks. It is effective now for care providers who join our network on or after Jan. 1, 2018. 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 with us.
- “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.
- “Us,” “we” or “our” refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this guide.

Medicare 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 and MA members enrolled in UnitedHealthcare Community Plan Medicare Advantage plans, and UnitedHealthcare Dual Complete members in Arizona, Massachusetts, New Jersey, New York and Tennessee. If a particular section does not apply to such MA members, it is indicated.

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 with us and this guide, your agreement controls (except where your agreement with us 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.

*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 you may need for most UnitedHealthcare benefit plans. 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 with us 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	<i>Advance Notification/Prior Authorization Requirements</i> to this guide. Myallsaversprovider.com
MDIPA: MD Individual Practice Association, Inc.	DC, DE, MD, VA, WV Some Counties in: Southeastern PA	<i>Mid-Atlantic Regional Supplement</i> to this guide. UHCprovider.com
Medica HealthCare	FL counties: Broward and Miami-Dade	<i>Medica HealthCare Supplement</i> to this guide. UHCprovider.com
Capitated and/or Delegated Providers Commercial and MA	All Markets	<i>Capitation and/or Delegation Supplement</i> to this guide.
NHP: Neighborhood Health Partnership, Inc.	FL	<i>Neighborhood Health Partnership Supplement</i> to this guide. UHCprovider.com
OCI: Optimum Choice Inc.	DC, DE, MD, VA, WV Some Counties in: PA	<i>Mid-Atlantic Regional Supplement</i> to this guide. UHCprovider.com
OneNet PPO:	DC, DE, MD, NC, PA, VA, WV Limited Network in: FL, GA, SC, TN	<i>OneNet PPO Supplement</i> to this guide. UHCprovider.com

Plan Name	Location of Most Members Subject to Additional Guides	Location of Plan Information
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.	<i>Oxford Commercial Supplement</i> to this guide. For commercial benefits: OxfordHealth.com For Medicare benefits: UHCprovider.com
Preferred Care Partners	FL counties: Broward, Miami-Dade and Palm Beach	<i>Preferred Care Partners Supplement</i> 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 the following 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.	<i>River Valley Entities Supplement</i> 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	<i>UnitedHealthcare West Supplement</i> to this guide. UHCprovider.com
UnitedHealthOne: - Golden Rule Insurance Company Group #705214 - Oxford Health Insurance, Inc. Group #908410	All Markets New Jersey	<i>UnitedHealthOne Individual Plans Supplement</i> 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 with us 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
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 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. uhccommunityplan.com and UHCprovider.com
UnitedHealthcare Community Plan Medicare Advantage 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 uhccommunityplan.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 Link self-service tools, medical policies, news bulletins, and great resources to support administrative tasks including eligibility, claims and prior authorizations and notifications. UHCprovider.com replaces unitedhealthcareonline.com and UHCwest.com as these sites are being retired.

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 apps, 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. Link is your gateway to our online tools and is accessible on UHCprovider.com.

After submitting your transaction using Electronic Data Interchange (EDI), use Link apps to quickly find transaction

and documentation information related to our members and your submissions.

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 applications.

There are several Link apps to choose from. Here is a list of our most frequently used apps.

- **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/PriorAuth.
- **My Practice Profile**—View and update* your provider demographic data that UnitedHealthcare members see for your practice. For more information go 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 app 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 app is available to Link Password Owners only.

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

Watch for the most current information on Link updates by email, in the Network Bulletin, or on UHCprovider.com/Link.

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

Commercial & Medicare Advantage Products

Topic

Where to go

UnitedHealthcare Provider Website

To make navigating to our provider portal even easier, we have created 'vanity URLs' such as UHCprovider.com/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 claims reconsiderations.

Help Desks:

866-842-3278 (option 1 for UHCprovider.com and Link assistance). M-F, 7 a.m. to 9 p.m., Central Time (CT)

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/priorauth

Phone: United Voice Portal, 877-842-3210

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*.

Appeal – (Clinical) Urgent Submission

(Commercial members)

(MA – follow the directions in the customer decision letter)

All Savers, UnitedHealthOne 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 Medical 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, Radiology, and Outpatient Injectable Chemotherapy

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

Commercial & Medicare Advantage Products

Topic	Where to go
Claims (Filing, payments, reconsiderations)	EDI: UHCprovider.com/edi . View our Claims Payer List to determine the correct Payer ID. Link: UHCprovider.com/claimslink 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: Optumhealthfinancial.com > Physicians & Health Care Providers > Electronic Payments and Statements Or: the EPS app on Link Help Desk: 877-620-6194
Electronic Data Interchange (EDI) EDI Support	Online: UHCprovider.com/edi Help: UHCprovider.com > Contact Us > Technical Assistance Phone: 800-842-1109 (M-F, 7 a.m. – 9 p.m. CT)
Fraud, Waste and Abuse (Report potential non-compliance or suspected issues)	Online: uhc.com/fraud , select the “Report A Concern” icon. Phone: 877-842-3210 (United Voice Portal) Phone: 844-359-7736 For more information on Medicare fraud, waste, and abuse prevention efforts, refer to: <i>Chapter 14: Fraud, Waste and Abuse</i> .
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.
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	EDI: EDI278R transaction Link: UHCprovider.com/eligibilityLink > Submit 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, OR 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

Electronic Data Interchange (EDI)

The fastest and preferred communication is electronic. Using EDI to exchange information with us and other payers has many advantages:

- 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

Getting Started

- If you have a practice management or hospital information system, contact your software vendor to find out what electronic transactions are offered.
- Contact clearinghouses to review which electronic transactions can interact with your software system. Read our [Clearinghouse Options](#) page for ideas.

EDI Education and Support

The ASC X12 Technical Report Type 3 publications are the leading resource for EDI Transactions. You can buy the ASC X12 Technical Report Type 3 publications from Washington Publishing at wpc-edi.com.

UHCprovider.com/edi can help you with EDI connectivity, tips to submit claims electronically and better understand the purpose of each available EDI transaction. Our [Companion Guides](#) have the required data elements for exchanging EDI transactions with us.

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:

- **EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse
- **Online:** Using [eligibilityLink](#)
- **Phone:** 877-842-3210

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

The EDI transaction is a powerful online tool that 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/state > Select your state > CommercialUnitedHealthcare 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.

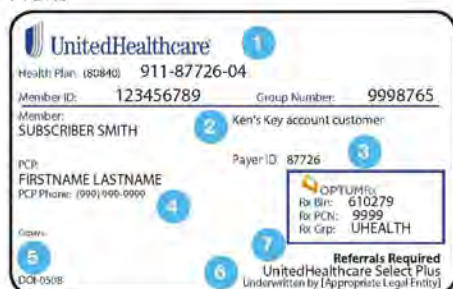
Bar-coded Health Care ID Cards

We use bar codes on most health care ID cards to make it easy for you to access 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



- UnitedHealthcare brand:** including UnitedHealthcare, AllSavers, Golden Rule, UnitedHealthcare Oxford, UnitedHealthOne.
- Member Plan Identifier:** This is a customized field to describe the member's benefit plan (i.e., Individual Exchange, Tiered Benefits, ACO, etc.).
- 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.
- 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.

- Copay information:** If this area is blank, the member is not required to make a copay at the time of service.
- The Benefit Plan Name:** Identifies the applicable benefit plan name.
- Referral requirements identifier:** Identifies plans with referral requirements. Requires PCP to send electronic referrals.
- For Members section:** Lists benefit plan contact information and if applicable, referrals and notifications information.
- For Providers section:** Including the prescription plan name.

Medicare Advantage (MA) Health Care ID Card

To see specific MA benefit plan ID cards go to UHCprovider.com/plans > Select your state > Select the Medicare Advantage cell.

MA ID Example

Front



Back



MA ID card legend:

- 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.
- 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.
- 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 FL 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
 - Care Improvement Plus 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 your patients who are our members. If you are arranging a substitute care provider, please use those who participate with the member’s benefit plan so that services may be covered under the member’s network benefit.

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 standards for appointment access and after-hours care to help ensure timely access to care for members. We use these standards 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

The guidelines listed above 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.

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

Services provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities, as required by state and federal regulations.

Primary Care Physicians (PCP) Responsibilities

As a PCP, you are responsible to provide medically necessary primary care services. You are the coordinator of your patients’ 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 provider performance data.

Demographic Changes



If you have received the upgraded My Practice Profile and have editing rights, providers can access Link's My Practice Profile App to make many of the updates required in this section. Facilities can use the UnitedHealthcare Facility Demographic Updates app. 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

Send notice of the following occurrences to the address noted in your provider agreement. This is needed within 10 calendar days of it occurring.

- 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.

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.

You must 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)

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 will apply 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 the discretion of UnitedHealthcare. 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 app on Link from UHCprovider.com to update your information. For Medica Healthcare and Preferred Care Partners you must contact their Network Management Department by email, pcp-NetworkManagementServices@uhcsouthflorida.com, or phone, 877-670-8432. Changes should not be made in Link.

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. For Medica Healthcare and Preferred Care Partners you must contact their Network Management Department by email, pcp-NetworkManagementServices@uhcsouthflorida.com, or phone, 877-670-8432.

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** app for Providers; UnitedHealthcare Facility Demographic Updates app 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.

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 provider 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.

Effective April 1, 2017, 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 participation agreement ends for any reason, you may be required to help your patients find another participating care provider. You may need to provide services at our contracted rate during the continuation period, per your participation 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.

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 Medicare Advantage (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 plan, 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](#).
- 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 network participation 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, 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 describe 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 will send the letter to the member.

In addition to making sure the letter is approved by the governing regulatory body, we will 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 the date of the reporting deadline that we establish.

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 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 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 <i>Chapter 6: Medical Management</i> 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 <i>Chapter 6: Medical Management</i> 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.
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 <i>Chapter 6: Medical Management</i> 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 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 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.	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.
NexusACO OAP[®]	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).		
UnitedHealthcare NexusACO R[®]	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.	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.
UnitedHealthcare NexusACO RP[®]	NexusACO R provides out-of-network benefits. ³ NexusACO RB and RP do not (except for emergency services). All NexusACO benefit plans are tiered.		

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 generally less than 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 healthcare 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 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.

Primary Care Providers (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.

There are three ways to identify the member's assigned PCP:

- **EDI:** Transactions 270/271 through your vendor or clearinghouse
- **Online:** Using [eligibilityLink](#)
- **Phone:** 877-842-3210

Remember, you can submit address corrections on [UHCprovider.com/mypracticeprofile](https://uhcprovider.com/mypracticeprofile) or call the phone number on the back of the member's health care ID card.

HRAs and HSAs 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 UHCCommunityPlan.com 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 provider network. For information about UnitedHealthcare MedicareDirect, go to: UHCprovider.com/plans > Select your state > Medicare.

This guide also does not apply to the UnitedHealthcare Dual Complete plans in Arizona, Massachusetts, New Jersey, New York and Tennessee. Otherwise, all other UnitedHealthcare Dual Complete plans follow this guide.

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 HMO-POS MedicareComplete Plus	Members who are Medicare eligible.	Members choose a PCP from the 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 <i>Medicare Advantage (MA) Referral Required Plans</i> , or call 877-842-3210. Please have the health care ID and your TIN available. PCPs should coordinate care with the appropriate network specialists.	Yes, see guidelines in <i>Chapter 6: Medical Management</i> .
Local PPO and Regional PPO (RPPO) benefit plans under the UnitedHealthcare or AARP brands: - MedicareComplete Choice - MedicareComplete Choice Essential Local PPO and RPPO benefit plans under the Care Improvement Plus name: Care Improvement Plus Medicare Advantage	Members who are Medicare eligible.	Members choose a PCP from the 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 <i>Chapter 6: Medical Management</i> .

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 communities and require an institutional level of care.	Members choose a PCP from the 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 <i>Chapter 6: Medical Management</i> .

* The benefit level for non-emergency services from non-network physicians and other care providers is generally less than that for services from 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, PPO and Regional PPO) (For a detailed list of DSNP product names, go to UHCprovider.com/plans .)	Members who are both Medicare and Medicaid eligible.	Members choose a PCP from the 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 network specialists.	Yes, see guidelines in <i>Chapter 6: Medical Management</i> .
Chronic Special Needs Plans (PPO and Regional PPO) - Care Improvement Plus Gold Rx - Care Improvement Plus Silver Rx	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 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 <i>Chapter 6: Medical Management</i> .
Erickson Advantage Plans	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.*	No, a referral is not needed.	Yes, see guidelines in <i>Chapter 6: Medical Management</i> .

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 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 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 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 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 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 a 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 community 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.

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

Primary Care Physicians (PCP) Selection

Members are required to select a 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

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 Update Bulletin. This online resource provides notice to our network care providers of changes to MA Coverage Summaries. The bulletin is 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](#). As a supplemental reminder to the detailed policy update summaries announced in the Medicare Advantage Coverage Summary Update Bulletins, a list of recently approved, revised and/or retired Coverage Summaries, as well as Policy Guidelines, is also included in the monthly Network Bulletin available on UHCprovider.com/News.

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 network hospital to receive their full benefits.

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

Network hospitals agree to waive the Part A Inpatient Hospital Deductible (\$1,316 in 2017). While your hospital waives the Part A Deductible, your hospital still receives the remaining reimbursement from Medicare, which is about 90% of the total charges on average. 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. UnitedHealthcare reimburses these expenses directly to the hospital helping to remove the risk of bad debt collection. You 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 network, they may use their Original Medicare (Part A) benefits. However, the member is responsible for the Part A deductible that would have otherwise been paid for by UnitedHealthcare, 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 providing coverage for:

- 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. Our Electronic Payer ID is 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

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](https://www.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 benefit 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 the member's care. The member's PCP needs to submit electronic referrals to us before the member sees another network care provider (a network care provider that is not within the same tax ID as the member's PCP). Referrals are valid for any care provider within the same TIN as the specialist listed.

Online Referral Submission & Status Verification

There are multiple ways to submit referrals electronically:

1. **EDI:** Transaction 278R
2. **Link:** Go to UHCprovider.com/eligibilityLink to determine referral requirements by plan until you have access to referralLink
3. **Link:** ReferralLink will be expanded to all providers and markets during 2018.

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. Online referral submissions tools vary based on the member's benefit plan. The easiest way to determine the correct online submission method is to look up the member in [eligibilityLink](#). You'll see whether a referral is required and you can click on the “Referrals” link to open the correct submission tool.

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

You should 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 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. To access 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](#) > All UnitedHealthcare Plans > 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 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 app also shows 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**

* Delegated benefit plans may follow a separate referral exclusion list.

** Applies to select MA benefit plans.

- 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

The member's assigned PCP must:

- Submit referrals electronically using > EDI Transaction 278R
 - › UHCprovider.com/eligibility
 - › 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
- Follow all requirements
 - › If not, we deny the claim and the charge is non-billable to the member.

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

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.

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)
- M.D.IPA, Optimum Choice or OneNet
- Neighborhood Health Partnership (NHP)
- *Oxford Commercial*, except for UnitedHealthcare Oxford Navigate benefit plans
- Benefit plans subject to the *River Valley Entities Supplement*.
- UnitedHealthcare West or UnitedHealthcare West
- UnitedHealthcare Dual Complete Plans in Arizona, Massachusetts, New Jersey, New York and Tennessee.
- 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 UnitedHealthcare Commercial Advance Notification/Prior Authorization Requirements.

We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if the services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization Requirements, 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:

- 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 participation agreement with us.

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](#).

*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.

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

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.

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.

It may take up to 15 calendar days (14 calendar days for MA) for us to make a decision. We may extend this time if we need additional information.

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
- 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
- Neighborhood Health Partnership (NHP)
- *Oxford Commercial*, except for UnitedHealthcare Oxford Navigate Benefit Plans
- Benefit plans subject to the *River Valley Entities Supplement*.
- *UnitedHealthcare West* or UnitedHealthcare West
- Erickson Advantage
- UnitedHealthcare Community Plan Medicare Advantage benefit plans
- UnitedHealthcare Dual Complete plans in Arizona, Massachusetts, New Jersey, New York and Tennessee.
- 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 delay of notification 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 Care Plus 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](#).

* 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:
 - You must supply all requested information within four hours
 - If you receive our request after 1 p.m. local time:
 - Try to 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. For MA members, we use Medicare coverage guidelines. These guidelines overrule the nationally recognized criteria. 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.

	EDI 278 Transactions	Link/ UHCprovider.com	Live Call	VoiCert	Fax
Method	Electronic Advance Notification and Prior Authorization (278A) and Admission Notification (278N).	Electronic UHCprovider.com/priorauth Your vendor's website	Non-Electronic Advance Notification and Prior Authorization and Admission Notification; Notification Status for previously submitted notifications.	Non-Electronic Inpatient admission notification.	Non-Electronic Advance notification and prior authorization and 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.	Commercial members: 866-756-9733; MA members: 800-676-4798; Medicare Special Needs Plan members: 800-538-1339.
Business Hours (all times Eastern)	Monday – Friday: 7 a.m. to 2 a.m. Saturday: 7 a.m. to 6 p.m. Sunday: 7 a.m. to 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. to 12 a.m. Saturday: 7 a.m. to 6 p.m. Sunday: 7 a.m. to 5 p.m. Holidays: Same as above	Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.	VoiCert can be used 24/7, but submissions are processed the following business day: Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.	Faxes can be sent 24/7, but submissions are processed the following business day: Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.

Updating Advance Notification or Prior Authorization Requests

Before we make a coverage decision, you may update or provide additional information supporting your request. Once we approve the request, you can only update the date of service, as long as the original date of service has not passed. Make this change through UHCprovider.com or by phone. If you need to change anything else, you must submit a new request. If we do not approve the request, you cannot make changes. You can submit an appeal by following the instructions listed in the adverse determination letter we send.

You cannot make updates to an existing advance notification or prior authorization request after the service has been delivered. If, during the service, you perform an additional or different service than was originally approved, submit the supporting clinical information for the service at the time of claim submission for prompt adjudication of your claim.

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 and drug policies, and coverage determination guidelines and 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 medical policies, drug policies, and coverage determination guidelines (CDGs)) 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 guidelines 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.

Coverage Policies, Summaries and Guidelines for MA

We follow CMS guidance (including NCD and LCD guidelines) if the tools and guidelines 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 these policies and guidelines are on UHCprovider.com/policies > Medicare Advantage Policies. You can also call the telephone number listed on an Adverse Determination Notice.

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 noncovered 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.
- Comply with our request for additional information or documents and discussions, including any 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 Policies, Drug Policies and Coverage Determination Guidelines is available on UHCprovider.com/policies > Commercial Policies > [Medical & Drug Policies and Coverage Determination Guidelines](https://UHCprovider.com/policies).

We develop medical policies, drug policies, coverage determination guidelines and other 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 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 and Guideline 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.

Expedited or Urgent Appeals

If you have already provided the service, an urgent appeal is not available.

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 on UHCProvider.com/policies > Commercial Policies > [Medical & Drug Policies and Coverage Determination Guidelines](#) > Clinical Trials – Commercial Coverage Determination Guidelines (PDF), or UHCprovider.com/policies > Medicare Advantage Policies > [Coverage Summaries for Medicare Advantage Plans](#) > Experimental Procedures and Items, Investigational Devices, Clinical Trials.

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.

Denials, Delays or Modifications

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

Referral 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 (or pharmacist, 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,
- Referral requests being considered for denial will be reviewed by UnitedHealthcare staff qualified to make an appropriate determination, 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 [Redacted] 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 party member, member has authorized representative, or a non-contracted care provider, must be:

- Clearly stated;
- Include the specific reason for the reopening;
- In writing, and
- Files 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

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. This includes 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.

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. **Exception:** Care providers are required to follow this protocol for Options PPO benefit plans for members in Colorado. Colorado members are not responsible for providing notification or 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, 17245, 17246; AARP® MedicareComplete® Plan 1 - Group 18027, 18028, 18029, 18030; AARP® MedicareComplete® Plan 2 - Group 55860; AARP® MedicareComplete® Access Group 55306, 55307, 55430, 55431

New York: AARP® MedicareComplete - Group 66093; AARP® MedicareComplete Plan 1 - Group 66074 & 66091; AARP® MedicareComplete Plan 2 - Group 13012 & 66092; AARP® MedicareComplete Plan 3 - Group 66089; AARP® MedicareComplete Essential - Group 66075; AARP® MedicareComplete Mosaic - Group 66076

Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.

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 Requirement Resources.

Erickson Advantage Plans

UnitedHealthcare Nursing Home and UnitedHealthcare Assisted Living Plans (HMO SNP), (HMO-POS SNP), (PPO SNP)

UnitedHealthcare Senior Care Options (HMO 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, UnitedHealthOne, 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 App.
- **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:

- 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. Once the discussion is complete, 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/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 or 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/prior authorization request following the 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 is not a participating care provider, 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:

- 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 get the notification number from the participating ordering care provider 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:

- 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/priorauth > Prior Authorization and Notification Resources > 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 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. **Exception:** Care providers are required to follow this protocol for Options PPO benefit plans for members in Colorado. Colorado members are not responsible for providing notification or 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

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, 17245, 17246; AARP® MedicareComplete® Plan 1 - Group 18027, 18028, 18029, 18030; AARP® MedicareComplete® Plan 2 - Group 55860; AARP® MedicareComplete® Access Group 55306, 55307, 55430, 55431

New York: AARP® MedicareComplete - Group 66093; AARP® MedicareComplete Plan 1 - Group 66074 & 66091; AARP® MedicareComplete Plan 2 - Group 13012 & 66092; AARP® MedicareComplete Plan 3 - Group 66089; AARP® MedicareComplete Essential - Group 66075; AARP® MedicareComplete Mosaic - Group 66076

Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.

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 Requirement Resources.

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 > Prior Authorization and Notification Resources > 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 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. 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, UnitedHealthOne, 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 App.
- **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 this 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. This includes whether we require a physician-to-physician discussion.
- If we require a physician-to-physician discussion, 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 start date for the 45-day period in which you must perform the procedure. If you do not do the procedure within 45 calendar days, you must request a new notification/authorization number.

Urgent Requests During Regular Business Hours

The ordering care provider may make an urgent request for a notification or 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 this process:

- Documentation must explain why:
 - The procedure must be done on an urgent basis
 - You could not request a notification/authorization number w 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

Prior to 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 is not a participating care provider, and is unwilling to complete the notification/prior authorization process, the rendering care provider is required to complete the notification/prior authorization process. They also need to verify that we issued a coverage d 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 we issued a coverage determination.

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.
- 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 get the notification number from the participating ordering care provider 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 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 prior to the rendering of services.
- If you determine we did not issue a coverage determination and the ordering care 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 prior to rendering the 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 the member's benefit plan does not cover. 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 prior to 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 prior to 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 contact OptumRx:

Online: [Optumrx.com](https://www.optumrx.com)

- 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 (Non-specialty meds)

Fax: 800-853-3844 (Specialty meds)

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 medications, 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 participation agreement.

Specialty Pharmacy Program Requirements

This protocol applies to the specialty medications listed on UHCprovider.com/pharmacy > [Specialty Pharmacy Program](#) > Additional Specialty Pharmacy Resources.

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 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 prior to dispensing of 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 with us.

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

MA Pharmacy

Pharmacy Network

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

Reimbursement for prescriptions from a non network pharmacy may be available to some members without of network coverage.

MA Prescription Drug Formulary

We utilize 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, 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 35% of the total cost of brand-name drugs and 44% of the total cost of generic drugs in 2018. 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 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 via pump 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:

OneTouch® Ultra® 2, OneTouch® Verio™, OneTouch® Verio Flex™, OneTouch® UltraMini™, OneTouch® Verio® IQ, ACCU-CHEK® Aviva Plus, ACCU-CHEK® Guide, ACCU-CHEK® Nano SmartView, and ACCU-CHEK Aviva Connect.

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.

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 preventative 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 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 any findings. If you have any 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 oral medications
 - › Fax: 800-853-3844 for injectable/specialty 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 via 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 at least eight unique Part D Drugs; and
- Incur an annual cost of at least \$3,967 for all covered Part D drugs.

We use the MTM program to help make sure 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 prior to 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 up to a maximum of 31 days. During the first 90 days of plan calendar year only.	Length of the prescription up to a maximum of 31 days. During the first 90 days of the plan calendar year only.
Long Term Care Facility Pharmacy	No more than 31 days per prescription, and refills up to a maximum of 98 days total.	No more than 31 days per prescription, and refills up to a maximum of 98 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 'Additional 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 our provider agreement with you.

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.

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

Members will pay more for services if they use an out-of-network lab. You are required to refer lab services to a participating lab provider, except if we authorize otherwise. You can search for lab providers in our Physician Directory on UHCprovider.com. To confirm a lab's participating and see if a test is covered, please contact us in advance. Some benefit plans are capitated for lab services; the member can only use the capitated lab provider.

Administrative Actions for Out-of-Network Laboratory Services Referrals

Our care providers use participating labs often. We expect that you can find participating labs that meet all of your needs.

If we see that a care provider is referring members to out-of-network labs, we remind them that they are required to refer our members to other participating providers. If the referrals to out-of-network labs continue, we will take administrative action. This includes:

- 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 with us.

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

In 2015, UnitedHealthcare implemented a new protocol requiring electronic submission of lab results within 30 days of a lab test. This initiative helped to increase HEDIS closure rates and significantly reduced the burden of manual chart requests on our providers.

As a result of this success, we have broadened the scope of our data sharing protocol – going forward, providers will be 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 your patients.
- Reduce the administrative burden of manual information sharing.
- Drive quality outcomes for you and your patients by closing gaps and improving coordination of care.

To begin sharing the required information, please contact our Data Acquisition Technical Support (DATS) team via 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 nonparticipating 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 nonparticipating 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 utilize 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 participation agreement. Such actions may include, but is not limited to payment sanctions, ineligibility for performance based compensation, or termination of your participation 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

If these PCP protocols differ from or conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan members, these PCP protocols govern unless statutes and regulations dictate otherwise.

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

If these protocols conflict with other protocols regarding our Nursing Home Plan and Assisted Living Plan members, these protocols apply, unless statutes and regulations dictate otherwise.

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 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 with us 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. To check the status of a claim, [EDI 276/277 Claim Status Inquiry and Response](#) transactions are available through your vendor or clearinghouse.
 - e. If you need additional information on EDI, visit our [EDI Contacts](#) page.

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 access to EPS at: Optum.com/enroll.

After your billing service enrolls they are be 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 via 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

While funds are deposited 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. Not available for all products.

Pricing and payment calculations for professional commercial claims are available under the Pre-Determination of Benefits option. Allow enough time for your claims to process (45 calendar days). 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 include 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 healthcare ID card.

If we receive a claim electronically with missing information or invalid codes, we may reject the claim, not process or 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 (dd/mm/yyyy), 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, their signature or representative's signature, address where service was rendered, "Remit to" address, phone number, NPI and federal TIN
- Referring physician's name and 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 NDC (National Drug Code) 11-digit number, NDC unit of measure (F2, GR, ML, UN) must be added 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 or the LIN03 and CTP04-05 segments of the HIPAA 837 Professional 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 with us
- 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 nondiagnostic services that occur within three calendar days of an inpatient admission and are not related to the admission

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 if 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 internal audit. Audits may come from CMS, HHS, or 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 via 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 strongly encourage you to submit all other NPIs.

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 app for providers; UnitedHealthcare Facility Demographic Updates app for facilities.
- **UHCprovider.com** : Sign in and go to "Practice/Facility 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 you have given 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

As a care provider in our MA network, you 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 any 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.

- Allow 15-20 days to receive and review the Explanation of Medicare Benefits (EOMB) from Medicare before filing the secondary claim to UnitedHealthcare, if required.
- Remark code MA-18 on the EOMB indicates the claim was sent by Medicare to the secondary payer. Allow an additional 15-30 days for us to receive and process the crossover claim.
- Do not send claims to us that Medicare crossed over. Sending another claim when one is already in our system slows the payment process and creates confusion for the member.
- If code MA-18 is not on the EOMB, you may file the secondary claim electronically.
- Allow up to 30 days after receiving the EOMB before following up on the receipt of the secondary claim by UnitedHealthcare from Medicare.
- To follow up on the receipt or status of a claim, check claim status (276/277) through your practice management system, or a clearinghouse, or claimsLink through UHCprovider.com.
- 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.

Hospital Responsibilities

Participating hospitals agree to a reduced or waived reimbursement of the Medicare Part A inpatient deductible. Cost savings associated with this help to lower premium costs for members.

To submit a Medicare Part A claim for a Medicare Select member, mail a completed copy of the UB-04 claim form, or submit the electronic equivalent, along with a Medicare Explanation of Benefits or Medicare Remittance Advice to:

UnitedHealthcare Claim Division

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.

Claim Submission Tips

Submit your claims and encounters as an 837 EDI Transaction

- 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.

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.

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 X12 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

To support the discussions you may have with your patients about treatment costs, take advantage of the Claim Estimator on UHCprovider.com (not available for all products).

The Claim Estimator tool 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 827 EDI transaction or UHCprovider.com/claims 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 approved 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](https://www.uhcprovider.com/policies) > Commercial (or Medicare Advantage) Policies > Reimbursement Policies > 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 name of the referring care provider and NPI number of the referring care provider, 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/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 participation agreement), from the date of identification. 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](https://www.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.

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

Submit your notification of the dispute within 30 calendar days from the date you receive the overpayment notification letter. The notification of the dispute must clearly state the items in dispute, with the relevant authority and relevant 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 online portal that lets you securely communicate with payers to address claim errors. This portal has the ability to replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- 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

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.

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 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 gives workers and their families who lose their health benefits have the right to choose to continue group

health benefits provided by their group health plan for limited periods of time under certain circumstances, such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. COBRA generally requires group health plans sponsored by employers with 20 or more employees in the prior year to offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end. Continuation coverage may be available to the member at group premium rates. Coverage benefits and limitations for COBRA members are identical 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 information on eligibility.
- 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 to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

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:

- Use the [claimsLink](#) application 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 legislation. Refer to *Provider Dispute Resolution (CA, OR, and WA Commercial Plans)* section for more information.

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 your Claim Reconsideration within 12 months (or as required by law or your participation agreement) from the date of the original EOB or PRA.

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](#) application. 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.

Attachments

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

1. **Online:** Use claimsLink application.
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:

1. **Electronic claims** - include confirmation that we received and accepted your claim.
2. **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 requests must also include documentation that the claim is for the correct patient and the correct date of service.

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 1, 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 participation 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 participation 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 application 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.

UnitedHealthcare Provider Appeals
P.O. Box 30997
Salt Lake City, UT 84130-0575

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.

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 contract 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 with us.

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 any claim appeal, or for any other dispute other than claim appeals, you may pursue dispute resolution.

If your concern/complaint is regarding:

- Your relationship with us, then send a letter containing the details to the address listed in your agreement with us. 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 with us. For disputes regarding payment of claims, you must timely complete the claim reconsideration and appeal process as set forth in this guide prior to initiating arbitration.
- Your compliance with your provider 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 with us. Arbitration proceedings will be held at the location described in your agreement with us, or if a location is not specified in your agreement, then at a location as described in the Arbitration Counties by Location section below.

Arbitration Counties by Location:

Unless your agreement with us 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 participating 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 > Member Service Request 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. Reopen 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, within two hours of overturn notice
 - › Standard appeals, within 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

Our reimbursement policies are available online at:

- UHCprovider.com/policies > Commercial Policies > [Reimbursement Policies](#)
- UHCprovider.com/policies > Medicare Advantage Policies > [Reimbursement Policies](#)

We may use the terms “reimbursement policies” and “payment policies” interchangeably.

Charging Members

Members are only responsible for applicable copayments, deductibles and coinsurance associated with their benefit plans. You should collect copayments at the time of service; however, to determine the exact member responsibility related to the benefit plan deductibles and coinsurance, if any, we recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) when billing members.

Annual Copayment/Deductible Maximum (Commercial)

Annual out-of-pocket maximum is the combined total of annual deductible (if any) and annual copayment maximum (if any), as shown on the member's Schedule of Benefits. Cost share is defined as amounts paid by the member 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 that apply to 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 after the out-of-pocket maximum reached.

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 amounts. 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 satisfy the family deductible for the year.

As specified above, 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 based upon UnitedHealthcare's contracted rates, percentage copayments (coinsurance) and contracted rates.

Annual Out-of-Pocket Maximum (Medicare Advantage)

Annual out-of-pocket maximum is the total of 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 defined as amounts paid by the member such as copayments, coinsurance and deductibles according to their plan benefits.

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

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

- Completion of certain forms (described in the previous section)

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. 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.

You must follow this process if you know, or have reason to suspect that their benefits may not cover the service.

For MA members, in addition to the member's written consent, 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.

When you submit an advance notification request using UHCprovider.com/priorauth, you are requesting a pre-service organization determination. A service or item may not be covered if:

- We have provided notice through an article on UHCprovider.com including clinical protocols, medical and drug policies, and/or coverage determination guidelines; 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 the the member for covered services beyond their normal cost sharing amounts (copayment, deductible, or coinsurance).

For MA members eligible for Medicaid, you cannot:

- Bill,
- Charge,
- Collect a deposit,
- Seek compensation,
- Seek remuneration,
- Seek reimbursement, or
- Have recourse against the member or their representative, or the MA organization.

You must either:

1. Accept payment made by or on behalf of the MA organization as payment in full; or
2. Bill the appropriate state source for such cost-sharing amount.

Medicaid (MA)

Qualified Medicare Beneficiaries (QMB) 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 when 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. 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.

We may be able to process some claims while the member is still in your office. You can use the claim submission feature on UHCprovider.com to submit after you render services. Within seconds, you receive a fully adjudicated claim that shows the benefit plan's responsibility and the member's responsibility. This helps promote accurate collections and avoid overpayment or underpayment situations.

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 Preventive Care Services Coverage Determination Guidelines (CDG) to help you identify and correctly code preventive services.

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 > Providers > [Health Reform for Providers](#) > Preventive Services.
- Coverage Determination Guideline: [UHCprovider.com/policies](#) > Commercial Policies > [Medical & Drug Policies and Coverage Determination Guidelines](#) > Preventive Care Services.

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. If we only used a subset of the SVRS, you can supply the all of the medical records in the SVRS. If you want a more complete audit, we can select a larger sample and re-estimate the error rate.

Please handle overpayment disputes as outlined in this guide and in your provider agreement.

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. They are located on: aamas.org > Resources > [Nat'l Audit Guidelines](#). Facility audits help to identify billing and coding errors. The audits are to identify contract risks. 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 facility 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 facility 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 give 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 with us.
- 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 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
 - The participation agreement or state law says otherwise

Technical Denials

The hospital is required to submit, or give access to, medical records upon our request. Failure to do so may result in a technical denial. Medical records request that do not comply with our guidelines follow the technical denial process. The technical denial also consists of needing additional information, notifying the care providers, 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](https://www.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

You are required to (unless otherwise stated in your provider agreement):

- 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.

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

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 good for our programs. A referral from a health risk assessment, the NurseLine, or a member/caregiver can also help identify these high-risk patients. You can refer these members to the appropriate program by calling the number on the member's health care ID card. Participation in these programs is voluntary. Upon referral, we assess members for the appropriate level of care for their individual needs. The programs vary based on the member's benefit plan.

Case Management

Our case managers are registered nurses. They engage the appropriate internal, external or community-based resources to support the member's needs. When applicable, we refer to other internal programs such as:

- Disease management
- Complex condition management
- Mental 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 help to minimize pregnancy complications.
- Our provider-focused strategies including premium provider designation program ensures members receive care from high quality and cost-effective providers & facilities. Members have access to the Centers of Excellence Fertility Providers.
- 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. Members can download the app at no cost from the App store® or Google Play™ store.

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.

Wellness and Behavioral Health Programs

We offer many care coordination programs. 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.

Wellness Programs

Healthy Weight: This is an intense weight management coaching program. It focuses on changing behaviors and lifestyles to achieve long lasting weight loss, reduced health risks, and an improved quality of life.

Tobacco Cessation: We offer a comprehensive tobacco cessation solution integrating industry and employer best practices. Our Quit Power program combines specialized tobacco coaching with nicotine replacement therapy.

Wellness Coaching: This is a phone or mail-based program. It helps members identify and prioritize unhealthy behaviors and set personalized goals that focus on positive, healthy behavior change. We added new digital features, new health topics such as mindfulness, and the ability to chat with coaches.

Real Appeal: Real Appeal takes an evidence-based approach to support weight loss. The program helps people make small changes necessary for larger longterm health results, based on weight-loss research studies commissioned by the National Institutes of Health. Real Appeal uses a highly interactive weekly internet show, videos and live online coaching to drive small behavior changes week by week over a full year. The program is designed to support members who are obese (body mass index or BMI over 30), overweight (BMI of 25 to 29.9) or simply ready to lose weight.

Wellness Incentive Programs

Wellness Incentive programs available for both fully-insured and self-insured members help control health care costs while sustaining competitive employee benefits by rewarding employees with financial incentives when they participate in wellness activities and achieve targeted health outcomes.

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.

Behavioral Health Solutions: A mental health and substance use benefit helps members get help for problems such as depression, drug or alcohol use disorder and Autism. This program is available around the clock. Optum offers confidential, comprehensive services and arranges a wide array of treatment options from acute inpatient care to individual outpatient counseling.

When members and caregivers call Optum for assistance, they speak directly to a specialist who can answer questions related to their mental health and substance use benefits. Working in strict confidence, trained professionals listen to each person carefully. They match referrals to specific needs using a nationwide network.

Employee Assistance Programs (EAP): This gives confidential support for a variety of everyday challenges. It is available to members and their families who have EAP benefits.

The EAP provides short-term counseling for individuals who may be struggling with stress at work, seeking financial or legal advice, coping with the death of a loved one, or just want to strengthen relationships with their family. It also offers assistance, support or referral for other 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
- Eating disorders

Consumer Transparency Tools: MyHealthcareCostEstimator (myHCE)

This is an online cost estimator tool 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 and Hospital Quality Ratings. Information about each program can be found on myuhc.com > Estimate Health Care Costs.

If you would like to review your cost data and a description how myHCE 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.W. 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 for free online. You may also email your request to Optum on BHInfo@uhc.com. For more information and resources on depression and alcohol use disorders, members may access the Optum website, liveandworkwell.com or go to providerexpress.com > Clinical Resources > [Clinical Tools and Quality Initiatives](#).

To refer a member to an Optum network care provider for assessment and/or treatment, call the toll-free 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 available there as well.

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, liveandworkwell.com (type in the word "clinician" to enter anonymously), 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 your patients to, and
- A listing of support resources for you, our members, and their families.

Collaboration Between Primary Physicians and Behavioral Health Clinicians

Many patients with serious medical illnesses also have mental health or substance use problems. Continuity and coordination of care are very important for patients with severe and persistent mental health and/or substance use problems. This is especially true when the member:

- Is prescribed medication
- Has co-existing medical/psychiatric symptoms
- Has been hospitalized for a medical or psychiatric condition

Please talk to your patients about the benefits of sharing essential clinical information. We encourage you to obtain a signed release from each member that allows you to share appropriate treatment information with the member's behavioral health clinician.

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 an assessment process using established quality improvement principles.

We use our QM program to:

- Identify the scope of care and services given
- Develop clinical guidelines and service standards where clinical performance is measured
- Monitor and assess the quality and appropriateness of services given to our members
- Review the medical qualifications of participating health care professionals
- Achieve continued improvement of member health care and services
- Enhance 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, which include:

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

This committee makes suggestions for the selection of QM studies based on high-volume, high-risk and problem-prone areas identified in their regions. They develop and implement regional components of the QM work plan.

The Regional Quality Oversight Committee (RQOC) oversees the health plan quality improvement activities.

The Regional Peer Review Committee (RPRC) has a forum for physicians to investigate, talk about and take action on member cases when there are significant concerns about quality of care. The RPRC has the authority to make decisions for the National Peer Review Committee (NPRC).

The NPRC has 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 Provider Sanctions Committee (NPSC) has a forum for physicians to talk about and take action on sanction reports regarding compliance with our credentialing plan, and/or patient safety concerns. Sanctions that relate to Licensed Independent Practitioners are monitored by government agencies and authorities including CMS, Medicaid agencies, state licensing boards, and the Office of the Inspector General within the federal Department of Health and Human Services.

Program Scope

- Identifying high-volume, high-risk and problem-prone areas of care and service affecting our members.
- Developing clinical practice guidelines for preventive screening, acute and chronic care, and appropriate drug usage. This is based on the availability of accepted national guidelines, the ability to monitor compliance and aspects of care.
- Doing quality improvement studies in clinical areas identified through claims data analyses. This includes frequency and cost breakdowns by member's age, sex and line of business, episode treatment groups, major medical procedure categories, diagnosis, and diagnosis-related groups (DRGs).
- Utilizing preventive health care audit results to review the level of preventive care delivered throughout our membership. QM completes separate studies for special risk groups.
- Conducting regular surveys to gauge member, care provider, and employer satisfaction, and to track reasons for voluntary care provider disenrollment.
- Measuring adherence to physician service standards such as wait times for appointments, in-office care and practice size and availability. We use complaint data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey information and GeoAccess analysis to measure adherence.
- Checking to make sure providers perform QM related activities as required in our contracts.
- Conducting routine medical record audits to determine if medical record review standards and preventive care guidelines are met.

Note: This is not the only reason we audit medical records. Other audits may have different procedures and processes depending on their purpose and design.

- Helping to ensure medical record documentation provides the plan for your patients' care. This includes continuity and coordination of care with other physicians, facilities and health care professionals. Complete and accurate documentation in the medical record reflects the care you gave to your patient. It also serves as both a risk management and patient safety tool.
- Reviewing and resolving member complaints about medical care and services. Investigation may include contact with the member and the physician or other health care professional. We may also review relevant medical records and your responses to potential concerns.

UnitedHealth Premium® Designation Program (Commercial Plans)

The UnitedHealth Premium® program provides physician designations based on quality and cost-efficiency criteria to help members make more informed choices about their medical care.

To evaluate care providers across 16 premium specialties which represent 46 sub-specialties, this program uses:

- Evidence based standards
- Medical society standards
- National industry standards
- Transparent methodology
- Robust data sources

The program shows how a care provider's cost-efficiency compares to peer groups in the same geographic area.

Cost-efficiency is assessed by comparing the physician's case-mix adjusted cost of care to a benchmark and applying a statistical test to determine if the difference is statistically significant.

Evaluation for quality compares a physician's observed practice to the UnitedHealthcare national rate among other physicians who are responsible for the same services. The quality evaluation is separate from the cost-efficiency designation. The results of the quality and cost-efficiency evaluation, but if a physician is not evaluated for quality or does not meet the UnitedHealth Premium program quality care criteria, the physician is not eligible for the Premium Care Physician designation are used together to determine the physician's Premium designation.

Quality and cost efficiency evaluations include adjustments for the physician's case mix and the level of the patient's severity of illness where appropriate.

The referrals you make impact your UnitedHealthcare Premium designation. This includes referrals for DME/orthotics, medical devices, and to care providers or

facilities. For example, if you often refer to higher cost care providers or services, your designation in the UnitedHealth Premium program may be impacted.

Physicians receive one of the following 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.

Employers may choose to offer their employees a tiered benefit plan. This may offer an enhanced benefit of lower out-of-pocket costs for using Premium Care Physicians. For more information on tiered benefits, go to UHCprovider.com/plans > select your state.

For more information regarding the UnitedHealth Premium program (including the measures, measurement methodology and how we use the results), go to UHCprovider.com/reports, or call 866-270-5588.

Note: The UnitedHealth Premium program does not apply to MA benefit plans.

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. Quality scores are provided on a one to five-star scale, with one star representing the lowest quality and five stars representing the highest quality. Star Ratings scores come from four sources:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or patient satisfaction data,
2. HEDIS or medical record and claims data,
3. Health Outcomes Survey (HOS) or patient health outcomes data, and
4. CMS administrative data on benefit plan quality and member satisfaction.

To learn more about Star Ratings and view current Star Ratings for MA and Part D benefit plans, go to the CMS consumer website at [cms.gov](https://www.cms.gov).

Member Satisfaction

We contract an NCQA-certified vendor to conduct an annual assessment of member satisfaction using the CAHPS survey. Members rate their experience in multiple areas, including their overall satisfaction with:

- The health plan
- Their health care
- Care providers
- Access
- Referral process
- Specialty care
- Benefits
- Member service

For more information on CAHPS, and other quality improvement programs, go to UHCprovider.com/reports.

Imaging Accreditation Protocol

This Imaging Accreditation Protocol promotes compliance with nationally recognized quality and safety standards. If you perform outpatient imaging studies and bill on a CMS 1500, or the electronic equivalent, you must get accreditation from one of the accrediting agencies listed on UHCprovider.com/priorauth > Prior Authorization and Notification Resources > [Radiology](#).

The accreditation process takes six to nine months to complete. Once we notify you, failure to obtain accreditation affects your right to be reimbursed for these procedures. We may do an administrative claim reimbursement reduction for global and technical service claims.

To avoid a decrease in payment, we require accreditation for:

- CT scan
- MRI
- Nuclear medicine/cardiology
- PET scan
- Echocardiography

This applies to global and technical service claims.

You can apply for accreditation by submitting an application and fulfilling accreditation standards.

More details about imaging accreditation are available on UHCprovider.com/join > [Imaging Accreditation](#).

Chapter 14: Credentialing and Re-Credentialing

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 re-credential 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 comprehensive, written credentialing program, outlined in our Credentialing and Recredentialing Plan on UHCprovider.com/join. We review and revise our credentialing program at least every two years, to follow NCQA standards as well as state and federal regulations.

When we delegate contracted organizations to perform credentialing activities, they must meet our standards as outlined in this guide, the Credentialing and Recredentialing Plan and the delegation agreement.

We are a member of the Council for Affordable Quality Healthcare (CAQH). We use CAQH ProView to collect credentialing data for physicians and health care professionals. There is no charge to physicians and other health care professionals.

The CAQH process reduces costs by:

- Eliminating the time required to complete credentialing applications for multiple health benefit plans,
- Reducing the need for credentialing software, and
- Minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We use the CAQH process as our only credentialing application, unless state law requires differently. All 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](#)

Participating physicians and health care professionals are responsible for verifying their clinical staff have applicable licenses and other credentials.

Non-Discrimination

Credentialing and recredentialing decisions are not based on a care provider's or other health care professional's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or members they

specialize in. However, we may elect to include care providers in our network who meet certain demographic or specialty needs, such as 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 qualification

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. We contractually require Delegated Entities to maintain the confidentiality of credentialing information. Credentialing staff or representatives must not disclose confidential care provider credentialing and recredentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

Medica HealthCare and Preferred Care Partners

For Medica HealthCare and Preferred Care Partners Credentialing process, please contact the plans' Network Management Department by emailing pcp-NetworkManagementServices@uhcsouthflorida.com or calling 877-670-8432.

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 notify applicants in writing, by fax or email, if we find any information that varies substantially from the information provided by the applicant. Applicants must submit corrections, in writing, directed by the Credentialing Entity within 30 days of the notification of the discrepancy.
- Be informed of the status of your credentialing or recredentialing application, upon request. 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.

Initial Credentialing Process

Instructions, information and policies about our credentialing plan are located on UHCprovider.com/join > [Credentialing for Care Providers](#).

Applicants must contact the United Voice Portal at 877-842-3210. They enter their Tax ID, then select the following prompts: 1) Credentialing, 2) Medical, 3) join the network. After entering the last prompt, the system provides the applicant the information required for the credentialing process. The applicant is transferred to a credentialing member service representative to notify us of their application.

From there, the process is completed online by logging into the CAQH Proview website at caqh.org.

Applicants to delegated medical group/IPAs must use the delegate's application form and process.

Network care providers and health care professionals are responsible for getting and maintaining licenses and other credentials of their clinical support staff.

Credentialing Criteria

Each licensed independent practitioner (LIP) must meet the following criteria. They also must meet state and federal requirements, as applicable:

- Having the requisite medical or professional education and training to practice within the scope of the care provider's license, including residency completion if applicable to practice;
- Verification of post-graduate education or training;
- Current license or certification in all states where the applicant practices without material restrictions, conditions or any other disciplinary action;
- Valid DEA or Controlled Substance Certificate or Acceptable Substitute, as required per practice;
- Medicare/Medicaid program participation eligibility;
- Work history — five years;
- Malpractice Insurance or State-Approved Alternative, equal to or greater than the minimum amounts required and outlined in care provider's contract;

- Malpractice history —five years;
- Passing score on site visit, as applicable;
- No sanction or limitation on being licensed;
- No prior denials or terminations within the last 24 months; and
- Admitting hospital privileges or arrangements with a participating licensed care provider to admit and provide facility coverage at a UnitedHealthcare participating hospital.

A completed application includes a signed statement attesting to:

- Applicant's current professional liability insurance policy;
- Limitations on ability to perform functions of the position with and without accommodation;
- History of loss or limitation of privileges or disciplinary activity;
- Absence of current, illegal drug use;
- History of loss of license and felony convictions; and
- Completeness and accuracy of the information provided.

The credentialing program applies to:

- Allopathic care providers (MDs)
- Osteopathic care providers (DOs)
- Dentists (DDSs, DMDs)
- Podiatrists (DPMs)
- Chiropractors (DCs)
- Behavioral Health (MDs, PhDs, LCSWs)
- Other licensed independent health care providers approved to provide services to our members outside the inpatient setting and listed in our care provider directory

While current board certification is not required to join our network, it is a requirement to take part in the UnitedHealth Premium designation program. Providing updated board certification is part of the credentialing application process.

Collection and Verification of Information

After we receive a completed application, we verify the professional credentials and qualifications. Next, we present the application to our credentialing committee. The process generally takes up to 25 calendar days to complete, depending on response times from medical schools, residencies, specialty boards, and hospitals.

Right to Reapply

Care providers who were denied initial credentialing or were terminated (for reasons other than network need) can reapply. They must wait 24 months from the date of their denial to reapply under their current criteria. We reserve the right to review the applicant against all credentialing criteria applicable at the time of the reapplication.

Recredentialing Process

We perform recredentialing of network care providers at least every 36 months. The process finds and evaluates changes in the care provider's:

- License
- Training
- Experience
- Competence
- Health status

This helps to determine the care provider's ability to deliver healthcare services.

Recredentialing Application Form

We send letters to each care provider who falls within the scope of this policy. The letter includes:

- CAQH care provider identification number,
- Specific CAQH application status, and
- Instructions on what the next steps are.

If you attest to all the data in your CAQH ProView application every 120 days and maintain a complete and current application with supporting documentation, you do not need to do anything. If CAQH information is not current, you must complete a re-credentialing application form on their website. This includes the Attestation and Release and all information requested on the application. If a care provider does not return the requested information in the established timeframe we may elect to terminate their participation agreement with us.

Collection and Verification of Information

ONCE we receive a completed recredentialing application, we re-verify your professional credentials and qualifications through the primary sources. Then we submit the application and profile to a credentialing committee. The committee reviews and determines your eligibility.

Credentialing Committee Decision Making Process (Non-Delegated)

Care Providers Who Meet Criteria

Every business day we send credentialing information on care providers who meet established criteria to one of the national Medical Directors for their review and approval.

Care Providers Who Do Not Meet Criteria

When a care providers does not meet established criteria for credentialing we give information and related documents from the care provider's profile to the to the National Credentialing Committee. The committee may request further information from any persons or organizations, including the care provider, to assist with the evaluation process.

Determination 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.

Care Provider Notification

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 of a decision to terminate a care provider's participation within 14 calendar days.

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. We send written notice that the contract is active. We send written notice to providers in Maryland and New York for recredentialing approvals. It lists the contract participation effective date.

Listings in Care Provider Directories and Other Member Materials

Information provided in member materials, including care provider directories, is the publicly available information obtained in the credentialing process. This includes:

- Education
- Training
- Certification
- Specialties

Monitoring of All Network Care Providers

We monitor sanction activity from state medical 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;
- 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 thresholds. We evaluate the effectiveness of those actions at least every six months via follow-up visits, until offices meet the thresholds. 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 [uhcmedicareolutions.com](#) > Our Plans > Medicare Advantage Plans > Resources and Plan Materials > Plan Information and Forms > [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 give patients written information on:

- State laws about advance treatment directives
- Patients' rights to accept or refuse treatment
- 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

Provide a copy of your own code of conduct, or the UnitedHealth Group’s (UHG’s) Code of Conduct (at [unitedhealthgroup.com](https://www.unitedhealthgroup.com) > About > Ethics & Integrity > [UnitedHealth Group’s Code of Conduct](#)).

What You Need to Do

Provide your own or the UHG’s Code of Conduct as outlined in the Standards of Conduct Awareness Section included herein and 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

Provide FWA and General Compliance training to employees and contractors of the FDR working on MA and Part D programs.

As of Jan. 1, 2016, CMS requires the use of CMS published training materials to meet compliance training requirements. You have met CMS FWA training and education requirements if you complete FWA certification through a fee-for-service Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); however, FDRs must still complete the General Compliance Training available on the CMS Medicare Learning Network® at [cms.gov](https://www.cms.gov).

You cannot alter the published CMS training material content, but you can download CMS training material and add information specific to your organization.

What You Need to Do

- Administer FWA and General Compliance training. You can access the materials available on the CMS Medicare Learning Network® at: [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html)
- Maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), attestations or electronic certifications that include the date of the training) for 10 years. We, or CMS, may request documentation from you to verify compliance with this requirement.

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 benefits or services.

What You Need to Do

- Make sure that 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, please see 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.

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

Reporting suspected fraud is simple – and it's important.

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:   

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 2018, 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 2
May	May 1
June	Jun 1
July	Jul 2
August	Aug 1
September	Sep 4
October	Oct 1
November	Nov 1
December	Dec 3

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

On the first calendar day of every month we publish 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, Drug Policies, Coverage Determination Guidelines, Utilization Review Guidelines and Quality of Care Guidelines. It is posted on the first calendar day of every month. It is accessible on UHCprovider.com/policies > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines > [Medical Policy Update Bulletins](http://UHCprovider.com/policies). As a supplemental reminder to the detailed policy update summaries announced in the Medical Policy Update Bulletin, a list of recently approved, revised and/or retired policies 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 small employers (those with two to 50 employees). 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 ; select the <i>Go to Prior Authorization and Notification App</i> . Phone: 866-889-8054	Request prior authorization for services as described in the <i>Outpatient Cardiology Notification/ Prior Authorization Protocol</i> section of <i>Chapter 6: Medical Management</i>
Chemotherapy (outpatient injectable)	Online: UHCprovider.com > Notifications/Prior Authorizations Phone: 866-889-8054	
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 Fax for Non-specialty Meds: 800-527-0531 Fax for Specialty Meds: 800-853-3844 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 Phone: 800-999-3404	Prior authorization and admission notification is required as described in <i>Chapter 6: Medical Management</i> . 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 ; select the <i>Go to Prior Authorization and Notification App</i> . Phone: 866-889-8054	Request prior authorization for services as described in the <i>Outpatient Radiology Notification/ Prior Authorization Protocol</i> section of <i>Chapter 6: Medical Management</i>

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 OptumHealthFinancial.com > Physicians & Health Care Providers > [Electronic Payments and Statements](#).

Claim Reimbursement (Adjustments)

If you think your claim was processed wrong, 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 that was overpaid, payment is due within 30 calendar days.

If you disagree with our decision regarding a claim adjustment, you can 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

participation 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 should 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. You can find a description of this process in your participation 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 (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 published by the ADA.

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. You can 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

Applicability of this Supplement

Does this supplement apply to me?

It applies if you are:

- A capitated provider.
- A delegated provider.
- A 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). In a few instances the capitated provider may be an ancillary provider or hospital.

If you do not have a capitation agreement with us, this supplement does not apply to you. Refer to the main guide or appropriate supplement.

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 such 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. If there is more information 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.

Additionally, capitated providers may be subject to the protocols, policies and procedures related to any or all

delegated activities. Capitated providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities, if any, the capitated providers are performing on behalf of UnitedHealthcare.

Delegated Providers and Accountable Care Organizations

What is a Delegated Provider/ACO?

Delegation is a process that we use to give another entity the authority to perform specific functions on our behalf. UnitedHealthcare 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. UnitedHealthcare remains responsible to external regulatory agencies and other entities for the performance of the delegated activities. As such, a delegated provider/ACO (referred to in this supplement as “delegated entity” or “delegate”) must demonstrate compliance with our established standards before we delegate any activities to them. Additionally, a delegated provider/ACO must continuously comply with our standards to retain delegation status. We may revoke any or all delegated activities if the delegate is noncompliant with the delegated activity.

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:

1. Whose medical group, IPA, or other care provider performs any of the above functions on behalf of UnitedHealthcare, or
2. Whose 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

Check the member's eligibility and benefits prior to rendering services. This helps ensure that you submit the claim to the correct payer, collect copayments, determine if a referral and prior authorization or notification is required and reduces denials for non-coverage.

There are three easy ways to verify eligibility and benefits:

- **EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse
- **Online:** eligibility [Link](#)
- **Phone:** 877-842-3210

We can provide you with daily member eligibility information using an electronic 834 file containing eligibility changes. We can provide a full eligibility file monthly. 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 can 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

Customers must meet all eligibility requirements established by the employer group and us. We may request evidence to validate eligibility requirements.

Qualified Medical Child Support Order (QMCSO)

A member (or person otherwise eligible to enroll in a UnitedHealthcare product) may enroll an eligible child after presenting appropriate documentation.

To receive coverage, all care (except for emergency and urgently needed services) must be arranged in our service area by the designated PCP or medical group/IPA selected by the custodial parent or person having legal custody. A dependent eligible under a QMCSO does not need to reside within the service area to be eligible.

Full Time Student Eligibility

A dependent under the age of 26 and enrolled full-time as a student in a college may remain eligible when temporarily located outside our service area. To receive coverage, the designated PCP or medical group must provide or arrange all care (except for emergency and urgently needed services) in our service area.

Dependent Definition

Dependents of the subscriber are eligible for coverage, based on the subscriber's benefit plan, and may include the following:

- Spouse or common law spouse
- Domestic partner
- Unmarried child under the limiting age, such as :
 - Stepchildren
 - Children placed for adoption or legally adopted children
 - Grandchildren (only if subscriber has legal guardianship or the employer has purchased additional eligibility coverage)
 - Full-time students — proof of student status is required periodically for persons under the age of 26
 - Dependents with a physical or mental handicap, which have been identified as permanently disabled, and where the disabling condition occurred prior to reaching the limiting age

Certain Disabled Dependents Coverage

Certain disabled dependents, regardless of age, may have coverage under a subscriber's benefit plan, provided:

- They cannot engage in self-sustaining employment;
- They depend on the subscriber for support; and
- The disability occurred prior to the dependent reaching the employers limiting age.

The subscriber must submit proof of disabled dependents continuing eligibility, including the care provider's diagnosis and prognosis, as outlined in the subscriber's benefit plan. Further proof of incapacity and dependency may be required according to terms and conditions of a plan agreement and state law.

Domestic Partners

We acknowledge domestic partnerships the same as any spousal relationship for any employer group that accepts domestic partners under its benefit plan. Unless the subscriber's benefit plan or state law dictates otherwise, covered domestic partners must satisfy the administrative requirements below.

A domestic partnership is defined as an ongoing, intimate and committed relationship between two persons of the same or opposite sex, who are not legal spouses:

- Both partners must be 18 years or older (except as provided by California Family Code 297.1);
- Neither party may be currently married to another party;
- Neither may be related to the other by blood closer than would prohibit legal marriage;
- Domestic partners do not include roommates, friends or other similar relationships;
- Neither party has a different domestic partner now, nor has had a different domestic partner within the last six months, unless the previous domestic partnership was terminated by death;
- Both partners agree to be economically responsible to third parties for their common welfare and financial obligations.

Enrollment

To enroll for membership, 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. Care providers should make a copy of the enrollment form. If unable to verify member eligibility online or through our voice response systems, you should 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.

We may receive enrollment/eligibility information from employer groups electronically or manually. We use this information to update member records.

Enrollment in Rural Areas

Certain rural areas may have limited access to local care providers, and exceptions made to the guidelines governing enrollment.

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, but many employers select different dates throughout the year. 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/MCO plans, are required to choose a primary

care provider (PCP), as outlined in Chapter 3: Commercial Products: *Primary Care Physicians (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: State Knox-Keene regulations dictate eligible newborns coverage for the first 30 days beginning on date of birth. If the newborn is not enrolled as a dependent on the subscriber's plan (mother's or father's), the newborn will have 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 will cover the newborn for the first 30 days, even if the newborn is not enrolled on his plan.

Note: We cannot deny the enrollment or eligibility of a newborn covered under their parent's health plan based on the following:

- The child was born out of wedlock,
- The child is not claimed as a dependent on the subscriber's federal income tax return, or
- The child does not reside with the subscriber.

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 from the facility. When the father is primary for the newborn per the birthday rule, his plan will cover the newborn for the first 30 days, even if the newborn is not enrolled on his plan. 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 subscriber's benefit plan dictates 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 the 1st 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). Per 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 receipt of request. Some care provider groups may only accept new members during an

open enrollment period. If the member meets all eligibility requirements, the member will become 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, in the following instances:

- 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
- The member calls to request a change within 30 calendar days 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 will not be 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 will be provided with at least 30 calendar days (exception: 60 calendar days in California) to select another medical group, IPA, PCP or facility.

Each Medicare member will be provided with 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 is in need of care and it is determined 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 knows and agrees that UnitedHealthcare has the right to move a medically stable member to another medical group/IPA or care provider, if due to a strained relationship between the medical group/IPA and member.

For instance, a member may refuse to accept a medical group/IPA's recommended treatment, counsel or procedure. The medical group/IPA may regard such refusal to accept its recommendations as incompatible with the continuance of the care provider-member relationship and as obstructing the provision of proper medical care. If a member refuses to accept the recommended treatment, counsel or procedures, and the medical group/IPA believes no professionally acceptable alternatives exist, the member is advised.

The medical group/IPA may request UnitedHealthcare to change a member to a different medical group/IPA if the care provider-member relationship is materially damaged by the member's refusal to accept recommended treatment, counsel or procedure. We will evaluate such request considering the member's best interests and the geographic accessibility of another medical group/IPA. If we approve the request for transfer, we shall request the member to select another medical group/IPA within 30 calendar days. If the member fails to select another medical group/IPA, we shall designate another medical group/IPA on the member's behalf. If, however, 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 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.

If you receive notification of a member's intent to sue, please tell your physician advocate.

Send copies of all notification letters, request for removal and supporting documentation to your provider advocate.

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.

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 towards 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 UnitedHealthcare 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 towards 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 towards 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

We can provide member eligibility information using an electronic 834 file containing eligibility changes daily. We can provide a full eligibility file monthly.

Starting electronic eligibility requires coordination with your software vendor and us.

Some of the advantages of receiving electronic eligibility are:

- An eligibility upload may reduce the administrative overhead by minimizing the effort currently required to maintain eligibility manually.
- Eligibility updates can be loaded into your system in a timely manner.

Please contact your Physician Advocate for more information.

Eligibility Lists

Upon your request, we send each medical group/IPA a monthly eligibility list of all its assigned members. This may contain:

- Member ID number
- Name
- Date of birth
- Plan code
- Employer group number (if applicable)
- Care provider effective date
- Benefit plan effective date
- Care provider name
- Group number
- Gender
- Eligibility status (currently eligible, newly eligible)
- Effective dates of terminations and transfers
- Benefits, including copayments and deductible
- Address (including ZIP code)
- Managed care plan/benefit plan selected
- Identity of third party coverage (if known)
- Enrollment/disenrollment date
- Type of change to coverage
- PCP
- Member copay total
- Member copay max date
- Member deductible total
- Member deductible max date

The most common eligibility report used is the EL915. This report is available electronically. It is sent to the capitated care provider through a file transfer protocol and viewed on UHCprovider.com. We generally provide eligibility information once per month. We can provide it weekly if needed.

Eligibility (MA)

Medicare beneficiaries who elect to become members of a UnitedHealthcare MA plan must meet the following qualifications:

- Beneficiaries must be entitled to Medicare Part A and enrolled in Medicare Part B
- Beneficiaries must 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)
- Beneficiaries must not have End Stage Renal Disease (ESRD), unless they meet one of the following exceptions:
 - › Beneficiary with ESRD, whose enrollment with another MA plan was impacted by the plan's termination or service area reduction, is allowed to enroll in UnitedHealthcare MA.

- › Member who developed ESRD after enrollment may remain on the program.
- › Beneficiary with ESRD covered under a UnitedHealthcare commercial plan is eligible to join UnitedHealthcare MA, as long as there is no lapse in coverage. The beneficiary with ESRD must be a member of the Commercial plan at the time he/she developed ESRD to be considered a true rollover and become eligible for benefits. A beneficiary who developed ESRD prior to their enrollment in the Commercial plan would not meet the eligibility criteria.
- Exceptions have been made for a UnitedHealthcare group retiree member with ESRD:
 - › If an employer or union group offers an MA plan as a new option to its employees and retirees, a retiree with ESRD may select this new MA plan option (regardless of whether it has been an option in the past) as the employer's or union's open enrollment rules allow.
 - › If an employer or union group that has been offering a variety of coverage options consolidates its employee/retiree offerings (i.e., it terminates one or more plans), current members of the dropped plans may be accepted into a MA plan that is offered by the group.
 - › If an employer or union group has contracted locally with an MA organization in more than one geographic area (for example, in two or more states), an ESRD retiree who relocates permanently from one geographic location to another may remain with the MA organization in the local employer or union MA plan.

ESRD information is accessible on UHCprovider.com.

- Beneficiaries receiving Medicare hospice benefits are eligible to join UnitedHealthcare MA.
 - › We are financially responsible for covered additional and optional supplemental benefits not covered under original Medicare.
 - › All Medicare-covered services related to the terminal illness coverage through original Medicare.
- Beneficiaries must maintain monthly premiums in geographic areas, where applicable.

Change of Membership Status (MA)

If a Medicare beneficiary is an inpatient at any of the following 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](#).

Benefit Plan Changes

When an MA member has a benefit plan change, they must complete and submit an Individual Enrollment Request Form and Statement of Understanding. If the member completes the form over the phone, we make the plan changes the first of the following month. The member does not have to submit paperwork. 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 to be out of the service area and will be 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 that we 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

To enroll for membership in MA, an applicant must do one of the following:

- Complete and sign an Individual Enrollment Request Form and Statement of Understanding;

- Call UnitedHealthcare Medicare Advantage and complete a telephonic enrollment;
- Meet with a licensed sales representative;
- Log on to UHC Medicare Solutions.com, or AARP Medicare Plans.com for online enrollment;
- Log on to medicare.gov to enroll online (may not apply for all SNPs); or
- Call 800-MEDICARE or 800-633-4227 to enroll (may not apply for all SNPs).

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.

UnitedHealthcare Group MA processes eligible *Individual Enrollment Request Forms and Statement of Understanding Forms*. Forms 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 received is complete. The effective date is delayed if the enrollment request form is incomplete, needs additional information, or lacks documentation of proof of entitlement to Medicare Parts A and B. We will try to resolve any outstanding issues with the enrollment request form to complete the enrollment process.

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 can 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](#).

Transfer of Members

In accordance with CMS, a member may not change medical groups/IPAs or PCPs for any reason, such as the following:

- The member is an inpatient in a facility, a skilled nursing facility or other medical institution at the time of request to transfer;
- The change may have an adverse effect on the quality of the member's health care;
- The member is an organ transplant candidate; or
- The member has an unstable, acute medical condition for which he/she is receiving active medical care.

In the following instances, a member may request a medical group/IPA or PCP change, outside the 15/30 rule, that will be effective the first of the following month:

- The member calls to request a change within 30 calendar days of the effective date with UnitedHealthcare due to the wrong medical group/IPA or PCP being assigned;
- The member calls to request a change within 30 calendar days of the effective date with UnitedHealthcare and has not received services with the originally assigned care provider; or
- The member calls to request a change within 30 calendar days due to a household move over 30 miles and the member has not received services with the originally assigned care provider.

If a member changes his or her medical group/IPA or PCP while an inpatient at any the following facilities, the capitated entity at risk for Part A services at the time of the admission will retain financial risk until discharge to home or another care setting.

- An acute care facility
- A critical access facility
- A long-term care facility
- A psychiatric facility
- An inpatient rehabilitation facility

Financial responsibility for Part B services will be the responsibility of the new medical group/IPA or PCP on the effective date of the transfer.

Refer to UHCprovider.com/policies > [Medicare Advantage Policies](#) and look to UnitedHealthcare Medicare Advantage Coverage Summaries for additional information about coverage of ambulance transfers due to a medical group/IPA change while the member is an inpatient.

Involuntary Transfer

If the member/care provider relationship has been seriously impaired, an involuntary transfer from the Current PCP/Medical Group/IPA to another PCP/Medical Group/IPA is implemented by the following the guidelines:

First Occurrence

At the first occurrence, you should send the member a certified/return receipt-warning letter advising him/her of the issue and potential consequences of dismissal.

Document the specific information including the care provider's name, date of occurrence, and issue. The letter must tell the member that PCP/medical group/IPA is notifying us regarding the matter and offer the member the right to respond to the allegations. PCP/Medical group/IPA must maintain full documentation. Send a copy of the letter directly to your provider advocate.

Second Occurrence

Send the member a second certified/return-receipt warning letter advising them of the continued issue and potential consequences of dismissal. Your documentation should include the additional issues, care provider's name and date of occurrence. The letter to the member must state the PCP/medical group/IPA's recommendation for cooperation, indicate that the PCP/medical group/IPA will be requesting our intervention in initiating a medical group transfer and offer the member the right to grieve the allegations. Send a copy of the letter and full documentation directly to your provider advocate.

Third Occurrence

On the third occurrence, immediately notify your provider advocate with a request to remove the member from the PCP/medical group/IPA. Be sure to include all prior documentation. We will review the PCP/medical group/IPA documentation outlining the continued issues. Based on the documentation, we may reassign the member to a new PCP/medical group/IPA. If so, we will contact the member and arrange for a PCP/medical group/IPA transfer or disenrollment from the plan.

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

Disenrollments

Member Elected Disenrollment

If a member requests disenrollment 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 will be effective the 1st day of the following month.

Disenrollment for Cause (MA)

We may initiate disenrollment, as dictated by CMS, for the following reasons:

- Failure by the member to pay plan premiums, subject to the 90 calendar day grace period and appropriate notification;
- Disruptive, unruly, abusive or uncooperative behavior that seriously impairs the organization's ability to furnish services to either the member or other members;

- The member provides fraudulent information when enrolling or permits others to use the member's health care ID card to obtain services;
- The member resides outside the service area for over six months (or nine months if using the UnitedHealth Passport® benefit) as defined by the evidence of coverage;
- The beneficiary loses entitlement to Medicare Part A or dis-enrolls from Part B.

If you receive notification of a member's intent to sue, please notify your provider advocate. Send copies of all notification letters, request for removal and supporting documentation directly to your provider advocate.

Once we receive a completed "Incident Report for Removal of Members" and related documentation, we will respond to the member as appropriate and copy the PCP or medical group/IPA on all correspondence.

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 all your assigned members. We make current eligibility information 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 through the Enterprise Voice Portal, care provider website or toll-free phone number. 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 provides an opportunity for reimbursement to the medical group/IPA for covered services provided to an individual whom:

1. UnitedHealthcare 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 no authorization has been provided ("Eligibility Guarantee"); and
3. UnitedHealthcare provided an authorization and who we confirmed as eligible on or two business days prior to the date of service but who is 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 that the individual was not a member at the time the health care services were provided, medical group/IPA may seek reimbursement for such services by following the procedure set forth below.

- 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 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 using the address included in the *UnitedHealthcare West Bulk Claims Rework Reference Table*, in the Appeals section of the UnitedHealthcare West Supplement in its guide:
 - 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

Verification of the medical group/IPA's compliance with the eligibility guarantee billing procedures with reimbursement to the medical group/IPA for services which are eligible under the eligibility guarantee policy, within 45 business days of receipt of the information stated above at the cost of care rates defined in the contract but no greater than

100% of the uncollected balance. Medical group/IPA shall be responsible for reimbursing the care provider of service if it is financially responsible for issuing payment for the applicable service under its contract with us.

Provider Responsibilities

Demographic Updates

To help ensure we have your most current provider directory information, 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/findprovider for the Provider Demographic Change Submission Form and further instructions.

Electronic Data Interchange (EDI)

EDI is our preferred choice for conducting business transactions with physicians and health care industry partners. We accept EDI claims submission for all of our product lines. You can find information and help with EDI by going to UHCprovider.com/EDI, and in this guide under *Electronic Data Interchange (EDI)* section of Chapter 2: Provider Responsibilities.

ASC X12 Technical Report Type 3/Companion Guides

The ASC X12 Technical Report Type 3 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.

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 and its care providers and other licensed independent health care professionals shall continue to accept members until the expiration of the notice period. UnitedHealthcare has 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.



California Requirements for Capacity Reporting

Effective July 1, 2017, UnitedHealthcare requires capitated providers to give us updates within five business days if capacity changes effect your ability to accept new members. If we receive notification that your information is inaccurate, the provider group/IPA or physician 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 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 Only)

The California Department of Managed Health Care's (DMHC) approved Notice of Availability of Language Assistance (Notice) must be included with each nonstandard vital document containing member specific information issued to UnitedHealthcare West LAP members by the delegated care provider group. The Notice must be included in UnitedHealthcare West's threshold languages (English, Spanish and Chinese). Non-standard vital documents include, but are not limited to UM modification, delay, or denial letters issued to UnitedHealthcare West LAP members by the delegated care provider group. We will review compliance with this requirement as part of the annual assessment of delegated medical management.

UnitedHealthcare West has 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 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. The delegated care provider shall arrange for auxiliary aides and/or sign language interpreters at no cost to the member.

The care provider or medical group/IPA must arrange provision of these services promptly as not to delay care to the members.

Interpretative and/or auxiliary aide services must be provided, at no cost to the member, when requested. 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 standard UnitedHealthcare methods have been explained and offered by the care provider, and the member refuses. Care providers are strongly encouraged to 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 utilize 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)

California replaced the Commercial Hospital Incentive Program (CHIP) with the Integrated Healthcare Association (IHA) P4P Value Based Incentive Program effective Jan.

1, 2017 for new agreements or renewal dates of Jan. 1, 2017 and after. The new incentive program will not be a component of the capitation agreement. It is now under a separate letter of agreement.

The budget for the Medicare Advantage Hospital Incentive Program (MAHIP), (formerly known as Secure Horizons Hospital Incentive Program [SHIP]), 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 DOFR section of the participation 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 rendered 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), less:
 - › Reinsurance recoveries; and
 - › Third party recoveries received during the period of calculation.

Monitoring Performance

The following information used to monitor the medical group/IPA performance:

- 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

UnitedHealthcare performs interim settlements and 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 shall contain 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 can 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 signatures by all parties to be valid. The medical group/IPA must submit the following required information, along with an original, signed letter stipulating that 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.

The following 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 for data entry it will be entered 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 that is 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 that those 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 that lists 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:

- NICE 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

The Discrepancy Report used to request research of the payment or denial of a claim that we processed. After reviewing the Monthly Shared Risk Claims Report, the medical group/IPA should complete the Discrepancy Report by completing all required fields. Submit the completed Discrepancy Report via electronic means to our Network Care Provider Management department. Returned files sent to the medical group/IPA as incomplete. If the required fields are not completed, the files will be returned to the medical group/IPA as incomplete. 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 on at least quarterly. However, we'd rather receive monthly submissions. We will not pursue recoveries of

overpayments you submit late and not in a timely manner, as dictated by your agreement with us, or by state law.

We reserve the right to deny/reject any request for review that is 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 updated annually and given the option for each medical group/IPA/facilities to elect to participate or not 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 participation 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 participation agreement or the ISL election letter for the applicable contract year, less the medical group's ISL coinsurance amount.

For a facility that purchases reinsurance through UnitedHealthcare is reimbursed for services that exceed the reinsurance deductible at the reinsurance program rates specified in the participation 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. The following format should be included 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, copies of cancelled checks showing actual amounts paid will be required. 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.
- The following 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. (referred to as a "delegate") 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 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

For capitated providers who are no longer eligible due to a sanction that results in the loss of license or material restriction, the termination date will be retroactive to the first day of the month of that action to support the group capitation and facilitate member transitions as required.

Confidentiality

We also contractually require delegated entities to maintain the confidentiality of credentialing information. Credentialing staff or representatives must not disclose confidential care provider credentialing and recredentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

Initial Credentialing Process

When credentialing is delegated, applicants must use the medical group's/IPA's application form and process.

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

Based on the compliance assessment findings, we may require the delegate to develop an improvement action plan designed to bring the delegate back into compliance with credentialing standards.

Delegates that do not achieve compliance within the established timeframes may require continued oversight until they achieve compliance. Credentialing delegation is a function that is subject to revocation for continued noncompliance with credentialing standards.

Credentialing Reporting Requirements for Delegates

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 the following 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 the following information:

- 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, UnitedHealthcare 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, UnitedHealthcare's default position is to 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 facility staff status or facility clinical privileges, including 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.

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 will be 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, the medical group/IPA must allow the member direct access to any eye care provider participating and available under the plan. An eye care provider 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, the medical group/IPA must allow the member direct access to any participating chiropractor and available under the plan. The medical group/IPA may utilize managed care cost and containment techniques.

PCP and Provider Responsibilities

We will 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)

The member's PCP is responsible for directing the member to the clinically appropriate in-network provider based on the network specialists, medically necessary clinical criteria, the members' benefits and in accordance with regulations on geographic and timely access requirements. If a provider of a service required by the member based on their PCP's medical decision is not available in-network or is available in-network but such referral would not comply with the applicable geographic distance or timely access standards, the member's PCP shall submit a request for an out-of-network provider review to the delegated medical group/IPA for accessibility. If approved, arrangements for access to an appropriate specialist outside of the PCP's network will be made and the member's financial responsibility for services rendered by the out-of-network provider shall not exceed the member's applicable in-network co-payment, deductible, and coinsurance associated with their benefit plan.

Referral Contracts (MA)

We encourage the medical group/IPA to establish contracts with care providers to whom they 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 utilize existing UnitedHealthcare contracts unless they are delegated for claims processing. Delegated medical group/IPAs must negotiate their own contracts. Such contracts must comply with the requirements of this guide.

- No contractual arrangement between the medical group/IPA and any subcontracting care provider may violate any provision of law.
- The medical group/IPA must make sure that all provisions of its agreement with any care provider who provides services to MA members includes all provisions required under the medical group/IPA's Medicare Advantage participation agreement and regulatory requirements and applicable accreditation standards.
- If a care provider has opted out of the Medicare program, the medical group/IPA 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)

CMS regulations require us to make sure applicable provisions are contained in the written agreements the medical group/IPA has in place with its care providers.

We recommend that the medical group/IPA complete an annual review of the most current model subcontracts it uses to help ensure that all are fully compliant with federal law. We will conduct at least an annual review of each delegated medical groups/IPA's down-stream contracts to determine compliance with CMS regulations and guidance.

We will require Improvement Action Plans (IAP) for any medical group/IPA with non-compliant contracts. The IAP will identify specific findings, actions and expected time frame for compliance.

Referral Authorization Procedure

The delegated medical group/IPA may be responsible to initiate the referral authorization process when a request made to refer a member for services. Please refer to their Notification/Prior Authorization list. These

capitated medical services are examples where a referral authorization may be needed:

- 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 services, treatment or referral to a care provider, the PCP or treating care provider shall review the request for medical necessity.
- If there is no medical indication for the requested treatment, the care provider shall discuss an alternative treatment plan with the member.
- If the treatment option selected by the member 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 commentary on the referral regarding the reason that 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 develop procedures by which a member may receive a standing referral/extended referral for specialty care. Procedures shall provide for a standing referral or extended referral to a specialist, or specialty care center. If the member and PCP, in consultation with the specialist, determine the member requires: (i) continuing care from a specialist or specialty care center over a prolonged period of time; and/or (ii) extended access to a specialist for a life-threatening, degenerative or disabling condition that requires coordination of care for the member by such specialist. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visit be authorized and/or require that the specialist provide the

PCP with regular reports on the health care provided to the member.

For an extended specialty referral, the requesting PCP and the specialist should determine which health care services each of them manage. The PCP shall record the reason, diagnosis, or treatment plan necessitating the standing referral. The specialist must refer the member back to the PCP for primary care.

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 that 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 available a mechanism to refer members to a qualified HIV/AIDS specialist outside of the group. The state regulations contain the qualification of an HIV/AIDS specialist California Health and Safety Code (Ca H&SC 1300.67.60).

Referral and/or Authorization Forms

The delegate may design its own request for referral and/or authorization forms, without approval by UnitedHealthcare. 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. When the referral or authorization form is not at least 12-point font, then the delegate sends a written notification that is. For Medicare Advantage members, UnitedHealthcare provides an approval template letter.

At a minimum, the form or written notice of approval must include all of the following components:

- 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
- 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 following:

- 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 (MA)

CMS regulations 42 CFR 422.568(a) 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. 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. The medical group/IPA must use the date and time the member first called as the received date and time of the request to comply with required turn-around times. The member's request may have happened before the date and time the request reached the department that processes referrals and authorizations.
- Working with UnitedHealthcare on requests for referrals or authorizations of services for cases in which a member who has contacted us to request services. The medical group/IPA must use the date and time of the member's 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 group/IPAs that also provide and administer behavioral healthcare services must collect information at least annually about opportunities to work together with its behavioral healthcare providers to improve coordination of care between medical and behavioral healthcare services. Based on that data, the medical group/IPA must work with its behavioral healthcare specialists to identify, analyze and take collaborative action on identified opportunities for improvement. The medical group/IPA submits this report at least annually to its quality improvement committee or the appropriate committee, as determined by the medical group/IPA's structure. The medical group/IPA must have a documented process that describes how it will complete this cycle. UnitedHealthcare will assess the process and report during its annual assessment of the capitated medical group/IPA.

A medical group/IPA that is capitated for providing and paying for behavioral healthcare services is also responsible for conducting an annual measurement of

its members' experience using behavioral healthcare services. This includes performing a member survey including a description of how it will conduct the survey and its sampling methodology. Based on survey results, the medical group/IPA then assesses the data, analyzes the results, identifies opportunities for improvement and describes its reasons for taking (or not taking) action, and implements interventions that are likely to contribute to improvement of the identified opportunities. The medical group/IPA then measures effectiveness of its interventions. It submits this report at least annually to its quality improvement committee or the appropriate committee, as determined by the medical group/IPA's structure. UnitedHealthcare will assess the process and report during its annual assessment of the capitated medical group/IPA.

Medical Management

The protocols outlined in this section are those that are unique to capitated and/or delegated medical management entities. The protocols outlined in *Chapter 6: Medical Management* may also apply if UnitedHealthcare is financially responsible for the service.

If we are financially responsible for the service, or responsible for processing the claim for such services, consult with us to determine if an authorization is required before you make any authorization decision.

Clinical Delegation Oversight

Regulatory agencies and other entities hold us responsible for the performance of delegated activities. We hold our delegates to those same requirements. We perform clinical assessments of the delegated activities prior to delegation to ensure the potential delegate meets the requirements. We perform assessments after delegation to ensure continued compliance and rapid remediation of noncompliance. We help our delegates by providing them with the information they need to know and meet the 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. A clinical reviewer and medical management consultant request submission of 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). The clinical reviewer and Medical Management consultant also 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 on at least an annual basis, 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 an Improvement Action Summary report 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 on at least a weekly basis, working with the delegate to attain compliance. We expect the delegate to put quality controls into place to measure its compliance on an ongoing basis. A reassessment is performed within 30 calendar days of the written notice to document the delegate's progress toward compliance.

If the delegate does not demonstrate compliance by the IAP completion date, we escalate the IAP to engage leadership at the delegate and within UnitedHealthcare to facilitate remediation. Continued noncompliance may result in our beginning the de-delegation process while continuing to work with the delegate to achieve compliance.

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 utilize multiple resources and guidelines to determine medical necessity and appropriate level of care.

Hierarchy of Criteria Use

When using criteria to make decisions about requests for services, 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 Coverage Determination Guidelines and Benefit Interpretation Policies
- 4. Evidence-based criteria such as MCG and InterQual
- 5. Other evidence-based criteria such as Hayes or evidence based literature
 - Medicare Advantage
 - 1. Plan eligibility and coverage (benefit plan package)
 - 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 (e.g. Coverage Summary, Medical Policy)
 - 4. Evidence-based criteria such as MCG and InterQual
 - 5. Other evidence-based resources 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 Coverage Guidelines
 - 4. Evidence-based criteria such as MCG 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 that 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 utilize the most current service codes (i.e., ICD-10-CM, UB and CPT codes). We also require that the care provider make sure 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 except in the case of emergent or urgent services.

To confirm prior authorization has been requested and approved, the Prior Authorization and Notification app on Link, or UHCprovider.com/priorauth. 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 UnitedHealthcare (or its 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 application of any payment policies or in 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 to provide services for UnitedHealthcare members; or
 - A care provider contracted with a participating medical group/IPA terminates its agreement to provide services for UnitedHealthcare members. This occurs when the medical group/IPA holds the contract with its care providers.

Typically, a condition that would warrant 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 emergent 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.

UnitedHealthcare (or the medical group/IPA delegated for continuity of care) shall 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 UnitedHealthcare and current network care providers providing similar services, who are not capitated and who are practicing in the same or a similar geographic area.

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 from UnitedHealthcare, the admitting care provider initiates an authorization request by fax or online at least three business days prior to the scheduled date of service.

- You must complete and submit the appropriate prior authorization request forms. Incomplete forms 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 an emergency admission of our member within 24 hours of admission, or as soon as the member's condition has stabilized. The Medical Management Department can receive 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. Please refer to your participation agreement for your specific service area definition.

Urgent or emergent 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 participation agreement states otherwise.

Out-of-Area (OOA) Medical Services

OOA medical services are those emergent or urgently needed services to treat an unforeseen illness or injury that arises while a member is outside of the medical group/IPA's contracted service area, typically 30 miles from medical group/IPA based on the shortest route using public streets and highways. These OOA services would have been the financial responsibility of the medical group/IPA had the services 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 participation 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 those 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-emergent medical services provided outside of the medical group/IPA's defined service area.
- The medical group/IPA shall notify 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 will:

- Determine the appropriate mode of transportation and obtain any required authorization
- Determine the appropriate level of care or facility for the member's care and obtain any required authorization
- Arrange 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 UnitedHealthcare to return the member to a network care provider and facility in a timely fashion.
- The medical group/IPA shall facilitate the return of the member to network care provider by making sure that the following process occurs in a timely fashion:
 - If the medical group/IPA delays the transfer of a member considered medically stable for transfer, UnitedHealthcare 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 in the same manner 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 otherwise 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 for 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 shall review and authorize care and trauma services using the applicable provision review criteria.

Transplant Services/Case Management

For medical groups/IPAs that have risk for transplant services, notify the 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 that do not have risk for transplant services, must refer members into UnitedHealthcare's transplant case management program who have been identified as:

- Requiring evaluation for a bone marrow/stem cell or solid organ transplant
- Undergoing a transplant evaluation
- Receiving a transplant
- Receiving post-transplant care within the first year following the transplant

Optum serves as UnitedHealthcare's transplant network. The transplant case manager works in conjunction 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 that 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 otherwise dictated by the member's benefit or federal/state law.
- Optum is responsible for the authorization and management of donor care and services directly related to transplant services from date of initiation of the stem cell/bone marrow collection, or 24 hours prior to solid organ donation surgery, until 60 calendar days post-transplant date, unless otherwise dictated by the member's benefit or state law.
- Optum is responsible for authorization and reimbursement of all travel expenses as covered under 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.
- You may submit referrals to Optum via:
 - › Phone: 866-300-7736
 - › Fax: 888-361-0502

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.
- VAD/MCSD evaluations and surgery must be performed at a facility in Optum's 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 authorization for a second opinion. The medical group/IPA is also responsible for claims payment if delegated for claims.

- 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 UnitedHealthcare's 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 that he or she believes 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 that 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 that the recommended action will be determined to be 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/IAP 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 nonparticipating 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.
- If the member gets a second medical opinion without prior authorization from the participating medical group/IPA, or from us, the member will be financially responsible for the cost of the opinion.

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 related to 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](#) > Clinical Trials - Commercial Coverage Determination Guidelines, 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. Noncompliant services will not be 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.

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 to you in the terms of your agreement.

A member or care provider may request authorization from you for medication carved out of the terms of your agreement. You should notify the member that 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 request prior authorization for select drugs must be made by the care provider medical group (medical group/IPA). You can 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 all necessary information has been received. 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's benefit restrictions (applied to the requested agent(s)/therapeutic class, and the prior authorization process), are not exceeded.

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. Noncompliant 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 are accountable to 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 impact 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 the following data elements:

- 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 plan demand, 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 (60 minutes) 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 that are:

- 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 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 participation agreement, the delegate is financially responsible for:

- ER and post-stabilization services in area, and
- OOA services if responsible for OOA per the participation 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 that 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 that matches 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 the UnitedHealthcare, care provider dispute resolution process will manage UnitedHealthcare or its delegate facility disputes issuing a denial.

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 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)
- Stereotaxic Radiosurgery (SRS)
- Stereotaxic 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 for Payment to be Processed

You can initiate a request for prior authorization of outpatient therapeutic radiation services (IMRT, STS, and SBRT) carved out of capitation on UHCprovider.com/priorauth. 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.

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.

You can 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 that 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/ Notice of Denial of Medical Coverage (IDN/NDMC) 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 following:

- 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 that 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, 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 or Medicaid)
- 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 Job Aids and Best Practices

In April 2016, CMS published two job aids to address the source of most of CMS's audit findings:

When Processing Medicare Part C Organization Determinations and Reconsiderations, What's Reasonable Outreach?

- First, decide if expedited or standard decision is needed, the type or level of service requested and if any information is missing or needed for approval.
- If additional information is missing or needed, reach out to the provider. This is recommended within a few hours of receiving the request. Notify the provider of the specific information needed to approve coverage. Document the date/time and method of all outreach

attempts. Document the success of the outreach; that is, all requested missing information is obtained.

- Make at least two additional attempts, using different methods from your initial outreach (e.g., phone, fax, automated system or a letter). Make requests within business hours; if not feasible, follow the provider's after-hours instructions on their voicemail or answering service. Leave at least a few hours for the provider to respond and after final outreach attempt prior to issuing a decision.
- If you made at least three outreach attempts, used different methods of outreach, and thoroughly document all attempts.

Medicare Part C Denial Notice Rationale

Information Needed to Approve Coverage (extension)

- List specific diagnosis or clinical criteria required, if any.
- Give details on the clinical information needed from the provider to approve coverage of the requested item or service.
- Provide relevant information from the plan's Evidence of Coverage or Medicare coverage policy, if appropriate.

Writing the denial rationale:

- Use the OMB-approved Notice of Denial of Medicare Coverage (NDMC)
- Know the type and level of service requested
- Determine the denial type, such as medical necessity or benefit exclusion
- List any criteria used from the plan's Evidence of Coverage, Medicare or CMS-approved Plan coverage criteria, or any other criteria used in making the decision.
- Rationale should match the case notes on why the request was denied and be appropriate to each specific case.
- Write in plain language easily understandable by an enrollee, and tailored appropriately to the enrollee (e.g., Spanish speaking or large print).

If your denial rationale follows these steps and it has all the information needed to approve coverage, then your denial rationale is sufficient.

In February 2017, CMS published a memo about Updated Guidance on Outreach for Information to Support Coverage Decisions, relating to the job aid about "What's Reasonable Outreach?" This memo identified best practices that would result in more timely and accurate coverage decisions for Medicare Advantage enrollees. Since CMS plans to update the Medicare Managed Care Manual Chapter 13 to include these as requirements, we have included the best practices in the annual assessment process so that our delegates are prepared in advance to implement them when they become requirements.

- Standard pre-service organization determinations: make at least three outreach attempts, the first within two calendar days of receipt of request and during the provider's business hours when feasible.
- Expedited preservice organization determinations: make at least three outreach attempts, the first upon receipt of request and during the provider's business hours when feasible.
- The memo provides additional details on "Outreach Methods and Involvement of Plan Physicians" and "Documenting Requests for Information."

Delegation of Complex Case Management and Disease Management

We may delegate the functions of complex case management or disease management. Requirements are based on NCQA accreditation standards. In the case of Community Plans, delegation may include state-specific requirements around CCM, variously called care coordination or care management. In this context, the requirements differ from medical management. Some Community Plans may have additional disease management requirements.

If these functions are delegated to a medical group/IPA or other organization, we will conduct pre-contractual and post-contractual assessments. If assessments identify deficiencies, we will 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 that are sent to the member.

UnitedHealthcare has provided the 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 need not be added into the body of the communication but may be included as a separate sheet in the mailing envelope. Only a single tagline sheet need be included in every mailing, even if the envelope contains multiple communications.

Claims Processes

Commercial Delegated or Capitated Claims Process

We may delegate claims processing to medical groups/IPAs and facilities (collectively referred to as "delegated entities" in this section) that have requested delegation and have shown through a pre-delegation assessment that they are capable of processing claims that are compliant with applicable federal regulatory requirements.

Delegated entities must develop and maintain claims operational and processing procedures that allow for accurate and timely payment of claims. 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 that is consistent with processes utilized by UnitedHealthcare.

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;
- Appropriateness of admission, length of stay and level of care;
- Eligibility verification;
- Initiation of appropriate follow-up for utilization, quality and risk issues;
- Appropriateness of billing; and
- Identifying and resolving claims-related issues as they relate to medical necessity and UnitedHealthcare claims payment criteria and/or guidelines.

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 that are 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. A care provider shall 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 shall monitor appeals and overturn rates for emergency department claims, and develop and execute improvement action plans when they identify deficient performance or processes.

Compliance Assessments

We have established policies and procedures specifically designed to monitor the delegated entities' compliance with state and federal claims processing requirements. Our auditors will conduct claims processing compliance assessments. We review delegated entities found in compliance at least annually. Our auditors conduct additional reviews for other circumstances, such as:

- Assessment results indicate non-compliance
- Self-reported timeliness reports indicate noncompliance 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 the claims processing compliance assessment, we will request copies of the delegated entity's universal claims listing for contracted and non-contracted care providers. The auditor will review the reports accuracy and randomly select claims for examining. They tell the delegated entity which claims they selected at random from the universal claims listing. The delegated entity must be ready for the auditor at the time of assessment. Examples of the categories assessed include:

- 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

Delegated entities found not compliant with state and/or federal regulations, as well as UnitedHealthcare standards for claims processing, will be required to provide a remediation plan describing how identified deficiencies are to be corrected. The remediation plan should include timeframe in which the deficiencies will be corrected. Delegated entities not remediating deficiencies may be subject to additional oversight, sanction and potential de-delegation.

If the delegated entity is found to be 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 a 90-calendar days timeframe we give to a delegated entity after a non-compliant review. They have 90 days to demonstrate compliance or remain in the cure period until they achieve compliance. We conduct frequent reviews during the cure period. We may sanction delegated entities who do not achieve compliance within the established cure period. Claims processing is a delegated function that is subject to revocation. Sanctions may consist of additional/enhanced assessing, 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 components 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

In instances when a member is financially responsible for a denied service, UnitedHealthcare or the delegated entity's claims department (whichever holds the risk) must provide the member with written notification of the denial decision in accordance with 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. The denial letter must be sent within the appropriate regulatory timeframes.

If the member is enrolled in a benefit plan subject to ERISA, a claim denial letter issued to the member 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 receipt of the claim.

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 tell them:

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 that the member is not to be 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 are required to submit clean claims for reimbursement no later than the time specified in the care provider's participation agreement or the timeframe specified in applicable laws, whichever is greater. Neither UnitedHealthcare nor the plan's capitated provider that pays claims will impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. If UnitedHealthcare or the capitated provider is not the primary payer under coordination of benefits, UnitedHealthcare or the capitated provider shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.

If a network care provider fails to submit a clean claim within the foregoing timeframes, UnitedHealthcare reserves the right to deny payment for such claim. Claims that are denied for untimely filing, cannot bill to a member. We have established internal claims processing procedures for timely claims payment to our care providers, and we are committed to paying claims for which we are financially responsible within the timeframes required by state and federal law.

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 used for the receipt of all paper claims. 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

To meet legal and regulatory timeliness standards, 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 shall forward the claim to us within 10 working days of the receipt of the claim.

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.

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 are responsible for updating their claims systems to help ensure members are not charged for copayments or coinsurance/deductibles once the annual maximum out-of-pocket expense met.

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, unclear, 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 participation 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 that can 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 (MA) Delegated or Capitated

Claims 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.

Interest Payment Requirements

CMS requires the payment of interest for non-contracted care provider clean claims not paid within 30 calendar days from the first date stamp. Interest is paid at the current rate for the period beginning on the day after the required payment date and ending on the date the check is mailed. CMS updates the interest rate twice annually, in January and July. You can find this information in the Federal Register or on the official CMS website.

Claims Disputes and Appeals

Contracted Care Provider Disputes

Contracted care providers who have a claim dispute with a delegated medical group/IPA must make sure they have followed all the guidelines set forth by the medical group/IPA prior to rendering services to a UnitedHealthcare member.

Claim Reconsideration Requests and Rework Request (Does Not Apply in CA)

You may request a reconsideration of a claim determination. These requests are typically 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). You must submit requests within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines. The most efficient way to submit your requests is through UHCprovider.com/claimslink, which also allows attachments.

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 be handled as follows:

- Request must provide a clear, accurate, written explanation
- Request must be issued within 365 calendar days from the last date of payment for the claim
- The care providers given 30 working days to send written notice contesting the request for reimbursement for overpayment

Medicare Advantage 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 that 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). You 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.
- Establish and communicate the Timely Filing Limit of 180 calendar days from the original claim determination 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 that 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 that 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 that 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, etc.;
- 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.

Second Level Payment Disputes (MA Claims)

Forward second level disputes to UnitedHealthcare. Any materials that we request related to the dispute must be submitted by the delegated entities in a timely manner. This will help ensure all relevant documentation is considered. We have 60 calendar days to review and respond to second level disputes.

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 that have not been 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.

UnitedHealthcare West Delegated Care Provider Claims Appeals

Delegated Claims Reporting

CA/OR/WA: Updated versions of the Medicare Claims self-timeliness report (ICE Claims Medicare MTR) and the Commercial Claims self-timeliness report (ICE Claims Comm Mo Qtr.) found on the Iceforhealth.org website. The most current version of the form needs submission at all times. This applies to both Commercial and MA products. The California Delegated Entity must submit the timeliness form via email to providerAuditClaimsReports@uhc.com. Monthly timeliness report submissions are due within 15 days from the end of the reporting month. Commercial quarterly reports must be submitted no later than the 30th day following the end of the quarter. Medicare quarterly report submissions are due by the 15th day, following the end of a quarter. Maintain a copy of the reports for your records.

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 that 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 (Commercial in OK & TX Only)

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, 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.

Commercial Delegated Provider Payment Dispute Resolution Process (CA Only)

The commercial provider Payment Dispute Resolution (PDR) process includes any decisions where a delegated provider appeals the amount paid by the organization.

The following are the regulatory and UnitedHealthcare compliance requirements:

- "Written Acknowledgement" of provider disputes within two working days for electronic submission and 15 working days for paper submission.
- Resolution and a "Written Determination" must be completed within 45 working days after the date of

receipt of the provider dispute or the amended provider dispute.

- Resolution of a provider dispute or amended provider dispute involving a claim and which is determined in whole or in part in favor of the provider, must include payment of any outstanding monies determined to be due, and all interest and penalties must be paid within five working days of the issuance of the written determination.
- Incomplete provider disputes where additional information has been requested, the provider has 30 working days to submit additional information.
- Late payment on a complete claim for emergent/urgent services shall include the greater of \$15 or 15% per annum for the period of time that the payment is late.
- Late payment on all other complete claims shall include interest at the rate of 15% (0.000411) per annum for the period of time that the payment is late. Penalty for failure to include interest due on a late claim payment shall pay \$10 for that late claim in addition to the required interest payment.
- Quarterly Dispute Resolution Mechanism Reports must be submitted and signed by the Principal Office within 30 days of the close of each calendar quarter.
- Timeliness is measured from the earliest date stamp within your facilities if you are the financially responsible payer through the date the payment check or notice contesting that claim has been mailed.
- Written procedures for Provider Dispute & Resolution must be established which must include; address, directions for submission, timeframe guidelines and phone numbers for inquiries.
- Improvement Action Plans must be submitted when specified.
- Review process requirements are complied with, including:
 - › Keeping the scheduled assessment appointment
 - › Having all claims and supporting documentation ready at the time of the inspection
 - › Canceled checks or bank statements
 - › Operational Review Questionnaire(s) and Attestations signed and are all available for review



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 will be 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

UnitedHealthcare is 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 validate the reported cost share information and notify the member and their capitated care provider in writing that the member has met their annual individual out-of-pocket/deductible maximum.

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 refund any cost share amounts collected in excess of the member's annual individual out-of-pocket/deductible maximum amounts to the member. Additionally, we ask the capitated care provider to verify that the member has received all appropriate reimbursements.

UnitedHealthcare's Compliance Assessment team will monitor the capitated care provider's compliance with this annual individual out-of-pocket deductible maximum policy to help ensure all requests for reimbursement completed timely.

If necessary, UnitedHealthcare will work with the capitated care provider to help ensure that each member 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, UnitedHealthcare may reimburse the member directly and recover the payment via capitation deduction as specified in your participation 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 will be available to view the Member's Cost Share accumulation:
 - › EL915 M
 - › EL917
 - › EL918
 - › IVR
 - › 5010 version of the 270/271 — refer to the EDI companion guide
- We notify members when they 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 to help ensure members not charged for

copayments, coinsurance, and deductibles once the annual maximum is met.

- UnitedHealthcare conducts assessments to help ensure appropriate administration of member cost share accumulation.

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 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 owe any further cost share amounts for those services that apply to the out-of-pocket maximum. For benefit plans with both individual and family maximums, no family member will owe further cost share amounts for those services that apply to the out-of-pocket maximum. When a family's out-of-pocket expenses have reached their family out-of-pocket maximum benefits. Cost sharing still applies to those plans with benefits that do not apply to the out-of-pocket maximum and for excluded benefits after the out-of-pocket maximum reached.

Cost sharing is defined as amounts paid by the member such as copayments, coinsurance and deductibles according to their plan benefits.

There is no coverage for certain covered services 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 amounts. 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 satisfy the family deductible for the year.

As specified above, 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 based on UnitedHealthcare's contracted rates, percentage copayments (coinsurance) and contracted rates.

Financial Responsibilities for MA Members

Annual Out-of-Pocket Maximum

Annual out-of-pocket maximum is the total of 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 benefits after the annual out-of-pocket maximum reached.

Cost sharing 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 via 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 the care provider contract.
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 the Medicare Allowable Rate for the location at which the service is rendered.

This coinsurance calculation is consistent with the definition of coinsurance as an amount a member may be required to pay as their share of the cost for services or prescription drugs. The methodology is used for all UnitedHealthcare Medicare Advantage plans nationwide.

The correct system setup and consistent coinsurance calculation will help reduce member appeals and complaints.

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 sent using Electronic Data Interchange 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.

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 that 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 that 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, to within the CAS segment

of the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned MA members.

To comply with CMS regulation 42 CFR 422.111(b)(12) an EOB for Part C benefits must report total costs incurred by the health plans (us) for capitated and/or delegated provider services, on encounter submissions from contracted care providers processed with dates of service on or after Jan. 1, 2015.

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 we denied the claim.

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.

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 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.

Capitation Payments and Reporting

Capitation Reports

A Capitated care provider group submits semi-annual reports to UnitedHealthcare as outlined in their contract.

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 participation 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 participation 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 reports online for the current month and the prior month. Previous reports purge from our website before new reports post.

We recommended that you complete your capitation download in a timely manner to make sure that 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 Hierarchical Condition Category (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 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 participation 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

UnitedHealthcare makes 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 specified in the participation agreement. If the due date falls on a non-banking day, the capitation payment 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. The EFT initial set-up, or a change in banking information, requires three weeks processing time to take effect.

We deposit Capitation payments via EFT by the end of the banking/business day on the date specified in the participation agreement.

Note: Most financial institutions charge a per transaction fee, on electronic funds transfers.

The Authorization Agreement Payments form online at Link. You can submit completed forms on Link.



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

Capitation calculation methods are detailed in your participation 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 participation 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 participation 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 participation 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 participation 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 (PC PNI). 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 can be reported at both a summary and detailed levels. 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).

Medicare Advantage (MA) Capitation Capitation Calculation Process

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 participation 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 participation agreement, multiplied by various factors.

It contains three components:

1. Base rate — is detailed in the participation 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 participation 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 that is used for the percent of premium calculation. The algorithm, methodology-blend percentage and rates/factors are posted on the CMS website at [cms.gov](https://www.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 began reducing care provider capitation payments for MA membership by 2% beginning in April, 2013. 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

As reviewed in the Percent of CMS Premium Capitation section, 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.

A request for sample member capitation assessment is limited to one request per contract year.

MA plan requests are limited to only one review month within the last 12-month period, and is limited to not more than six members.

A medical group/IPA or capitated facility may request one member capitation assessment, covering one month within the last 12-month period, and not 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 participation 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 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 Medicare Advantage premium payment adjustments to UnitedHealthcare that can 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

As part of our effort to support the goals of Triple Aim to improve care experiences, health outcomes and total cost of care, delegate performance evaluation is in order. An analysis of clinical, quality and health outcomes conducted 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, to identify variations from peer benchmarks and sharing that information with you, we can work collaboratively to improve value for our members.

Together we can 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 can best support your efforts in providing high quality, cost-effective care to our members.

Delegate performance domains include, but are not limited to, the following areas of focus:

- Clinical utilization management
- 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 on a regular basis, compared to peers benchmarks, and communicated to the delegate in the form of performance reports.

Improvement Action Plans

Based on delegate performance findings, 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.

The delegation of any services is subject to revocation for continued noncompliance with our standards. Failure to meet performance requirements may be cause for revocation of delegated services.

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 may vary, depending on the 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 using the contact information in the applicable How to Contact Us reference table under the Expedited Appeals and Standard Member Appeals sections.
- 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 help state and explain 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, MN, ND, PR, SD, USVI, WI. 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 participation agreement with the entity operating the leased network (your "Master Contract Holder").

Follow your Master Contract Holder agreement for how to:

- update demographic information,
- submit National Provider Identification information,
- credential/re-credential, and
- appeal.

The information in the main guide does not apply.

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 can 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 Phone: 866-273-9444 Fax: 855-307-8531 M-F 9 a.m. to 5 p.m. After Hours Phone: 305-421-1220 M-F 5 p.m. to 11 p.m. S-S, 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/eligibility Phone: 800-348-5548 Fax: 305-421-1220	• Verify eligibility and benefits of enrolled members
Claims	Online: UHCprovider.com/claims Phone: 800-348-5548 M-F, 8 a.m. to 5 p.m. ET Fax: 866-725-9337	• Submit or review claims, encounters, inquiries, status, or review requests
Technical Support for Change Healthcare claims submission network	Phone: 800-845-6592	• Obtain assistance with password or technical support issues

Resources	Where to Go	What you can do there
Audit and Recovery	Phone: 877-842-3210	Ask questions related to overpayments
Credentialing	Phone: 800-963-6495 M-F, 9 a.m. to 5 p.m. Fax: 866-567-0144	Update or complete credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility
DME and Infusion (MedCare)	Phone: 800-819-0751	- Register for these services: - On call 24 hours a day - You may also call Utilization Management or Network Management
Electronic Remittance (Facilitated by Change Healthcare)	Phone: 800-845-6592 Online: changehealthcare.com	Information and registration for electronic payment services
Fraud, Waste, and Abuse (FWA) Hotline	Online: medicaplans.com Phone: 800-455-4521, M-F, 9 a.m. to 5 p.m. Fax: 888-659-0617 Email: ReportFraud@UHCsouthflorida.com Mail: Medica HealthCare Special Investigations Unit P.O. Box 56-6596 Miami FL 33256-6596	Report concerns related to fraud, waste, or abuse.
Grievances & Appeals	Phone: Call the provider number listed on the back of the member's identification card. Mail: Medica Healthcare Grievances & Appeals Department P.O. Box 30997 Salt Lake City, UT 84130	Obtain information about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms.
Home Health (MedCare)	Phone: 305-883-2940	- Arrange for services - On-call 24 hours a day - You may also call Utilization Management or Network Management
Member Services	Phone: 800-407-9069 M-F 9 a.m. to 5 p.m. TTY: 711 Fax: 800-517-6924	- To 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: 877-670-8432 M-F 9 a.m. to 5 p.m. Fax: 888-659-0619 Email: pcp-NetworkManagementServices@uhcsouthflorida.com	- Ask questions regarding provider agreements, in-servicing and follow-up and outreaches - Report demographic changes - Submit Informal complaints - Find or request forms or other materials - Verify a member's eligibility, including plan benefits, deductibles, and information on the member's primary care provider, as applicable - Submit, search for, and print authorizations for outpatient services or inpatient stays - Search for, view, and check the status of claims
Pharmacy (OptumRx)	Phone: 800-711-4555 Fax: 800-527-0531	Verify pharmacy benefits and eligibility, adjudications, or authorizations

Resources	Where to Go	What you can do there
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: providerexpress.com Licensed clinicians are available 24 hours. Member Services – 24 hours. Phone: 800-985-2596 No DSNP 800-496-5841 DSNP & iSNP	- Obtain information about behavioral health and substance use services for all members - Access a list of behavioral health practitioners and care providers in the provider directory
Dental (Solstice)	Online: SolsticeBenefit.com Phone: 855-351-8163	Access a list of Solstice dental providers in the provider directory
Fitness (Silver Sneakers®)	Online: silversneakers.com Phone: 877-427-4788 M-F 8 a.m. to 9 p.m.	
Hearing (Hear-X/HearUSA)	Phone: 877-670-8432 M-F 9 a.m. to 5 p.m.	
Laboratory (LabCorp)	Online: labcorp.com Phone: 855-277-8669 Automated Line Phone: 800-877-7831 Live Scheduling	Find information on locations, to make an appointment, and to order lab tests and view results
Mail Order Pharmacy (OptumRx)	Online: optumrx.com Phone: 877-889-6358	Obtain mail-order medications
Podiatry - Network Mgmt Services (Foot and Ankle Network)	Phone: 877-670-8432 M-F 9 a.m. to 5 p.m.	Access a list of podiatrists in our provider directory
Transportation (Member Services)	Phone: 888-774-7772 M-F 9 a.m. to 5 p.m.	Request services
Vision - Network Mgmt Services (iCare)	Phone: 877-670-8432 M-F 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 Preferred Care Partners Medical Group (PCPMG), 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 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/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 that the member knows 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.

Prior Authorizations and Referrals

Simple Referral Process

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 can 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/priorauth.
- Upon submitting a referral request, the system automatically generates the referral number.
- For member convenience, you can 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.

Services Not Requiring Prior Authorization

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 > Prior Authorizations and Notifications > Advance Notification and Plan > under Plan Requirement Resources > Medica Healthcare and Preferred Care Partners Prior Authorization Requirements.

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 hospital admissions, including 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.

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

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 that 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 that 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 that 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 that the coverage approval is on file. This promotes conversations between the facility and the member about the cost for the procedure.

- Facilities are responsible for admission notification for inpatient services even if the coverage approval is on file.
- If a member is admitted through the emergency room, notification is required no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.
- If a member receives urgent care services, you must notify us within 48 hours of the services being rendered.

Admission Notification Requirements

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

- Planned elective admissions for acute care
- Unplanned admissions for acute care
- Skilled Nursing Facility (SNF) admissions
 - › Notify us of admissions to SNF within 24 hours. Prior authorizations are not required.
- Admissions following outpatient surgery
 - › Long Term Acute Care Hospital (LTACH) and Acute Inpatient Rehab (AIR) require prior authorization.
- Admissions following observation
- Acute inpatient rehabilitation admission
- LTACH admissions

- Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission (or by five p.m. local time 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 as well.
- 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 participation agreement with us
- Admission notifications must contain the following:
 - › 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 cannot 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 participation agreement and claim requirements.

How to Request Prior Authorization

- **Online:** UHCprovider.com/priorauth.
- **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 that 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™ 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 that is 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, 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 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. 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 can occur at different points during case activity in accordance with timeframes, once a medical director has rendered an Adverse Determination. A P2P reconsideration request can only occur before you file a formal appeal.

Medica 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 your patients, 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 that 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. local time 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. local time 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. There can be no modification of the NOMNC notification text.

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.

2018 Medica Benefit Summaries

The 2018 Medica benefit summaries are available on medicapplans.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 medicapplans.com. You can 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 communicate information, regarding the risks, benefits, and consequences of treatment or non-treatment, at a level the member can 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, via 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 that is 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 that 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 that 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 that 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 following:

- 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 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.

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 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 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, 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 your patients, select only one program that your member meets the criteria for, and email the CM/DM referral form, available on medicaplan.com > Physicians and Providers > [Provider Forms](http://southfl@optum.com), 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 can opt out at any time.

United Behavioral Health

We work with United 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 a framework for providing healthcare and healthcare plans designed by theory, evidence-based protocols and accepted standards. 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.

Structure and Process

We base the structure and processes of the SNP MOC program upon six structure and process measures to evaluate the structure, processes, and performance of SNPs. Through these measures, SNPs must demonstrate that they are providing quality health care for our members. These measures are:

- Complex Case Management;
- Improving Member Experience (satisfaction);
- Clinical Quality Improvements;
- Care Transitions;
- I-SNP relationships with facility; and
- Coordination of Medicare and Medicaid coverage.

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 that 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 medicaplan.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).

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 can be located on UHCprovider.com/protocols.

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 <i>Prior Authorizations</i> process located within this supplement. A complete list of codes requiring prior authorization can be located on UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > UnitedHealthcare Mid-Atlantic Plan Notification/Prior Authorization Requirements .	Yes; please view section on <i>Prior Authorizations</i> process located within this supplement. A complete list of codes requiring prior authorization can be located 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 primary care physician, 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 that 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 primary care physician.
PCP Referrals to Network Specialists	The member's PCP generates referrals for specialty care and facility care.
Reimbursement	Services for members enrolled in Optimum Choice HSA are excluded from your capitation payment and are paid on a fee-for-service (FFS) basis per the All Payer Payment Appendix included in the UnitedHealthcare physician agreement.
Optimum Choice HSA Member Health Care ID Card	The Optimum Choice HSA product name and member's PCP are indicated on the member's health care ID card. Specialist referral requirements are on the back of the health care ID card. When confirming eligibility, please use eligibilityLink .

Provider Responsibilities

For detailed information and instructions on verifying eligibility, the choice and role of the PCP and other care provider requirements, refer to *Chapter 2: Provider Responsibilities and Standards*.

Eligibility and Health Care ID Cards

ID card information may vary by health benefit plan. For example, some members may have health care ID cards which indicate M.D. IPA Preferred or Optimum Choice Preferred benefits. You can see an image of the ID card specific to the member when you verify the member's eligibility. For more information on ID cards and to see a sample health care ID card, refer to the *Health Care Identification (ID) Cards* section of Chapter 2: Provider Responsibilities and Standards.

Please check the member's health care ID card during each member visit, and keep a copy of both sides of the health care ID card for your records. Possession of a health care ID card is not proof of eligibility. Before seeing a member, it is important you verify their eligibility and benefits, as well as the member's PCP selection, to avoid payment issues. Go to [UHCprovider.com/eligibility](#).

The following unique features are located on M.D. IPA and Optimum Choice health care ID cards:

1. Laboratory provider information is located on the front of the cards; please see the following [Laboratory Requirements](#) section of this supplement.
2. Radiology county information is located on the front of the cards; please see the following [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/Protocols](#).

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)

Specific vendors are available for referral based on the county listed on the health care ID card.

A complete list of county specific radiology vendors is found on [UHCprovider.com/plans](#) > (choose your state) > Commercial > Radiology Vendors.

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 Management Contact > Select your state. Members are required to select a network PCP or a PCP is auto-assigned.

Discharge of a Member from Physician's Care

If, after reasonable effort, you are unable to establish and maintain a satisfactory relationship with a member, you may request the member be discharged from your care and transferred to an alternate physician. You must notify us to have the member removed from your panel. This number is on the back of the member's health care ID card. Reasons for discharge may include:

- Disruptive behavior
- Physical threats/abuse (this warrants immediate action which must be documented. Please notify the proper authorities)
- Verbal abuse
- Gross non-compliance with the treatment plan

You must provide adequate documentation in the member's medical record of the verbal and written warnings given to them. You are required to provide emergency care to the member for 30 calendar days from the member's receipt of the dismissal letter. For more information go to: UHCprovider.com/Protocols > Mid-Atlantic Health Plans Preferred PCP Selection, Panel Closure and Member Dismissal Protocol.

Referrals

For referral process information, check the Mid-Atlantic Health Plan Referral Protocol located on UHCprovider.com/protocols > [Mid-Atlantic Plans Referral Protocol](#) 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.

Forms and specific referral processes for some treatments can be found on UHCprovider.com/protocols > [Mid-Atlantic Plans Standard Care Referral Form](#).

Copays

Please verify the member's copayments when verifying their eligibility.

Prior Authorizations

How to Submit

There are multiple ways to submit prior authorization requests to UnitedHealthcare, including electronic options. To avoid duplication, once a prior authorization is submitted and confirmation is received, please do not resubmit.

- **Online:** UHCprovider.com/priorauth
Link: use the Prior Authorization and Notification application.
- **Phone:** 877-842-3210. Clinical Services staff are available during the business hours of 8 a.m. to 8 p.m. ET.
- **Fax:** Fax your request using the Universal Prior Authorization Request Form found on UHCprovider.com/priorauth > scroll down to 'Fax Forms' > Mid-Atlantic Health Plans Universal Request for Prior Authorization.

General Outpatient	866-255-0959
Infertility	866-369-4119
Durable Medical Equipment	866-362-6101
Homecare	877-269-1045
Radiology	866-589-4848
Transplant	866-537-9371
Medical Injectable	866-537-9371
Inpatient & Acute Rehabilitation	866-892-4582



The forms referenced below can be found on the UHCprovider.com/priorauth > [Advance Notification and Plan Requirement Resources](#) webpage.

Radiology Prior Authorization Requests and Prior Authorization List

Although prior authorization requests for radiology can be submitted electronically using our online prior authorizations, 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 can't be submitted electronically. Fax these prior authorization requests to the Clinical Care Coordination Department at 888-831-5080 using the Rehab Extension Form found at UHCprovider.com/plans > select your state.

Chiropractic Services Prior Authorization Request

Prior authorization requests for chiropractic services can't 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, 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 faxing a request to Outpatient Services at 866-255-0959. The most common exception requests are:

- Immunizations (outside the scope of health benefit plan guidelines)
- Referral of an HMO member out-of-network to a nonparticipating physician, health care practitioner or facility

Prior authorization is required for the listed elective outpatient services. It is the physician's responsibility to obtain any relevant prior authorization. But, the facility should verify that 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. local time on 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. local time on 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. Please remember 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: 800-352-0049.

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 above.

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 that is 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 day(s), if permissible under state law.

A clinical delay in service is assessed for any of the following 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 nationally-accepted 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 to the following 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](#).

Prior authorization requests can be faxed to 866-537-9371. 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

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.

Capitation

Capitation payment will be paid to the practice for covered services on a per member per month (PMPM) basis. 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.

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](#).

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). Copies of the reports above can be obtained 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 Management 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 the care provider fits into the following two categories:

1. Your participation 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. The participating care provider is 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, 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	Phone: 877-842-3210
Appeals	Address:
Urgent Appeals	UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 Fax: 801-938-2100
PreService Appeals	Medical appeals fax: 801-994-1083 Pharmacy appeals fax: 801-994-1058
Breast Pumps	Lincare: 855-236-8277 lincare.com Byram Medical: 877-902-9726 byramhealthcare.com Edgepark Medical: 888-394-5375 edgepark.com
Cardiology: Prior authorization of cardiology services as described in the <i>Outpatient Cardiology Notification/Prior Authorization Protocol</i> section of this guide.	Online: UHCprovider.com/cardiology ; select the Go to Prior Authorization and Notification App. Phone: 866-889-8054
Chemotherapy (outpatient injectable)	Online: UHCprovider.com/priorauth > Oncology Phone: 866-889-8054
Chiropractic Services Information	Quality Managed Healthcare, Inc. Phone: 954-236-3143 Fax: 954-236-3254

Resource	Where to go
Claims (Electronic)	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.
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	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)	Online: UHCprovider.com/eligibility Provider Services number is 877-842-3210. Please refer to the back of the health care ID card to help ensure the appropriate provider services department is contacted.
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)	Bioscrip: 844-839-5899 bioscrip.com Accredo: 855-315-3590 accredo.com Walgreens Infusion: 800-683-5252 walgreenshealth.com
Insulin Pumps and Supplies National Vendors	Minimed Distribution Group: 800-933-3322 minimed.com Animas Diabetes Care LLC: 877-937-7867 animascorp.com Roche Insulin Delivery Systems: 800-280-7801 accu-checkinsulinpumps.com Smiths Medical MD: 800-826-9703
Intensity Modulated Radiation Therapy (IMRT)	Phone: 800-550-5568 Fax: 800-731-2515
Medical Supply Providers (Disposable supplies, ostomy, urological, incontinence supplies)	Byram Medical: 877-902-9726 byramhealthcare.com Edgepark Medical: 888-394-5375 edgepark.com Liberty Medical: 800-615-0714 libertymedical.com Medline: 800-633-5463 medline.com McKesson: 855-404-6727 mckesson.com/providers/home-care/mckesson-patient-care-solutions/
Mental Health Services Prior Authorization United Behavioral Health (UBH), operating under the brand Optum	Phone: 800-817-4705
Pharmacy (OptumRx)	Prior Authorization: 800-711-4555 Customer Service: 888-739-5820 Fax: 800-837-0959

Resource	Where to go
Physical, Occupational and Speech Therapy (OptumHealth)	Phone: 800-873-4575 Fax: 248-733-6070
Podiatry Foot and Ankle Network (FAN)	Phone: 305-558-1227 Fax: 305-557-3810
Radiology/Advanced Outpatient Imaging Procedures: Prior authorization of radiology services as described in the <i>Outpatient Radiology Notification/Prior Authorization Protocol</i> section of this guide	Online: UHCprovider.com/radiology ; select the Go to Prior Authorization and Notification App. 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: 800-550-5568 • Ventricular Assist Devices: 877-842-3210 or fax 855-282-8929 • Transplant Resource Services: 877-842-3210 or fax 855-250-8157
Prior Authorization/Pre-Certification 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: 877-842-3210, Option 3, or the number on the back of the member's ID card. Fax: 866-756-9733 – using the prior authorization form found on UHCprovider.com/priorauth .

Discharge of a Member from Participating Provider's Care

If, after reasonable effort, the PCP is unable to establish and maintain a satisfactory relationship with a member, the PCP may request that the member transfer to another PCP. The PCP must submit the request in writing to NHP Member Care. Reasons for discharge may include:

- Disruptive behavior
- Physical threats/abuse
 - › This warrants immediate action, which must be documented. Please contact NHP Member Care and notify the proper authorities.
- Verbal abuse
- Gross non-compliance with the treatment plan

The PCP must provide adequate documentation in the member's medical record of the verbal and written warnings. The PCP is obligated to provide care to the member until it is determined that the member is under the care of another physician.

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 healthcare 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 888-LABCORP (522-2677), option #3 to determine how to conveniently access their services.
- Call Provider Services at 877-842-3210.

In the unusual circumstance that you require a specific laboratory test for which you find no participating laboratory is available, please contact NHP UM at 800-550-5568.

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 can make an initial referral. These must be made to participating care providers. We deny claims for services rendered without a proper referral. You cannot 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.

The following 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 800-550-5568. 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. Use [eligibilityLink](#) and click on the referral icon in the member's information.
- 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.

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 fax at the number designated on the top of the Prior Authorization Form 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.

* See the prior authorization section of this supplement.

Utilization Management (UM)

Submit your request electronically using one of the following:

1. EDI 278, directly to UnitedHealthcare or through a clearinghouse
2. UHCprovider.com/priorauth

Be sure to include the place of service and CPT codes in your request.

If you do not have electronic access, you can submit prior authorization requests by phone or fax:

Phone: 877-842-3210, option 3, or the number on the back of the member's ID card.

Fax: 866-756-9733

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 the following 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 and to check prior authorization requirements, please consult the

NHP Prescription Drug List Consumer Reference guide at MyNHP.com > Members > [Pharmacy](#).

Chemotherapeutic agents administered through the medical benefit require prior authorization. For the most current and complete list of medical drugs requiring prior authorization for NHP members and the requirements for the outpatient medications listed above, go to [myNHP.com](https://MyNHP.com) > Providers > [Pharmacy](#).

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

Phone: 877-488-5576

Fax: 866-756-9733

Concurrent Review

The continued stay for all inpatient admissions must be certified through the concurrent review process. Upon request, you must submit to NHP or its delegated entities, by phone, or fax, sufficient clinical information to:

- certify the continued stay,
- allow the review of the member's medical status during an inpatient stay,
- extend the member's stay,
- coordinate the discharge plan,
- determine medical necessity at an appropriate level of care, and
- perform quality assurance screening.

All discharge planning and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management. This includes OB care. If the diagnosis or treatment of a member is delayed secondary to the inability of the facility to provide a needed service, payment for these days is denied, including but not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in obtaining requested consultations and late rounding by the admitting physician.

Reimbursement for continued stay that does not meet NHP medical necessity criteria is denied. The member cannot 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.

* 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.

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

EPS is not available to care providers who participate under a capitated arrangement. However, you may enroll in 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 networks 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.

As of March 16, 2016, the OneNet PPO Medical Network product is no longer offered. The OneNet PPO Workers' Compensation Network continues to operate and, as of the published date, this is the only OneNet network 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 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), union health and welfare funds, workers' compensation administrators, workers' compensation insurance carriers, 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: 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 include:

- **Primary Participants:** 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.
- **Participants:** As used by OneNet and in this supplement, Participants refers to all Primary Participants and their spouses and dependents (including domestic partners, if applicable) who are authorized by OneNet to access network health care providers.

OneNet Payer: A OneNet Payer is a person or entity that has an obligation 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. In the case of workers' compensation, it may include the application of state or federal fee schedule rates, or other government-authorized pricing methodology or schedule. The terms "claim pricing" and "repricing" are used interchangeably.

Discontinuation of the OneNet PPO Medical Network Product

As of March 16, 2016, the OneNet PPO medical network product is no longer offered. There are no participants with access to the OneNet PPO medical network. Any health care ID card with the OneNet name or logo is no longer valid. The OneNet medical claim runoff period ended on March 15, 2017. OneNet medical claims are no longer being priced or adjusted. Forward outstanding OneNet medical claims to the payer listed on the health care ID card. Contact the payer directly for claims related questions.

The OneNet PPO Workers' Compensation Network continues to operate. Access is limited to employers and administrators contracted with Procura Management, Inc. (Procura), an Optum company. Some employers and groups formerly accessing the OneNet PPO Workers' Compensation Network directly or through another administrator may now access the network through Procura.

About OneNet PPO

OneNet PPO maintains the OneNet PPO Workers' Compensation Network. 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 third party administrators contracted with Procura, an Optum Company.

Procura's clients are responsible for the administration of workers' compensation benefit 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. Employers and groups formerly accessing the OneNet PPO Workers' Compensation Network directly or through another administrator may now access the network through Procura.
Website:	OneNet workers' compensation claim pricing sheets for Procura are available on UHCprovider.com/claims > Check Claim Status > Go to OneNet PPO Pricing Status Tool.
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 or Phone: 877-461-3750
Claim Payment Appeals	Direct Procura workers' compensation payment appeals to: Email: proppo@procura-inc.com . Please note that 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 participation agreement at least 30 calendar days prior, or as required under applicable laws. OneNet does not maintain Participant names and addresses and cannot 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 employment and eligibility. 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 employment. 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/claims > Check Claim Status > Go to OneNet PPO Pricing Status 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 cannot use many of the web tools on UHCprovider.com.

Some unavailable tools include:

- Determining workers' compensation 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

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 for guidance.

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.

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. The exception to this is the provision on Administration of Xolair in a Health Care Setting. 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 received benefits.

Behavioral Health Services

If you believe an injured worker would benefit from mental health/substance use services due to their job-related injury, 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 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 any of the following items.

- Items identified under the *Claims and Encounter Data Submissions* section of the UnitedHealthcare Guide
- Taxonomy Code (if submitting workers' compensation claims electronically)

Additional requirements for the CMS 1450 form:

- Items identified under the Additional Information Needed for a Complete UB-04 (or 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 CMS-1450/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 CMS-1450/UB-04 claim form or their electronic equivalents (when submitting workers' compensation claims electronically) and include all standard code sets that apply.

Claim Review Procedures

Our workers' compensation claim review procedures identifies 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 CMS-1450/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.
- Remember to 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
- 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, as examples. 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 cannot 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

We can only verify the receipt, pricing and mail date of a claim from participating care providers. Make other claims inquiries 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/claims > Check Claim Status > Go to OneNet PPO Pricing Status Tool. 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 member'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 cannot 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
- 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 can get this information by calling their employer or from the worker directly.

Claims Appeals (Post Service)

OneNet claim appeals cannot 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 the following 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.
- For health benefit plans, the participant's health benefit plan determines coverage. For workers' compensation, the workers' compensation carrier or administrator determines compensability.
- The online Claim Estimator available on UHCprovider.com cannot be used to estimate claims. OneNet claims cannot 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 for OneNet. If you believe a Participant accessing you through the OneNet PPO Workers' Compensation Network 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.

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 that 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 only offered in 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](https://www.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](https://www.oxfordhealth.com) > Providers (or Facilities) > Tools & Resources > Administrative Tools & Information. [UHCprovider.com](https://www.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 Oxford provider ID number. A Voice Portal quick reference guide is located on [OxfordHealth.com](https://www.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
UBH Appeals Optum
PO Box 30512
Salt Lake City UT 84130-0512
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 seven days a week

Policies: [OxfordHealth.com](#) > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > [Medical & Administrative Policy Index](#).

Phone: 877-PREAUTH / 877-773-2884 (Mon - Fri, 7 a.m. to 7 p.m. ET)

Chemotherapy Prior Authorization
Injectable Outpatient
Chemotherapy
Colony Stimulating Factors

Online: [UHCprovider.com/priorauth](#) > [Oncology](#)
Phone: 877-773-2884 (Mon - Fri, 7 a.m. to 7 p.m., ET)

Centers for Disease Control (CDC)
National AIDS hotline

Phone: 800-232-4636

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 Online (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 can 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 can speak with a representative (Mon – Fri., 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 (Mon – Fri., 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
Crisis Intervention Hotline: Connecticut	Phone: 800-203-1234
Crisis Intervention Hotline: New Jersey	Phone: (within New Jersey) 800-624-2377
HIV/AIDS Hotline: New York	State of New York and New York City information: 800-541-2437 Spanish/bilingual information: 800-233-7432 TTY/TDD (for the hearing-impaired): 800-369-2437 Department of Health Testing Hotline: 800-825-5448

Commercial Products	
RESOURCE	WHERE TO GO
Electronic Payments & Statements (EPS)	Information and Enrollment: Online: • OxfordHealth.com > Provider or Facilities > Tools & Resources > Administrative Tools & Information > Electronic Payments & Statements (EPS), or • Optumhealthfinancial.com > Health Care Professional > Log in Helpdesk: 877-620-6194
Electronic Data Interchange (EDI) Check status of referrals, precertifications, and claims; Patient 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, Mon - Fri, 8:30 a.m. – 5 p.m. ET
Eligibility and Benefits	EDI: 270/271 Eligibility and Benefits Inquiry and Response transactions are available through your vendor or clearinghouse. Online: OxfordHealth.com > Providers or Facilities > Transactions > Check > Eligibility and Benefits Voice Portal and Provider Services: 800-666-1353 (Say "Benefits and Eligibility" when prompted.) You can speak with a representative (Mon - Fri., 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)	Phone: 800-747-1446 Ext: 65212 Fax: 888-242-9058 Mail: UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265
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

Commercial Products	
RESOURCE	WHERE TO GO
Oxford On-Call® (Urgent and non-urgent care)	Phone: 800-201-4911 • Available 24 hours per day, 365 days per year • 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, seven days per week, including holidays
Pharmacy Prior Authorization	Phone: 800-711-4555 Available 24 hours per day, seven days per week, including holidays
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 Fax: Submit our form to: Hospitals: 800-699-4712 Providers: 800-303-9902 The form can be found on OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > Forms Phone: Provider Services 800-666-1353 (Mon - Fri., 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 Mon - Fri., 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) (Mon - Fri., 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 (Mon - Fri., 8 a.m. - 6 p.m. ET) Say "referral" when prompted.
Search for Participating Care Providers, Other Health Care Professionals and Facilities	Online: OxfordHealth.com > Providers or Facilities > Search > (select the provider type) Phone: 800-666-1353

Commercial Products

RESOURCE

WHERE TO GO

Termination Requests

Phone: 800-666-1353**Mail:** Physicians and other health care professionals send by certified mail, return receipt requested to:

UnitedHealthcare
 Network Contract Support
 Mail Route: TX023-1000
 1311 W President George Bush Highway, Suite 100
 Richardson, TX 75080-9870

Behavioral health providers only**Phone:** 877-614-0484

Care Provider Responsibilities and Standards

Confirming Eligibility and Benefits

Checking the member's eligibility and benefits before rendering services helps ensure that 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](https://www.oxfordhealth.com) > Providers or Facilities > [Transactions](#) > Check > Eligibility and Benefits.
- **Phone:** 800-666-1353, and say "benefits and eligibility" when prompted. (Mon. - Fri., 8 a.m. - 6 p.m. ET).

For additional help with Web, Oxford Voice Portal and EDI solutions, please refer to [OxfordHealth.com](https://www.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 can 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 can see a sample ID card image specific to the member when you verify eligibility using our eligibilityLink application.

Office and Access Standards

Your office must adhere to policies regarding the following:

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 ask for 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 can 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.

- Confidentiality of member medical records and related patient 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 patients 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 member 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 nondiscriminatory behavior in conducting business with all members. These documents should explain that this expectation applies to all personnel, clinical and nonclinical, 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.

Suggested Accessibility Standards

Resources and technical support are available:

New York State: through the New York State Office of Advocate for Persons with Disabilities: 800-624-4143 V/TTY; and the Mayor's Office for People with Disabilities: 212-788-2830;

Connecticut: through Disability Rights Connecticut, Inc.: 800-842-7303 (toll-free), 860-297-4300, 860-418-6172 (TTY);

New Jersey: through the New Jersey Office of Disabilities: 888-285-3036 (toll-free), 609-292-7800 (TTY).

Care for Members Who Are Hearing-Impaired

It is important for everyone to be able to communicate with their care providers. 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.

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/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.

* 28 CFR Sect. 36.301(c)

** 28 CFR Sect. 36.303(b)(1)

- 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 can 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 your patients' 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 your patients 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 shall:

- 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 can 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 entire 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 patients 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 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 can issue a referral to participating care providers:

- **Online:** OxfordHealth.com > Providers (or Facilities) > [Transactions](#) > Submit or Check Referrals (non-par providers should call the number below).
- **Phone:** 800-666-1353 (representatives are available Mon - Fri., 8 a.m.- 6 p.m. ET). Participating health care providers may use the prompts to submit or check the status of a referral 24 hours a day, seven days a week.
- **EDI** transaction 278 through your vendor or clearinghouse.

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 can bring this reference number to the specialist who can directly confirm a referral is on file through OxfordHealth.com or by phone (above).

For a complete list of submission and verification methods, please refer to the How to Contact Oxford Commercial list in the beginning of this supplement.



Additional details regarding our referral policy can be found 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 provider 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 can 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 Referral Policy referenced above. 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 created 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 can find more information on OxfordHealth.com > Providers (or Facilities) > Tools and Resources > Medical 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 (precertification) requests using the following methods:

1. **EDI:** Use your vendor or clearinghouse
2. **Online:** OxfordHealth.com > Providers or Facilities > [Transactions](#) > Submit > Precert Requests > (log in)
3. **Phone:** Provider Services 800-666-1353 (Mon - Fri, 8 a.m.- 6 p.m. ET)
4. **Fax:** Submit our form, which can be found on OxfordHealth.com > Providers or Facilities > Tools & Resources > Network Information > [Forms](#). (Hospital fax 800-699-4712, all other participating care providers 800-303-9902).

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.
 - 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 that 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, seven days a week
- Online: available 24 hours a day, seven days a week
- Provider Services: speak to a service representative during business hours

Medically Necessary Services

Medically necessary services are services or supplies provided by a hospital, skilled nursing facility, 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 can safely be provided.
- For inpatient services, it further means the member's condition cannot safely be diagnosed or treated on an outpatient basis.

Prior Authorization List

1. You can 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 & Administrative Policy Index](#) > Services Requiring Prior Authorization.

3. You can 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 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 a 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 can 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 for a call to 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 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 the 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 will deny the services.

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 must approve the referral, and it must include a treatment plan approved by our medical director, the PCP, and the non-participating care provider.

Participating Gastroenterologists Using Non-Participating Anesthesiologists: In-Office & Ambulatory Surgery Centers (New York)

Participating gastroenterologists located in New York performing non-emergent procedures with anesthesia in office (IO) or in an ambulatory surgery center (ASC), must use an Oxford participating anesthesiologist unless:

1. The member explicitly agrees pre-service (no more than 90 days before the scheduled date of the procedure) to receive services from a non-participating anesthesiologist by signing the *Non-Participating Provider Consent Form* and understands that the use of this care provider is:

Out-of-Network: For members with out-of-network benefits, we pay non-participating anesthesiologist claims at the out-of-network benefit level. Out-of-network cost shares and deductibles apply.

Denied: For members without out-of-network benefits, we deny non-participating anesthesiologist 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;

or

2. We have approved an in-network exception.

The following procedures and responsibilities apply in non-emergent situations when a participating gastroenterologist in New York (in office and ambulatory surgery center settings) provide the services:

1. Verbally discuss options and financial impact with the member. You must explain participating and non-participating options, provide the member with an understanding of all the care providers involved in the member's care (e.g., anesthesiologist) and include a conversation explaining the financial impact of using a non-participating care provider.

2. Obtain a completed Non-Participating Provider Consent Form. The member needs to either agree or disagree to receive out-of-network services, by signing, dating and returning the Non-Participating Provider Consent Form no less than 14 days before the scheduled date of the procedure.
3. Coordinate the member's care as directed by the member in the Non-Participating Provider Consent Form (including, but not limited to, using a participating anesthesiologist, network exceptions and/or claim appeals).

You must keep a signed copy of the Non-Participating Provider Consent Form on file. Oxford may request a copy of the signed form at any time, including when responding to a member appeal. Care providers are not required to submit this form with their initial claim.

If the participating gastroenterologist cannot provide the signed Non-Participating Provider Consent Form, within 15 days of the request, as proof they discussed the member's options for selecting a participating or non-participating anesthesiologist in advance of the service, Oxford will administratively deny the participating gastroenterologist claim. Any payment previously made for the gastroenterology service will be subject to recovery.

The participating gastroenterologist cannot balance bill the member for claims denied for administrative reasons.

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](#) > Participating Gastroenterologists Using Non-Participating Anesthesiologists: In-Office & Ambulatory Surgery Centers.

Participating Mastectomy Surgeon Using a Non-Participating Breast Reconstruction Surgeon (New York Products)

If a participating mastectomy surgeon is recommending the use of a non-participating breast reconstruction surgeon (including but not limited to plastic surgeons, assistant surgeons, etc.), for a reconstruction that is being performed within the same surgical or different operative session as the mastectomy, before making a recommendation or scheduling services the participating mastectomy surgeon is required to:

1. Verbally discuss options and financial impact with the member. The discussion must happen no more than 90 days and no less than 14 days before the scheduled procedure date. You must explain participating and non-participating alternatives, and you must provide the member with an understanding of all the care providers involved in the member's care (e.g.; plastic surgeon, assistant surgeon, etc.). You must explain the financial

impact of using a non-participating care provider in this discussion.

2. Obtain a completed Non-Participating Provider Consent Form. The member will need to either agree or disagree to receive out-of-network services, by signing, dating and returning the Non-Participating Provider Consent Form no less than 14 days before the scheduled procedure date.
3. Coordinate the member's care as directed by the member in the Non-Participating Provider Consent Form (including, but not limited to, using a participating breast reconstruction surgeon, plastic surgeons, assistant surgeons, etc., network exceptions and/or claim appeals).
4. You must keep a signed copy of the Non-Participating Provider Consent Form on file to provide to us upon request. If you cannot provide the signed Non-Participating Provider Consent Form within 15 days of the request, we will administratively deny your mastectomy surgery claim for failure to comply with this protocol. Any payment previously made for the mastectomy surgery service will be subject to recovery.

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 > [In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy](#).

Hospital Services, Admissions and Inpatient and Outpatient Procedures

Facilities are responsible for providing admission notification and obtaining prior authorization as needed 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 request prior authorization even if the care provider supplied a prior authorization and a pre-service approval is on file.

Care providers and ancillary providers are responsible for getting prior authorization for outpatient surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility.

Inpatient Hospital Copayment

State regulations for commercial benefit plans determine when a member should be charged for subsequent

inpatient hospital copayment(s) when readmitted into an inpatient setting. According to state laws, inpatient hospital copayments must be based on "per continuous confinement".

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 the day of admission if one has not been submitted. 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 all 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. local time, or make best efforts to provide requested information within the same business day if you receive the request after 1 p.m. local time (but no later than 12 p.m. the next business day).
- Oxford uses MCG™ Care Guidelines, which are nationally recognized clinical guidelines, to help clinicians make informed decisions in many health care settings.

Inpatient Maternity Stay and Subsequent Home Nursing

It is crucial the member, or their care provider, notify us of a pregnancy as early as possible to help ensure the proper application of benefits. Oxford follows state mandates regarding the length of an inpatient maternity stay and the coverage of subsequent home nursing visits. Regulations vary by state as outlined below.

Inpatient Maternity Length of Stay

Oxford will cover inpatient maternity stays for both mother and newborn as follows:

- 48 hours following a vaginal delivery
- 96 hours following a cesarean delivery.

Post-Discharge Home Nursing Visits

- Connecticut: Oxford will approve two (2) 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 (1) home nursing visit if both mother and newborn are discharged before the mandated length of stay described above.

Authorizations are required for non-emergency maternity admissions. Newborn coverage varies by benefit plan and state. For more details, refer to [OxfordHealth.com](https://www.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. We link the NICU bed levels of care to a revenue code defined by the National Uniform Billing Committee. We will assign NICU levels for those facilities contracted with more than one level of NICU. We base claims reimbursement on the pay codes and bed types (levels of care per 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. 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).
- Get prior authorization 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, at a specified hour that gives us time to create our End of Day Report (EDR).
- Verify the accuracy of the admission and discharge dates for our members listed on the EDR.

If the hospital does not provide the necessary clinical information, we deny the day. 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 deny the day. 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 certification for all services with a daily EDR when the hospital provides timely necessary clinical information.
- 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 provide coverage decisions for the next day on the EDR.
- We will notify the hospital and attending care provider or other health care professional either verbally or 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 he or she is 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 level of 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 your patients 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. This includes the following:

- Specimens collected in your office for processing by a non-participating care provider (on and off-site).
- Providing the member with a requisition form, prescription or other form to obtain laboratory or pathology services outside of your office.

Before you make the recommendation, involving, or referring a member to a non-participating laboratory or pathologist, you are required to:

1. Verbally discuss options and financial impact with the member. The discussion must explain participating and non-participating alternatives and the reason for any referral to a non-participating laboratory or pathologist. The discussion must also include a conversation explaining the financial impact of using a non-participating care provider.
2. Obtain a completed Laboratory & Pathology Services Consent Form. The member will need to either agree or disagree to the use of an out-of-network laboratory or pathologist by signing and dating the Laboratory & Pathology Services Consent Form.
3. Coordinate the member's care as directed by the member in the Laboratory & Pathology Services Consent Form.

You are required to keep a signed copy of the Laboratory & Pathology Services Consent Form on file to provide to us upon request. If you cannot provide the signed Laboratory & Pathology Services Consent Form within 15 days of the request, we will administratively deny and reverse the Evaluation & Management (E&M) code from the office

visit which generated the non-participating laboratory or pathology referral for failure to comply with this protocol. Any payment previously made for the service will be subject to recovery. You cannot balance bill a member for claims denied for administrative reasons.

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 that 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 And Cardiology Procedures

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

eviCore healthcare has established an infrastructure to support the review, development, and implementation of comprehensive outpatient imaging criteria. The radiology and cardiology evidence-based guidelines and management criteria are available on the eviCore healthcare website.

eviCore healthcare handles all pre-certification requests. To pre-certify a radiology or cardiology procedure, please contact eviCore healthcare.

Radiology Procedures

Oxford also requires a minimum care provider accreditation and certification requirements for MRI, PET, CT nuclear medicine studies. More detailed information can be found 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
- **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 has issued an authorization number. In the case of urgent examinations, or in 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 you 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, contact eviCore.

evicore.com

877-PRE-AUTH (877-773-2884)

Cardiology Procedures

Oxford has 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 has established correct coding and evidence-based criteria to determine the 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 patient clinical history and diagnostic information with the approved criteria for each imaging procedure requested. Qualified health care providers, including board certified radiologists and cardiologists, make utilization review decisions for cardiac based 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 information needed to make that decision.

For members, eviCore accepts requests for retrospective clinical certification review of medically urgent care up to two business days after the 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 of the 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 patient's medical record and/or letters received from specialists.

Radiation Therapy Procedures

Oxford has 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. The following radiation therapy treatments require prior authorization through eviCore healthcare for Oxford products:

- Ionizing radiation
- Brachytherapy
- Conventional external beam radiation therapy (CRT)
- Three-dimensional conformal radiation therapy (3D CRT)
- Intensity modulated radiation therapy (IMRT)
- Image-guided radiation therapy (IGRT)
- Proton beam therapy (PBT)
- Selective Internal Radiation Therapy (SIRT)
- Stereotactic radiosurgery (SRS)

- Other emerging therapies that use ionizing radiation to treat cancer such as hyperthermia and neutron beam therapy

Find a complete list of radiation therapy treatments requiring prior authorization through eviCore healthcare for Oxford products on: [OxfordHealth.com](https://www.oxfordhealth.com) > Providers (or Facilities) > Tools and Resources > Medical Information > Medical and Administrative Policies > [Medical and Administrative Policy Index](#) > Radiation Therapy Procedures Requiring Precertification for eviCore healthcare Arrangement.

eviCore healthcare has established correct coding and evidence-based guidelines to determine the medical necessity and appropriate billing of radiation oncology services. They carefully researched these guidelines. The guidelines are continually updated to keep consistent with the most current evidence-based guidelines and recommendations for the provision of radiation therapy from national and international medical societies and evidence-based medicine research centers.

Oxford New Jersey Small, Municipality, and School Board Members

Radiology and Radiation Therapy Procedures

eviCore healthcare will perform a medical necessity review before rendering the services. To obtain prior authorization for a course of radiation therapy, contact eviCore healthcare.

We require the submission of clinical office notes for specific procedures if a medical necessity review/utilization review is not conducted before the services were performed. Clinical notes include the patient'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;
- Patient'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 help ensure you provide the right information to determine the medical necessity of the requested services.

Referrals

Certain Oxford products require referrals for radiology 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 cannot 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.

Cardiology, Cardiac Catheterization, Echocardiogram and Stress Echocardiogram

Oxford has engaged eviCore healthcare to perform medical necessity review for outpatient cardiac imaging (CT, PET, MRI and Nuclear medicine), cardiac catheterizations, echocardiogram and stress echocardiogram studies. When services are provided in the emergency room, observation unit, urgent care facility, or during an inpatient stay, prior authorization is not required.

eviCore healthcare performs a medical necessity review before you deliver the services. To get a prior authorization for a course of radiation therapy, contact eviCore healthcare.

- Online: [evicore.com](https://www.evicore.com)

The referring care provider is responsible for providing medical documentation showing clinical necessity for the requested procedure (for review before service). eviCore policy does not permit prior authorization requests from persons or entities other than referring care providers. For post-service reviews (a review after service was provided) the referring care provider is still responsible for providing medical documentation showing clinical necessity for the procedure performed.

We require you to submit clinical office notes for specific procedures if a medical necessity review/utilization review is not conducted before you provide services. Clinical notes include the patient'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
- Patient's signs and symptoms
- Treatment, including type and duration

- Previous studies for the specific medical issue
- Any other pertinent clinical information to determine medical necessity



A list of Current Procedural Terminology (CPT®) codes requiring medical necessity review is available on: OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information.

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

You can find a list of codes that will require prior authorization online at OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > [Medical & Administrative Policy Index](#) > Services Requiring Prior Authorization. Prior authorization requirements can be verified through one of the following options:

1. Care providers can call the number on the back of the member's health care ID card and check eligibility.
2. Use the Diagnostic Heart Catheterization worksheets found online at eviCore.com to help ensure you have the required information to initiate the prior authorization process.
3. For more information, including the clinical criteria, please visit eviCore.com > eviCore Solutions > Cardiology > [Cardiology Tools and Criteria](#).

Infertility Utilization Review Process

Oxford has 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 patients through every aspect of the infertility process. Optum's infertility nurse case managers provide support and help patients in make informed decisions about their infertility treatment and care through: treatment education, considerations in choosing where to obtain care, and assistance in navigating the health care system.

For Oxford products, the rendering care provider is required to request prior authorization and/or notification of services. Make this request using the Managed Infertility Program Treatment form. Provide sufficient information to determine the medical necessity of the requested services.

Optum has been diligent in their research to help ensure the clinical policies and guidelines they are using are consistent with best practices and state mandates.

You can 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 has 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 can 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 patient'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 the clinical information and some or all of the following criteria/tools:

- Member benefits
- Oxford medical and reimbursement policies
- MCG Care Guidelines, 21st edition, 2017 (Inpatient Care)

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 currently manages our chiropractic benefit. To receive the 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 can 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 can 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. 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.

Once they receive the forms, OptumHealth Care Solutions will review the services requested for medical necessity, and will make any 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 all 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 following care provider types:

- Participating licensed acupuncturist (LAC)
- Participating licensed naturopaths
- Participating care provider (MD or DO) who has been 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 of our 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 updated it 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 them assign medications to tiers on the PDL. The information provided by the P&T Committee includes, evaluation of a medication's place in therapy, its relative safety and its relative efficacy.

The P&T Committee also 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 the 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 their 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 patient 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 a patient-specific report quarterly outlining the 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 all pertinent clinical data for the service requested. If we can't 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 can't 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 the 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 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.) do 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 the 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 stating to pay the procedure. 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 stating to pay the procedure. 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. The goals of UM are to:

- Promote the delivery of appropriate care for all members
- Promote necessary care in the appropriate setting, at the appropriate time and using appropriate resources
- Assess and offer appropriate alternative services

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 the 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 any symptoms, treatments, dosage and duration of drugs, and dates for other therapies. Dates of prior imaging studies performed and 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 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 being 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 a 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. The reasons for the determination including the clinical rationale;
2. Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals, and

3. Information we will provide (upon request from the member or the member's designee) the clinical review criteria relied upon to make our decision.
4. What, if any, other necessary information 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

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 verbally 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 that 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 the partial information. We will provide written acknowledgment to the appealing party within 15 days of the filing of a standard appeal if a determination is not made within fifteen days of the filing of the 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.

If we do not make a determination within the correct time periods 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

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 the 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.

Medical Necessity Determinations Mandatory Internal Appeals Process for Care Providers

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.

Note: There is a separate appeal process for member appeals.

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 have received 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 that 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 any documentation/information already requested by us (if not previously submitted) and any 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 have 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 15 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 15 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 30 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 the care of treatment that was 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 the 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 that 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 also 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, have 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 the 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 any 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 that the member or their authorized representative is entitled, following the requirements of the 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 their 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 that 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 the 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 that 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 can assist them with the filing of 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 the appeal procedures including a description on 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 the 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 of the 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 noncompliance;
- We for any reason expressly waive our rights to an internal review of any appeal; or
- The member and/or their care provider have 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 has 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 has 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 his or her recommendation, **and**

5. The specific health service or procedure recommended by the attending care provider would otherwise be covered under the policy except for the 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 has had coverage of a health care service denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary, but otherwise would have been a covered benefit, and
2. We have made a final adverse determination regarding the requested service, or
3. UnitedHealthcare and the member have 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 has 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 historical 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 go to OxfordHealth.com > Providers or Facilities > Tools and Resources > [Administrative Tools & Information](#) > Claims > Claims Submission Information. We use state and federal guidelines to determine whether the claim is complete and can be processed.

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 have 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 can't be sent electronically.

We participate in Medicare Crossover for all of 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 can 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 and need another copy, you can obtain one 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 the 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 can provide this information and 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 the 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 the payment and processing policies associated with the 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 will 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 as well as mailings that may go out. 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 surchargeable 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 who are 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 that was 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 shall prevail. You may balance bill a member when: