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 10 OF 13

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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 10 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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/s/ Karen Rodman
Employee of BAILEY❖KENNEDY

EXHIBIT 39

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EXHIBIT 39

- A service or item is not a covered benefit (i.e., the service is excluded in the "Exclusions and Limitations" section of the member's certificate of coverage); or
- A benefit limit is exceeded/exhausted; or
- Oxford denied a request for precertification, before the service was rendered, and the member proceeded to receive the service anyway; or
- Oxford denied a concurrent certification request (i.e., the member is currently receiving the service) and you obtained the member's signature to a clear, written statement that the service is not covered, and acknowledging s/he would be responsible for the cost of the service, before delivering the service; or
- If you do not participate in a member's network, and a member self refers to you (i.e., Liberty member self refers to you and you do not participate in Oxford Liberty Network). In this instance, if you participate in our W500 network, you may only bill up to your contracted rate for emergent services.

If you are uncertain whether a service is covered, you must make reasonable efforts to contact us and obtain coverage determination before seeking payment from a member. You are prohibited from balance billing the member for covered services when claims are denied for administrative reasons (lack of referral or authorization when one was required, etc.). If a member has been inappropriately balance billed by a care provider, the member has the right to file a complaint or grievance, verbally or in writing, regarding the balance billing. Participating care providers who repeatedly violate these restrictions will be subject to discipline up to and including termination of their provider participation agreement. If a care provider inappropriately balance-bills a member, Oxford will hold the member harmless and pursue the matter directly with the care provider.

Member Out-of-Pocket Costs

Out-of-pocket amounts for outpatient and inpatient care vary by group, type of care provider and type of benefit plan. Check the member's health care ID for the out-of-pocket cost specific to their benefit plan.

Claims Recovery, Appeals, Disputes and Grievances

See *Claim Reconsideration, Appeals Process and Resolving Disputes* found in *Chapter 9: Our Claims Process* for general appeal requirements.

Claims Recovery

The following information applies to care providers, but does not apply to facilities or ancillaries.

Oxford periodically asks care providers to return overpayments due to either:

- Administrative reasons: Duplicate payments, payments relating to fee schedules or billing/bundling issues, payments made where Oxford was not the primary insurer); or
- Behavioral issues: Upcoding, misrepresentation of service provided, services not rendered at all, frequent waiver of member financial responsibility.

Oxford may pursue such claim overpayments as permitted by law and following the applicable statute of limitations (usually six years). We use random sampling, examination by external experts, and reliable statistical methods to determine claim overpayments in situations involving large volumes of potentially overpaid claims.

Note: Once a care provider is given notice, we will initiate discussions and take actions during the following one year period.

We will not pursue collection of overpayments from individual participating care providers when overpayments are identified as isolated mistakes or where the care provider is not at fault, if the overpayments were more than one year prior to the date of notice of the overpayment or use extrapolation. Examples include overpayments related to duplicate claims, fee schedule issues, isolated situations of incorrect billing/unbundling, and claims paid when Oxford was not the primary insurer.

Exception: Oxford will pursue collection of overpayments beyond one year and utilize statistical methods and extrapolation in situations where:

1. Oxford has a reasonable suspicion of fraud or a sustained or high level of billing errors related to:
   - Extensive or systemic upcoding
   - Unbundling
   - Misrepresentation of services or diagnosis
   - Services not rendered
   - Frequent waiver of member financial responsibility
   - Misrepresentation of care provider rendering the services or licensure of such care provider, and similar issues
2. A care provider affirmatively requests additional payment on claims or issues older than one year
3. The Centers for Medicare and Medicaid Services makes a retroactive change to enrollment or to primary versus secondary coverage of a Medicare benefit plan member

Participating Care Provider Claims Reconsiderations and Appeals

Our administrative procedures for members with an Oxford product require facilities, and care providers participating in our network to file a claim reconsideration and/or appeal before proceeding to arbitration under their contract.

Claim Reconsideration

See *Claim Reconsideration, Appeals Process and Resolving Disputes* found in *Chapter 9: Our Claims Process* for general reconsideration requirements and submission steps. Continue below for Oxford specific requirements.

I. **Pre-Appeal Claim Review**
Before requesting an appeal determination contact us, verbally or in writing, and request a review of the claim's payment. We make every effort to clarify or explain our actions. If we determine that additional payment is justified, we will reprocess the claim and remit the additional payment.

II. **Who Can Submit a Reconsideration or Appeal**

A. Participating care providers appealing a decision on their own behalf, according to the terms of their agreement with us.

B. Any care provider or practitioner when appealing on behalf of the member, with signed member consent. You must follow the process for member administrative claims appeals. Refer to **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > Medical & Administrative Policy Index > **Member Administrative Grievance and Appeal (Non Utilization Management) Process and Timeframes**.

III. **Timeframe for Submitting a Reconsideration or Appeal**

A. **Claim Reconsideration and Appeal Process**
If you disagree with the way a claim was processed, or need to submit corrected information, you must file your reconsideration and/or appeal request of an administrative claim determination within 12 months (or as required by law or your participation agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). You must include all relevant clinical documentation, along with a Participating Provider Review Request Form.

The two step process described here allows for a total of 12 months for timely filing – not 12 months for step one and 12 months for step two. If an appeal is submitted after the time frame has expired, Oxford will uphold the denial.

Exceptions: There are separate processes for New Jersey (NJ) Participating Providers and Unilateral Coding Adjustments for New York Hospitals. Refer to the *New Jersey Participating Provider Appeal Process* and *Unilateral Coding Adjustments for New York Hospitals* sections for additional information.

1. **Step One – Reconsideration Level:** The request must include the *Claim Reconsideration Form* located on: **UHCprovider.com/claims** > Submit a Claim Reconsideration and all supporting documentation. If after reconsideration we do not overturn our decision, the EOB or response letter will include next level rights and where to submit a request for further review.
2. **Step Two – Appeal Level:** Participating care provider and practitioner appeals must be submitted in writing within the same 12 month time frame, as stated above. The appeal must include all relevant documentation including a letter requesting a formal appeal and a *Participating Provider Review Request Form*. If the appeal does not result in an overturned decision, the care provider must review their contract for further dispute resolution steps.

B. **New Jersey Participating Provider Appeal Process**
New Jersey (NJ) participating care providers are subject to the NJ state-regulated appeal process. If a NJ participating care provider has a dispute relating to payment of a claim involving a NJ commercial member, the dispute is eligible for an individual two step process.

1. **First Level:** The first level appeal is made through Oxford's internal appeal process. A written request for appeal must be submitted by the *Health Care Provider Application to Appeal a Claims Determination Form* created by the NJ Department of Banking and Insurance. This appeal must be submitted within 90 days of the date on Oxford's initial determination notice to:

   UnitedHealthcare
   Attn: Provider Appeals
   P.O. Box 29136
   Hot Springs, AR 71903

   The review will be conducted and results communicated to the care provider in a written decision within 30 calendar days of receipt of all the material necessary for such appeal.
2. **Second Level:** The second level appeal must be made through the external dispute resolution process. If a NJ participating care provider has completed the internal appeal process and is not satisfied with the results of that internal appeal, the care provider has the right under their contract to arbitrate the dispute with Oxford. Care providers should submit their request to:

   MAXIMUS, Inc.
   Attn: New Jersey PICPA
   50 Square Drive, Suite 210
   Victor, NY 14564

   Requests may be submitted by fax to 585-425-5296 (MAXIMUS, Inc. requests that faxes be limited to 25 pages).

   Consult your contract to determine the appropriate arbitration authority. Most such contracts provide for arbitration before the American Arbitration Association (AAA).The

costs of arbitration are borne equally by the participating care provider and Oxford, unless the arbitrator determines otherwise. The decision in such arbitration depends on the participating care provider and Oxford, pursuant to the terms of the care provider agreement. To commence arbitration, the care provider must file a statement of claim with the AAA at the address listed above.

C. **Unilateral Coding Adjustments for New York Hospitals**
If a New York hospital receives a remittance advice/payment indicating that Oxford has adjusted payment based on a particular coding (i.e.; assignment of diagnosis and or CPT/HCPCS or other procedure code), the hospital has the right to resubmit the claim, along with the related medical record supporting the initial coding of the claim, within 30 days of receipt/notification of payment. Oxford must review the medical records within the normal review timeframes (45 days). If Oxford's initial determination:

- Remains unchanged, the insurer's decision must be accompanied by a statement providing the specific reasons why the initial adjustment was appropriate.
- Changes and the payment is increased based on the information submitted by the hospital, Oxford must provide the additional reimbursement within the 45 day review timeframe.

If Oxford fails to provide the additional reimbursement within the 45 day review timeframe, Oxford must pay to the hospital interest on the amount of the increase. The interest must be computed from the end of the 45 day period after resubmission of the additional medical record information.

Note: Neither the initial or subsequent processing of the claim by Oxford may be considered an adverse determination if it is based solely on a coding determination.

IV. **Method for Submitting a Reconsideration or Appeal**
Appeals – Find the correct mailing address on Oxford's Participating Provider Claim(s) Review Request Form. There are separate processes for the following appeal types:

- Internal and external claims payment appeals for NJ participating care providers who treat NJ commercial members (above).
- The appeal of unilateral coding adjustments made to New York Hospital claims (above)

V. **Appeal Decision and Resolution**
Full documentation of the substance of the appeal and the actions taken will be maintained in an appeal file (paper or electronic). Written notification to the care provider will be issued by means of a letter or updated Remittance Advice (RA) statement at the time of determination of the appeal. This decision will constitute Oxford's final internal decision. If the care provider is not satisfied with Oxford's decision, they may arbitrate the issue as set forth in their contract with Oxford. Refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical and Administrative Policies > Medical & Administrative Policy Index > Timeframe Standards for Benefit Administrative Initial Decisions.

VI. **Arbitration**
If the care provider wants to file for arbitration after the first level appeal has been completed, the care provider must file a statement of claim with the AAA at the following address:

American Arbitration Association
Northeast Case Management Center
950 Warren Avenue 4th Floor
East Providence, RI 02914
Phone: 800-293-4053

Care providers located outside of NY, NJ and CT should refer to the AAA web site (adr.org) for submission guidelines.

- Participating care providers who are appealing an adverse determination are entitled under their care provider contract to bring the issue before the American Arbitration Association (AAA). They have this right only under the following circumstances:
  1. The first level internal grievance process has been completed.
  2. The appeal is on their own behalf (not on behalf of the member).
- Participating hospitals and ancillary facilities also have arbitration rights but those rights vary depending on contracts. If a hospital or ancillary facility calls to inquire about arbitration rights, they should be referred to their contract for the specific arbitration entity. Hospitals and ancillary facilities still must utilize the first level internal appeal process.

New York State-Regulated Process for External Review

For participating care providers and other health care professionals treating New York members, this external appeals process applies only to services provided to commercial members who have coverage by virtue of a HMO or insurance benefit plan licensed in New York State.

This appeals process does not apply to the self-funded line of business. Care providers cannot use this process unless there is written consent from the member or it is a case involving retrospective review. If the care provider's agreement includes arbitration language or alternate dispute language, the care provider must follow that process and the external review process is no longer an option for dispute resolution.

Medical Necessity Appeals

Standard Medical Necessity Appeals Process

If members or their designees would like to file an appeal, they must hand-deliver or mail a written request within 12 months of receiving the initial denial determination notice to:

Oxford Clinical Appeals Department
P.O. Box 29139
Hot Springs, AR 71903

Expedited Medical Necessity Appeals Process for Members:

- Members have the right to request an expedited appeal.
- To request an expedited appeal, the member or care provider or other health care professional must state specifically that the request is for an expedited appeal.
- The Clinical Appeals department will determine whether or not to grant an expedited request.
- If the Clinical Appeals department determines that the request does not meet expedited criteria set by the Clinical Appeals department the member will be notified.

Benefit Appeals

Appeals of benefit denials issued by the Clinical Services and Disease Management departments are handled by the Clinical Appeals department.

Administrative Appeals (Grievances)

Administrative appeals without the Clinical Services department's involvement are handled by the member appeals unit. If a member would like to file an appeal on a claim determination, they must mail all administrative appeals UnitedHealthcare Grievance Review Board. See *How to Contact Oxford Commercial* section for address information.

Second-level Member Appeals

Members have the right to take a second-level appeal* to our Grievance Review Board (GRB). If they remain dissatisfied with the first-level appeal determination, they may request a second-level appeal. Members with a CT line of business do not have the option of submitting a second-level appeal request for a benefit or administrative issue. The request for appeal and any additional information must be submitted to the UnitedHealthcare Grievance Review Board. See *How to Contact Oxford Commercial* section for address information.

External Appeal Process for Members

New York, New Jersey and Connecticut members have the right to appeal a medical necessity determination to an external review agent. They can file a consumer complaint with one of the following applicable regulatory bodies. The applicable regulatory body is determined by the state in which the member's certificate of coverage was issued, not where the member resides.

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

Connecticut	State of Connecticut Insurance Department 153 Market Street P.O. Box 816 Hartford, CT 06142-0816 860-297-3862
New Jersey	Division of Insurance Enforcement and Consumer Protection 20 West State Street P.O. Box 329 Trenton, NJ 08625-0329 Consumer Protection Services Dept. of Banking and Insurance P.O. Box 329 Trenton, NJ 08625-0329 800-446-7467 (in NJ) 609-292-5316 **Fax:** 609-545-8468
New York	Consumer Services Bureau State of New York Insurance Department 25 Beaver Street New York, NY 10004-2349 212-480-6400 Office of Managed Care Certification and Surveillance New York Department of Health Corning Tower, Room 1911 Empire State Plaza Albany, NY 12237 518-474-2121

New York Notice of Care Provider Contract Termination and Appeal Rights

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

A health care provider cannot be prohibited from, nor may the UnitedHealthcare terminate or refuse to renew a contract solely for the following:

- Advocating on behalf of a member,
- Filing a complaint against UnitedHealthcare,
- Appealing a decision made by UnitedHealthcare,
- Providing information or filed a report per PHL4406- c regarding prohibitions, or
- Requesting a hearing or review.

We grant care providers and certain health care professionals the right to appeal certain disciplinary actions imposed by us.

The appeals process is structured so most appeals for terminations, not including non-renewal of the care provider's contract with us, can be heard before disciplinary action is implemented.

A care provider or health care professional may request an appeal (fair hearing or review) after we take adverse action to restrict, suspend or terminate a care provider or health care professional's ability to provide health care services

to our members for reasons relating to the professional competence or conduct that adversely affects or could adversely affect the member's health or welfare.

A notice will be provided within 30 calendar days after the adverse action is taken that will include the following:

1. UnitedHealthcare has determined an adverse action is necessary and the final action will be reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and appropriate state licensing board.
2. A description of and reason for the action.
3. Right to request an appeal in writing within 30 calendar days after receipt of the notice. Failure to file such request shall constitute a waiver of all right to the appeal process, unless such a right is provided under state law.
4. A summary of the care provider's or health care professional's appeal rights provided

We will notify the care provider or health care professional of the fair hearing or review date within 30 calendar days of our the receipt of request for appeal, or within the timeframe required by state law. The fair hearing or review will take place within 60 calendar days of the date we receive the request for appeal, or within the timeframe required by state law.

The hearing panel will be comprised of at least three persons appointed by the UnitedHealthcare. At least one person on the panel will have the same discipline or same specialty as the care provider under review. The panel may consist of more than three members, provided the number of clinical peers constitutes one-third or more of the total panel membership.

The hearing panel will render a decision in a timely manner. Decisions will be provided in writing and include one of the following:

1. Reinstatement; or
2. Provisional reinstatement with conditions set forth by us, or
3. Termination.

Quality Assurance

Medical Records Requirements

As a participating care provider or other health care professional, you must provide us with copies of medical records for our members within a reasonable time period following our request for the records. We may request records for various reasons, including an audit of your practice. An audit can be performed at our discretion and for several different purposes, as we deem appropriate for our business needs.

Standards for Medical Records

A comprehensive, detailed medical record is vital to promoting high quality medical care and improving patient safety. Our recommended medical record standards are published each November for commercial benefit plans in the Network Bulletin found here: **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Network Information > **Network Bulletin**. Our requirements include, but are not limited to:

- Separate medical record for each member
- The record verifies the PCP is coordinating and managing care
- Medical record retention period of six years after date of service rendered and for a minor, three years after majority or six years after the date of the service, whichever is later.
- (Prenatal care only): A centralized medical record for the provision of prenatal care and all other services

Transferring Member Medical Records

If you receive a request from a member to transfer their medical records, do so within seven days to help ensure continuity of care. To safeguard the privacy of the member's records, mark them as "Confidential" and be sure no part of the record is visible during the transmission.

Electronic Medical Records (EMR)

EMR is any type of electronic concurrent medical information management system. This process improves efficiency and quality inpatient care through integrated decision support which provides better information storage, retrieval and data sharing capabilities. EMR systems allow care providers, nurses and other health care staff to be able to access and share information smoothly and quickly, to enable them to work more efficiently and make better quality decisions.

UnitedHealthcare's Credentialing and Re-credentialing Notifications

We complete our credentialing process and give notification of the results (within 60 days for NY, 45-60 days for NJ) of receiving a completed application. The notification will tell you whether you are credentialed, if more time is needed, or UnitedHealthcare is not in need of additional care providers at this time. If more information is needed we will notify the applicant ASAP, but no more than 90 days from the receipt of the application.

For more information on our credentialing program, refer to Chapter 14: Credentialing and Re-credentialing.

Healthcare Provider Performance Evaluations

UnitedHealthcare is required to provide health care professionals with any information and profiling data used to evaluate your performance. Periodically and at your request we provide the information, profiling data and analysis used to evaluate your performance. You will be given the opportunity to discuss the unique nature of your

patient population which may have bearing on your profile and we will work with you to improve your performance as needed.

Case Management and Disease Management Programs

We have created a number of programs designed to improve outcomes for our members and to allow us to better manage the use of medical services. Care providers may refer members to these programs, or members may self-refer.

For more information, go to OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical Information > Managing Disease or by calling our Member Service Department.

Case Management and Disease Management Programs Referrals

You may refer members, or members may self-refer to several Case Management and Disease Management programs. These programs are designed to improve outcomes for members and to help us better manage the use of medical services.

For a complete list of Case Management/Disease Management programs go to OXHP.com > Providers (or Facilities) > Tools & Resources > Managing Disease: Programs for Members.

Healthcare Effectiveness Data and Information Set (HEDIS) measures

The annual Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA). NCQA is an independent group established to provide objective measurements of the performance of managed health care benefit plans, including access to care, use of medical services, effectiveness of care, preventive services, and immunization rates, and each benefit plan's financial status.

CMS (Center for Medicare and Medicaid Services), state regulators (commercial), and prospective members use HEDIS measures to evaluate the value and quality of different health plans.

Each year we collect data from a randomly selected sample of our members' medical records for HEDIS. HEDIS is mandated by the New York Department of Health, New Jersey Department of Health and Senior Services, Connecticut Department of Health, and the CMS. The HEDIS medical record study measures our participating care providers' adherence to nationally accepted clinical practice guidelines.

Clinical Process Definitions

Some services may be subject to prior authorization and/or ongoing medical necessity reviews.

Acute Hospital Day

An acute hospital day (AHD) is any day when the severity of illness (clinical instability) and/or the intensity of service are sufficiently high and care cannot reasonably be provided safely in another setting.

Alternative Level of Care (ALC)*

We will determine that an inpatient ALC applies in any of the following scenarios:

- An acute clinical situation has stabilized.
- The intensity of services required can be provided at less than an acute level of care.
- An identified skilled nursing and/or skilled rehabilitative service is medically indicated.
- ALC is prescribed by the member's care provider or other health care professional.
- Inpatient ALC must meet the following criteria:**
  - The skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists are required; and
  - Such services must be provided directly by or under the general supervision of those skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

New Technology

New technology refers to a service, product, device, or drug that is new to our service area or region. Any new technology must be reviewed and approved for coverage by the Medical Technology Assessment Committee or the Clinical Technology Assessment Committee for Behavioral Health technologies.

Potentially Avoidable Days

A potentially avoidable day (PAD) arises in the course of an inpatient stay when, for reasons not related to medical necessity, a delay in rendering a necessary service results in prolonging the hospital stay. PADs must be followed by a medically necessary service.

There are several types of PADs:

- **Approved potentially avoidable day (AOPAD):** We caused delay in service; the day will be payable.
- **Approved care provider or other health care professional potentially avoidable day (APPAD):** The care provider or other health care professional caused delay in service; the day will be payable.

*ALC only applies if the facility has a contracted rate.
**Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria can result in denial of coverage.

- **Approved mixed potentially avoidable day (AMPAD):** A delay due to mixed causes not solely attributable to us, the care provider, other health care professional, or the hospital; the day will be payable.
- **Denied hospital potentially avoidable day (DHPAD):** The hospital caused the delay in service; DHPAD is a non-certification code, and the day is not payable.

We will not reverse any certified day unless the decision to certify was based on erroneous information supplied by the care provider or other health care professional, or a potentially avoidable day was identified.

Re-Admissions
When a member is readmitted to the hospital for the same clinical condition or diagnosis within 30 days of discharge, the second hospital admission will not be reimbursed when any of the following conditions apply:

- The member was admitted for surgery, but surgery was canceled due to an operating room scheduling problem.
- A particular surgical team was not available during the first admission.
- There was a delay in obtaining a specific piece of equipment.
- A pregnant woman was readmitted within 24 hours and delivered.
- The member was admitted for elective treatment for a particular condition, but the treatment for that condition was not provided during the admission because another condition that could have been detected and corrected on an outpatient basis prior to the admission made the treatment medically inappropriate.

In any of the situations noted above, the hospital cannot bill the member for any portion of the covered services not paid for by us.

Diagnosis-Related Group (DRG) Hospitals
DRG is a statistical system of classifying an inpatient stay into groups of specific procedures or treatments. When a hospital contracts for a full DRG, we will reimburse the hospital a specific amount (determined by the contract) based on the billed DRG rather than paying a per diem or daily rate (DRG facility). A DRG is determined after the member has been discharged from the hospital.

When admission information is received through our website, we will consider this to be notification only; first day approval will not be granted to hospitals with a DRG contract. When we receive notification of an admission to a hospital with a DRG contract, our case manager will review the admission for appropriateness. If the case manager cannot make a determination based on the admitting diagnosis, the case manager will request an initial review to determine whether the admission is medically necessary. The hospital is required to provide admission notification and a daily inpatient census of all our members.

Prepayment DRG Validation Program
We may request a DRG hospital to send the inpatient medical record before claim payment so we may validate the submitted codes. After review of all available medical information, the claim will be paid based on substantiated codes following review of the medical record. See the *Claims Recovery, Appeals, Disputes and Grievances* section of this supplement for Appeal Rights.

Hospital records may be requested to validate ICD-10-CM or its successor codes and/or revenue codes billed by participating facilities for inpatient hospital claims. If the billed ICD-10-CM codes (or successor codes) or revenue codes are not substantiated, the claim will be paid only with the validated codes.

Disposition Determination
A disposition determination is a technical term describing a process of care determination that results in payment as agreed at specific contracted rates, and is designed to eliminate certain areas of contention among participating parties and allow processing of claims. Specific instances where a disposition determination may apply:

- Delay in hospital stay
- APPAD/AMPAD when so contracted
- ALC determinations when so contracted, unless there is a separate ALC rate
- Discharge delays that prolong the hospital stay under a case rate

Late and No Notification
Late notification is defined as notification of a hospital admission after the contracted 48-hour notification period and prior to discharge. No notification is defined as failure to notify us of a member's admission to a hospital after discharge, up to and including at the time of submitting the claim.

Mental Health and Substance Use Services
The behavioral health department specializes in the administration of mental health and substance use benefits. The department consists of a medical director who is licensed in psychiatry, facility care advocates (licensed RNs and licensed/certified social workers) and intake staff who collectively handle certification, referrals and case management for our members.

We encourage coordination of care between our participating behavioral health clinicians and primary care providers as the best way to achieve effective and appropriate treatment. For this purpose, we developed a Release of Information (ROI) Form that is designed to facilitate member consent and to share information with the PCP in the presence of their behavioral health clinician. See the *How to Contact Oxford Commercial* section for telephone numbers.

Clinical Definitions and Guidelines
The behavioral health department uses the Optum Level of Care Guidelines when determining the medical necessity of inpatient psychiatric, partial hospitalization substance use treatment and rehabilitation, and outpatient mental health treatment. For a complete list of programs and detailed information on the level of care guidelines visit the Optum network website at **providerexpress.com**.

Inpatient Mental Health
Inpatient (or acute) care for a mental health condition is indicated when it involves a sudden and quickly developing clinical situation characterized by a high level of distress and uncertainty of outcome without intervention.

Partial Hospitalization - Mental Health
Partial hospitalization for mental health treatment involves day treatment of a mental health condition at a hospital or ancillary facility with the following criteria:

- The primary diagnosis is psychiatric.
- The facility is licensed and accredited to provide such services.
- The duration of each treatment is four or more hours per day.

Residential Treatment
Residential treatment services are provided in a facility or a freestanding residential treatment center that provides overnight mental health services for members who do not require acute inpatient care but who do require 24-hour structure.

Outpatient Mental Health
Psychotherapeutic approaches to treatment of mental health conditions, including methods from different theoretical orientations (e.g., behavioral, cognitive, and interpersonal) may be administered to an individual, family or group on an outpatient basis.

Inpatient Detoxification
Inpatient detoxification is defined as the treatment of substance dependence to treat a life-threatening withdrawal syndrome, provided on an inpatient basis.

Outpatient Substance Use Rehabilitation
Outpatient substance use rehabilitation is defined as the treatment of a substance use disorder including dependence at an accredited, licensed substance use treatment facility.

Member Rights and Responsibilities

For the entire list of **Member Rights and Responsibilities**, go to **UHC.com** > Individuals & Families > Member Resources > Legal > **Annual Member Notices**, select any code.

Medical and Administrative Policy Updates

We change or amend the contents of this supplement annually to reflect changes in policies or as required by regulation. A complete library of Oxford's Clinical, Administrative and Reimbursement Policies is available for your reference at **OxfordHealth.com** > Providers or Facilities > Tools & Resources > Medical Information > Medical and Administrative Policies > **Medical & Administrative Policy Index**. You can also request a paper copy of a Clinical, Administrative or Reimbursement Policy by writing to:

Oxford Policy Requests and Information
4 Research Drive
Shelton, CT 06484

Policy Update Bulletin

On the first calendar day of every month, we publish the Policy Update Bulletin. This online resource provides notice to our network care providers of changes to our Clinical, Administrative and Reimbursement Policies. You can find it on **OxfordHealth.com** > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > **Policy Update Bulletins**. As a supplemental reminder to the detailed policy update summaries announced in the Policy Update Bulletin, we also include a list of recently approved, revised and/or retired clinical, administrative and reimbursement policies in the monthly Network Bulletin available on **UHCprovider.com/news**.

Preferred Care Partners Supplement

About Preferred Care Partners

Preferred Care Partners (PCP), Inc. (a wholly owned subsidiary of UnitedHealthcare), is a Medicare Advantage (MA) health plan. We offer MA plans in three Florida counties: Broward, Miami-Dade and Palm Beach.

Mission Statement

We improve the health of our members by providing:

- Access to health care services
- Choices for their health care needs
- Simplification of the health care delivery system

We streamline authorization and referral processes. We build care provider networks around the needs of our members. This provides the best experience for our members and care providers. We commit to giving direct access to expert customer service representatives who understand member needs and helping them make informed choices.

How to Contact Us

Questions or Comments

Email questions or comments to Network Management Services (NMS) at PCP-NetworkManagementServices@uhcsouthflorida.com, or send mail to:

Preferred Care Partners Network Management Services
9100 South Dadeland Blvd. Suite 1250
Miami, FL 33156-6420

Contact Us Table

Resources	Where to Go	What you can do there
Authorizations and Notifications	**Online:** UHCprovider.com/priorauth **Phone:** 800-995-0480 **Fax:** 866-567-0144	• Submit notifications, prior authorizations, referrals, admissions and discharge planning. • Initiate requests for notifications and authorizations electronically. If the request cannot be completed electronically, our staff is available to answer questions or discuss any issues with referrals, prior authorizations, case management, concurrent review, and admission certification or notification.
Authorizations and Notifications (WellMed)	**Online:** eprg.wellmed.net **Fax:** 866-322-7276 **Fax (Inpatient notification): 877-757-8885**	
Claims	**Online:** UHCprovider.com/claims **Phone:** 866-725-9334 **Fax:** 866-725-9337 **Mail:** Preferred Care Partners P.O. Box 30448 Salt Lake City, UT 84130-0448	• Check claims, eligibility, benefits. • Use payer ID #65088.
Claims (WellMed)	**Online:** eprg.wellmed.net **Phone:** 800-550-7691 **Mail:** WellMed Claims P.O. Box 400066 San Antonio, TX 78229	• Check claims, eligibility, benefits. • Use payer ID #WELM2.

Resources	Where to Go	What you can do there
Technical Support for Change Healthcare Claims Submission Network	**Phone:** 800-845-6592	• Obtain assistance with password or technical support issues. • Obtain information on electronic claims submission.
Credentialing	**Phone:** 800-963-6495 M-F, 9 a.m. to 5 p.m. (ET) **Fax:** 866-567-0144	• Submit or update credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility.
Electronic Remittance **(Facilitated by Change Healthcare)**	**Online:** ChangeHealthcare.com **Phone:** 800-845-6592	• Get information and register for electronic payment services.
Eligibility and Benefits Verification	**Online:** UHCprovider.com/eligibility **Phone:** 866-725-9334	• Verify eligibility and benefits of enrolled members. • Access a summary of benefits for each plan online.
Fraud, Waste, and Abuse (FWA) Hotline	**Phone:** 866-678-8822 M-F, 9 a.m. to 5 p.m. (ET) **Fax:** 888-659-0617 **Email:** ReportFraud@UHCsouthflorida.com **Mail:** Preferred Care Partners Special Investigations Unit P.O. Box 56-5748 Miami, FL 33256-5748	• Report concerns related to fraud, waste, or abuse.
Grievances & Appeals	**Phone:** Call the provider number listed on the back of the member's identification card. **Mail:** Preferred Care Partners, Inc. Grievances & Appeals Department P.O. Box 30997 Salt Lake City, UT 84130	• For questions about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms.
Member Services	**Online:** mypreferredcare.com > Members **Phone:** 866-231-7201 M-F, 8 a.m. to 5 p.m. (ET) **TTY:** 711 **Fax:** 866-567-0144	• Members may ask questions about care providers, benefits, and claims • This toll-free phone number is also printed on the member's plan ID card.
Network Management Services Provider Relations and Contracting	**Phone:** 877-670-8432 M-F, 9 a.m. to 5 p.m. (ET) **Fax:** 888-659-0619 **Email:** PCP-NetworkManagementServices@uhcsouthflorida.com	• Ask questions regarding care provider agreements, in-servicing and follow-up or outreaches. • Report demographic changes. • Submit informal complaints. • Request forms or other materials.
Pharmacy **(OptumRx)**	**Phone:** 800-711-4555 **Fax:** 800-527-0531	• Verify pharmacy benefits and eligibility, adjudications, or authorizations. • See pharmacy benefit updates.
Risk Management	**Phone:** 952-406-4806	• Report incidents involving all privacy issues (potential breeches of PHI or PII) immediately to our risk manager.

Resources	Where to Go	What you can do there
Ancillary and Enhanced Benefit Providers		
United Behavioral Health	**Online:** providerexpress.com **Phone:** **800-985-2596** No DSNP **800-496-5841** DSNP & iSNP Member Services available 24 hours Licensed clinicians are on call 24 hours a day, seven days a week.	• Obtain information about behavioral health and substance use services for all members. • Access a list of behavioral health care providers in the provider directory.
Dental (Solstice)	**Online:** SolsticeBenefit.com **Phone:** **855-351-8163**	• Access a list of Solstice dental providers in the provider directory.
DME/Infusion (MedCare)	**Phone:** **800-819-0751** M-F, 9 a.m. to 5 p.m. (ET) **On call:** 24 hours a day, seven days a week	• Contact MedCare to arrange for these services. • Call UM or Network Management for additional assistance.
Fitness (Silver Sneakers®)	**Online:** silversneakers.com **Phone:** **888-423-4632** 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. (ET)	
Home Health (MedCare)	**Phone:** **305-883-2940**	• Contact MedCare to arrange for these services. • Call UM or Network Management for additional assistance.
Laboratory (LabCorp)	**Online:** labcorp.com **Phone:** **855-277-8669** Automated Line **Phone:** **800-877-7831** Live Scheduling	• Find information on locations, make an appointment, order lab tests and view results.
Mail Order Pharmacy (OptumRx)	**Online:** optumrx.com **Phone:** **877-889-6358**	• Obtain mail-order medications.
Nurse Hotline (Optum NurseLine)	**Phone:** **855-575-0293** Available 24 hours a day, seven days a week.	• Only available under certain plans • Speak to a nurse to triage emergency or urgent care, or to refer them to their primary care physician.
Podiatry—Network Mgmt Services (Foot and Ankle Network)	**Phone:** **877-670-8432** M-F, 9 a.m. to 5 p.m. (ET)	• 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. (ET)	• Request services.
Vision - Network Mgmt Services (iCare)	**Phone:** **877-670-8432** M-F, 9 a.m. to 5 p.m. (ET)	• Access a list of vision providers in our provider directory.

WellMed Medical Management, Inc. (WellMed)

WellMed handles utilization management (UM) and claim services for members who belong to a primary care physician (PCP) in the Preferred Care Partners Medical Group (PCPMG). To identify these members, refer to the member ID card. The payer ID is listed as WELM2. "WellMed" is listed in the lower right corner of the card.

Claims Processing for WellMed Members

Submit claims electronically to payer ID WELM2. If mailing, send to: WellMed Claims, P.O. Box 400066, San Antonio, TX 78229.

Confidentiality of Protected Health Information (PHI)

All employees, participating care providers, and delegates of Preferred Care are required to maintain the confidentiality of PHI. All information used for UM activities is kept as confidential in accordance with federal and state laws and regulations. We limit PHI access to the minimum necessary.

You must report all privacy issues immediately to Risk Management at 952-406-4806.

Examples of privacy incidents that must be reported include:

- Reports and correspondence containing PHI or Personally Identifiable Information (PII) sent to the wrong recipient
- Member or care provider correspondence that includes incorrect member information
- Complaint received indicating that PHI or PII may have been misused
- Concern about compliance with a privacy or security policy
- PHI or PII sent unencrypted outside of your office
- Lost or theft of laptops, PDAs, CDs, DVDs, flash or USB drives and other electronic devices
- Caller mentions they are a regulator (i.e. person is calling from the Office for Civil Rights, Office of E-Health Standards & Services, State Insurance Departments, Attorney General's Office, Department of Justice), or threatens legal action or contacting the media in relation to a privacy issue
- Caller advises your office of a privacy risk

Physician Extender Responsibilities

Physician extenders are state-licensed health care professionals who may be employed or contracted by physicians to examine and treat Medicare members. Physician extenders are advanced registered nurse practitioners (ARNP) and physician assistants (PA). When physician extenders provide care, they must:

- Be supervised by a physician. The physician must be on the premises at all times when the physician extender is seeing patients.
- Help ensure the member knows of their credentials. The member should be aware they might not see a medical doctor.
- Get the sponsoring physician's signature on all progress notes.
- Provide services as defined and approved by the sponsoring physician.

Prior Authorizations and Referrals

We do not require prior authorization for certain services. Please use the Enterprise Prior Authorization List (EPAL) to see what services do require authorization on UHCprovider.com/priorauth > **Advance Notification and Plan Resources** > under Plan requirement resources – Medica Healthcare and Preferred Care Partners Prior Authorization Requirements.

WellMed and Utilization Management

Prior authorization requests for Preferred Care Partners members can be done online at **eprg.wellmed.net** or by fax at 866-322- 7276.

Simple Referral Process

Palm Beach Members: The Simple Referral Process helps PCPs coordinate member care. Referrals are necessary for most participating specialists.* Requests for non-participating care providers need additional authorization.

- Register on our website **UHCprovider.com/newuser**.
- 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 is needed for referrals to specialists.
- Requests for referrals must be submitted electronically on **UHCprovider.com**
- Upon submitting a referral request, the system automatically generates the referral number.
- For member convenience, you can also provide members with a copy of the referral confirmation.
- The specialist has the ability to view referral via UnitedHealthcare portal.
- For additional questions call us at 877-670-8432 or email us at **pcp-NetworkManagementServices@uhcsouthflorida.com**.

WellMed Members: Fax inpatient hospital admission notification to 877-757-8885. Notifications must be received no later than the first business day following the admission.

WellMed requires a referral from the assigned PCP prior to rendering services for selected specialty care providers.

The referral must be entered by the PCP in the WellMed provider portal at **eprg.wellmed.net**.

The WellMed Florida Specialty Protocol List gives more information about which specialties/services may be exempt from the referral process. Providers may view the WellMed Specialty Protocol List in the WellMed Provider portal at **eprg.wellmed.net** in the Provider Resource Tab.

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

Authorization Requirements

- Obtain prior authorization for all services requiring authorization before the services are scheduled or rendered.
- Submit prior authorization for outpatient services or planned Acute Hospital Admissions and admissions to Acute Rehabilitation Hospital and Long-Term Acute Care (LTAC) as far in advance of the planned service as possible to allow for coverage review. We require prior authorizations to be submitted at least seven calendar days prior to the date of service.
- Submit prior authorizations for home health and home infusion services, durable medical equipment (DME), and medical supply items.
- Use Medcare, our Home Health Care (HHC) and DME capitated care provider.
  Note: You should not request an expedited (72 hours) review unless waiting for a standard (14 calendar days) review could place the member's life, health, or ability to regain maximum function in serious jeopardy. Once you determine the situation meets this definition, request that a prior authorization be expedited by placing "STAT/ urgent" on the Prior Authorization Form.
- We require prior authorizations to out-of-network specialty or ancillary care providers when the member requires a necessary service that cannot be provided within the available Preferred Care network. The referring physician must submit a completed Prior Authorization Form for approval.
- You and the member should be fully aware of coverage decisions before services are rendered.
- If you provide the service before the coverage decision is rendered, and we determine the service was not a covered benefit, we may deny the claim. You must not bill the member. Without a coverage determination, a member does not have the information needed to make an informed decision about receiving and paying for services.

Notification Requirements

- For any inpatient or ambulatory outpatient service requiring prior authorization, the facility must confirm, prior to rendering the service, that the coverage approval is on file. The purpose of this protocol is to enable the facility and the member to have an informed pre-service conversation. If the service will not be covered, the member can decide whether to receive and pay for the service.
- Facilities are responsible for admission notification for inpatient services, even if the coverage approval is on file.
- If a member is admitted through the emergency room, you must notify us no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.
- If a member receives urgent care services, you must notify us within 24 hours of the services being rendered.

Admission Notification Requirements

- Facilities are responsible for admission notification for the following types of inpatient admissions:
  - Planned or elective admissions for acute care
  - Unplanned admissions for acute care
  - Skilled Nursing Facility (SNF) admissions
    - Notification of admissions to SNF should be done within 24 hours. Prior authorizations are not a requirement.
  - Admissions following outpatient surgery
    - Acute Inpatient Rehabilitation (AIR) admission (requires prior authorization)
    - Long-Term Acute Care Hospital (LTACH) admissions (requires prior authorization)
- Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission (or by 5 p.m. local time on the next business day if 24-hour notification would require notification on a weekend or federal holiday).
- Admission notification by the facility is required even if notification was supplied by the physician. and a coverage approval is on file.
- Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual member's benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility's participation agreement with us.
- Admission notifications must contain the following]:
  - Member name and member health care ID number
  - Facility name
  - Admitting or attending physician name
  - Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
  - Actual admission date
  - Admission orders written by a physician
- For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us as soon as the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

If the requirements are not followed, the services may be denied. You cannot bill the member.

A notification or prior authorization approval does not ensure or authorize payment, subject to state rules and MA policies. Payment is dependent upon the member's

coverage, the care provider's eligibility, and participation agreement and claim requirements.

To initiate patient discharge or to request authorization for transition to AIR and LTAC, call 800-995-0460 or fax 866-587-0144.

Clinical Coverage Review

Certain services require prior authorization, which results in:

1. A request for clinical information,
2. A clinical coverage review based on medical necessity, and
3. A coverage determination.

You must cooperate with all requests for information, documents or discussions for purposes of a clinical coverage review including providing pertinent medical records, imaging studies or reports and appropriate assessments for determining degree of pain or functional impairment.

As a network care provider, you must respond to calls from our UM staff or medical director. You must provide complete clinical information as required within the timeframe specified on the outreach form.

In addition:

- We may use tools developed by third parties, such as the MCG™ guidelines, to assist us in administering health benefits. These tools assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. They do not constitute the practice of medicine or medical advice.
- For MA members, we use CMS coverage determinations, the National Coverage and Local Coverage Determinations (LCD), to determine benefit coverage for Medicare members. If other clinical criteria, such as the MCG™ guidelines or any other coverage determination guidelines, contradict CMS guidance, we follow the CMS guidance.

Clinical Coverage Review Criteria

We use scientifically based clinical evidence to identify safe and effective health services for members for inpatient and outpatient services. For Inpatient Care Management (ICM's), we use evidence-based MCG Care Guidelines. Clinical coverage decisions are based on the member's eligibility, state and federal mandates, the member's certificate of coverage, evidence of coverage or summary plan description, UnitedHealthcare Medical Policies and medical technology assessment information. For Medicare Advantage members, we use CMS NCDs and LCDs and other evidence-based clinical literature.

Coverage Determination Decisions

Coverage determinations for health care services are based upon the member's benefit documents and applicable federal requirements. Our UM staff, its delegates, and the physicians making these coverage decisions are not compensated or otherwise rewarded for issuing adverse non-coverage determinations. Preferred Care and its delegates do not offer incentives to physicians to encourage underutilization of services or to encourage barriers to receiving the care and services needed.

Coverage decisions are made based on the definition of "reasonable and necessary within MA coverage regulations and guidelines." Hiring, promoting, or terminating physicians or other individuals are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Prior Authorization Denials

We may deny a prior authorization request for several reasons:

- Member is not eligible;
- Service requested is not a covered benefit;
- Member's benefit has been exhausted; or
- Service requested is identified as not medically necessary (based upon clinical criteria guidelines).

We must notify you and the member in writing of any adverse decision (partial or complete) within applicable time frames. Our notice states the specific reasons for the decision. It also references the benefit provision and clinical review criteria used in the decision-making process. We provide the clinical criteria used in the review process for making a coverage determination along with the notification of denial.

Peer-to-Peer (P2P) Clinical Review

For Inpatient Care Management Cases, P2P requests may come in through the P2P Support team by calling 800-955-7615.

P2P discussions can occur at different points during case activity in accordance with time frames, once a medical director has rendered an adverse determination. A P2P reconsideration request can only occur before a formal appeal is filed.

Prior authorization staff offer the opportunity for a peer-to-peer discussion when notifying the requesting care provider of an adverse determination. Adverse Determination Notices may also advise the requesting care provider of the availability of a P2P discussion opportunity and standard procedure to follow. Call the clinical staff directly or the P2P support Team so the request can be processed appropriately.

Physicians conducting clinical review determinations are available by telephone to discuss medical necessity review

determinations with the member's physician requesting the service.

Additional UM Information

External Agency Services for Members

Some members may require medical, psychological and social services or other external agencies outside the scope of their plan benefits (for example, from Health and Human Services or Social Services). If you encounter a member in this situation, contact Network Management Services. You can also have the member contact our Member Services Department at 866-231-7201 for assistance with, and referral to, appropriate external agencies.

Technology Assessment Coverage Determination

The technology assessment process helps evaluate new technologies and new applications of existing technologies. Technology categories include medical procedures, drugs, pharmaceuticals, or devices. This information allows us to support decisions about treatments that best improve member's health outcomes, efficiently manage utilization of healthcare resources, and make changes in benefit coverage to keep pace with technology changes. It also helps ensure members have equitable access to safe and effective care. If you have any questions regarding whether a new technology or a new application of existing technologies are a covered benefit for your patients, please contact Utilization Management at 800-995-0480.

Hospitalist Program for Inpatient Hospital Admissions

The Hospitalist Program is a voluntary program for members. Hospitalists are physicians who specialize in the care of members in an acute inpatient setting (acute care hospitals and SNFs). A hospitalist oversees the member's inpatient admission and coordinates all inpatient care. The hospitalist communicates with the member's selected physician by providing records and information, such as the discharge summary.

Discharge Planning

Discharge planning is a collaborative effort between the inpatient care manager, the hospital/facility case manager, the member, and the admitting physician. It helps ensure coordination and quality of medical services through the post-discharge phase of care.

Although not required to do so, we may help identify health care resources available in the member's community following an inpatient stay.

UM nurses conduct telephone reviews to support discharge planning, with a focus on coordinating health care services prior to the discharge.

The facility or physician is required to contact us and provide clinical information to support discharge decisions under the following circumstances:

- An extension of the approval is needed. Contact must be made prior to the expiration of the approved days.
- The member's discharge plan indicates transfer to an alternative level of care is appropriate.
- The member has a complex plan of treatment that includes home health services, home infusion therapy, total parenteral nutrition, or multiple or specialized durable medical equipment identified prior to discharge.

To initiate patient discharge, call us at 800-995-0480 or reach us by fax at 866-567-0144.

Appeal & Reconsideration Processes

MA Hospital Discharge Appeal Rights Protocol

MA members have the right to appeal their hospital discharge to a Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO) for immediate review. The BFCC-QIO for Florida is KEPRO.

The BFCC-QIO notifies the facility and Preferred Care of an appeal and:

- Preferred Care facility onsite Concurrent Review Staff completes the Detailed Notice of Discharge (DNOD), and delivers it to the MA member or their representative as soon as possible but no later than 12 p.m. local time the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC- QIO; or
- When no Preferred Care facility onsite staff is available, the facility completes the DNOD and delivers it to the MA member or their representative as soon as possible but no later than 12 p.m. local time the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO and Preferred Care.

Facility (SNF, HHA, CORF) Notice of Medicare Non-Coverage (NOMNC) Protocol

CMS requires SNFs, HHAs, and CORFs deliver the NOMNC-required notice to members at least two calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If a member's services are expected to be fewer than two calendar days in duration, deliver the notice at the time of admission or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds two calendar days, give the notice no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of the member or their authorized representative if the member is incompetent. You must use the most current version of the standard CMS-approved form titled, "Notice

of Medicare Non-Coverage" (NOMNC). You can find the standardized form and instructions on the CMS website. You may also contact KEPRO the BFCC-QIO for Florida at kepro.com for more information. You may not change the NOMNC notification text.

Clinical Appeals: Standard and Expedited

To appeal an adverse decision (a decision to deny the authorization of a service or procedure because the service is determined not to be medically necessary or appropriate) on behalf of a member, submit a formal letter outlining the issues. Include supporting documentation. The denial letter you received provides you with the filing deadlines and the address to use to submit the appeal.

Submit the member's written consent with your appeal.

When we make a final decision, we notify you by mail. If we overturn the original determination, the service will be authorized. If we uphold the original denial determination, there is no additional action.

2017 Benefit Summaries

For information on 2017 benefits, please visit mypreferredcareprovider.com > Provider Resources > Summary of Benefits.

Member Rights and Responsibilities

The Member Rights and Responsibilities Statement is published each year in the Evidence of Coverage (EOC). It is available on our website at mypreferredcare.com or by contacting the Network Management Department at 877-670-8432. If your patient has questions about their rights, please refer them to the Member Services phone number on the back of their ID card.

Member Participation in Treatment Options

Members have the right to freely communicate with their physician and participate in the decision-making process regarding their health care, regardless of their benefit coverage. Each member has the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law, as applicable.

Competent members have the right to refuse recommended treatment, counsel or procedure. The health care professional may regard such refusal as incompatible with the continuance of the care provider/patient relationship and the provision of proper medical care. If this occurs, and the health care professional believes that no professionally acceptable alternatives exist, they must so inform the member in writing, by certified mail. The health care professional must give the member 30 calendar days to find another care provider. During this time, the health care professional is responsible for providing continuity of care to the member.

Advance Directives

The federal Patient Self-Determination Act (PSDA) of 1990 gives individuals age 18 and older the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive.

This law states that members' rights and personal wishes must be respected, even when the member is too sick to make decisions on their own. You may find the Patient Self-Determination Act at gpo.gov.

To help ensure a person's choices about health care are respected, the Florida legislature enacted Chapter 765, Florida Statutes. It requires all care providers and facilities to provide their patients with written information regarding treatment options.

This discussion should be documented at least once in the member's record.

To comply with this requirement, we also inform members of state laws on advance directives through our members' benefit material. We encourage you to have these discussions with our members.

Online Resources: You may find the federal Patient Self-Determination Act at gpo.gov. You may download free forms from the state at floridahealthfinder.gov/reports-guides/advance-directives.aspx.

Information is also available from the Robert Wood Foundation, Five Wishes. The information there meets the legal requirements for an advance directive in Florida and may be helpful to members. Five Wishes is available on AgingWithDignity.org.

Member Financial Responsibility

Members are responsible for the copayments, deductibles and coinsurance associated with their benefit plan. ollect copayments at the time of service. To determine the exact member responsibility related to benefit plan deductibles and coinsurance, we recommend you submit claims first. You will then receive the Summary of Benefits (SOB) to see what the patient needs to pay.

If you prefer to collect payment at the time of service, you must make a good faith effort to estimate the member's responsibility using our Claims & Payment tool. This tool is available on UHCprovider.com/claims.

Documentation and Confidentiality of Medical Records

You are required to protect records, correspondence and discussions regarding the member.

You must keep a medical records system that:

- Follows professional standards.
- Allows quick access of information.

- Provides legible information that is correctly documented and available to appropriate health care providers.
- Maintains confidentiality.

Our member should sign a Medical Record Release Form as a part of their medical record. Contact Network Management Services, 877-670-8432, to request a copy of this form.

Please follow these confidentiality guidelines:

- Records that contain medical, clinical, social, financial or other data on a patient are treated as confidential. They must be protected against loss, tampering, alteration, destruction, or inadvertent disclosure;
- Release of information from your office requires that you have the patient sign a Medical Record Release Form that is retained in the medical record;
- Release of records is in accordance with state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Records containing information on mental health services, substance use, or potential chronic medical conditions that may affect the member's plan benefits are subject to additional specific waivers for release and confidentiality.

Exemption from Release Requirements

HIPAA regulation 45 CFR § 164.512 (d) allows us to give PHI to government programs without member permission. This is given to determine member eligibility.

Medical Records Requirements

You must ensure your medical records meet the standards described in this section. The following are expanded descriptions of these requirements:

Patient Identifiers: Should consist of the patient name and a second unique identifier, and should appear on each page of the medical record.

Advance Directives: Provide the member with advance directive information and encourage them to retain a copy for their personal records. Document this conversation at least once in the member's medical record.

Biographical Information: Include the member's name, date of birth, address, home and work phone numbers, marital status, sex, primary language spoken, name and phone number of emergency contact, appropriate consent forms and guardianship information, if relevant.

Signatures: For paper medical records, have all entries dated and signed or initialed by the author. Author identification may be a handwritten signature or initials followed by the title (e.g., MD, DO, PA, ARNP, RN, LPN, MA or OM). There must be a written policy requiring, and evidence of, physician co-signature for entries made by those other than a licensed physician (e.g., MD, DO). Electronic signatures are acceptable for electronic medical records.

Family History: Document the family medical history no later than the first visit.

Past Medical History: Include a detailed medical, surgical, and social history.

Immunizations: Include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine. At a minimum, you must have members' vaccination history.

Medication List: List the member's current medications, with start and end dates, if applicable. Reconcile within 30 days after inpatient admissions.

Referral Documentation: If a referral was made to a specialist, the consultation report should be filed in the medical record. Include documentation that the physician has discussed abnormal results with the member, along with recommendations.

Chart Organization: Maintain a uniform medical record system of clinical recording and reporting with respect to services, which includes separate sections for progress notes and the results of diagnostic tests.

Preventive Screenings: Promote the appropriate use of age- or gender-specific preventive health services for members to achieve a positive affect on the member's health and better medical outcomes.

Required Encounter Documentation: For every visit, document the following:

- Date;
- Chief complaint or purpose;
- Objective findings;
- Diagnosis or medical impression;
- Studies ordered (lab, X-ray, etc.);
- Therapies administered or ordered;
- Education provided; disposition, recommendations or instructions to the member and evidence of whether there was follow-up; and,
- Outcome of services.

You must document that a written policy regarding follow-up care and written procedures for recording results of studies and therapies and appropriate follow-up is in place.

The member should sign a Medical Record Release Form as a part of their medical record. 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 Preferred Care Partners.

Below is the criteria for referrals to Optum CM and DM Programs:

- **Complex Case Management — (Special Needs Plan (SNP) members only)**
  - Three or more unplanned admissions and/or emergency room (ER) visits in the last six months or
  - Multiple, complex co-morbid conditions and/or
  - Coordination of multiple community resources/ financial supports to cover basic services
- **Heart Failure (HF) Disease Management Program**
  - Diagnosis of HF and
  - Has CHF on an inpatient claim or
  - HF admission in last three months
- **Diabetes Disease Management Program**
  - Diabetic with A1C 9% or greater or
  - An inpatient admission related to diabetes in the past 12 months or
  - Two or more ER visits related to diabetes
- **Advanced Illness Case Management** — The primary goal is to facilitate and support end-of-life wishes and services
  - Life expectancy of 12-18 months
  - Chronic, irreversible disease or conditions and declining health
  - Reduce disease and symptom burden
- **Transplant Case Management and Network Services**
  - Bone marrow/stem cell, kidney and kidney/pancreas, heart, liver, intestinal, multi-organs and lung transplants
  - Case management for one year post-transplant
- **End-Stage Renal Disease Case Management** — The member is diagnosed with end-stage renal disease and is undergoing outpatient dialysis including in-center or home hemodialysis, home peritoneal dialysis, etc.

If the member does not qualify for one of these programs, they have 24/7, 365 days a year access to speak with a nurse by calling the Optum NurseLine number on the back of their ID card.

NOTE: South Florida Preferred Care Partners no longer provides social worker evaluations without skilled services. Please direct your patient to their local social services department or the Florida State Department of Elder Affairs Help Line at 800-963- 5337.

To request CM or DM services for one of your patients, select only one program that your member meets the criteria for. Then submit the CM/DM referral form, which is available on mypreferredprovider.com, to southfl@optum.com.

Behavioral Healthcare Programs

We work with United Behavioral Health to provide behavioral health care services for our members. For more information on how to access the Behavioral Healthcare programs, you or our members may contact a representative through the phone number listed on the back of their health care ID card.

Special Needs Plans

Special Needs Plans (SNP) Model of Care (MOC)

The MOC is a framework for providing health care and health care 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.

SNP MOC Structure and Process

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

- Complex case management;
- Improving member satisfaction;
- Clinical quality improvements;
- Care transitions;
- I-SNP relationships with facility; and
- Coordination of Medicare and Medicaid coverage.

We have a Stars Improvement Department that has a direct focus on quality performance measures. We work closely with UnitedHealthcare to improve our performance. Many of these performance measures involve you and can be positively affected by the relationship between Preferred Care Partners and its network care providers. We strive for improved lines of communication and exchange of helpful tools and looks forward to receiving your feedback.

Risk Management

Risk management addresses liability, both proactively and reactively. Proactive is avoiding or preventing risk. Reactive is minimizing loss or damage after an adverse or bad event. Risk management in health care considers patient

safety, quality assurance, and patients' rights. The potential for risk is present in all aspects of health care, including medical mistakes, electronic record-keeping, care provider organizations, and facility management.

An adverse event is defined as an event over which health care personnel could exercise control rather than as a result of the member's condition. Identifying something as an adverse event does not imply "error," "negligence" or poor quality care. It indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process. Adverse events interfere with a care provider's delivery of medical care and may result in litigation.

Agency for Healthcare Administration

The Florida Agency for Healthcare Administration (AHCA), as directed under F.S. 641 Parts I, II, III and other applicable state laws, provides oversight and monitoring of health plans operating in the State of Florida as an HMO and their compliance to applicable regulations.

This includes implementation of a Risk Management Program (RMP). The program helps identify, investigate, analyze and evaluate actual or potential risk exposures by a state licensed risk manager. The RMP also corrects, reduces and eliminates identifiable risks through instruction and training to staff and care providers.

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.

Care Provider Reporting Responsibilities

You are required to report all adverse events as identified above, whether actual or potential. To report such incidents, call 952-406-4806.

You must report incidents to AHCA within 24 hours of it happening. You must report all serious incidents, such as those listed below, immediately. This allows us to quickly access the risk and address liability. Examples of serious incidents include:

- Death or serious injury;
- Brain or spinal damage;
- Performance of a surgical procedure on the wrong patient;
- Performance of a wrong site surgical procedure;
- Performance of a wrong surgical procedure;
- Medically unnecessary surgical procedure
- Surgical repair of damage from a planned surgical procedure; and
- Removal of unplanned foreign object remaining from a surgical procedure.

Care provider contracts include the obligation to participate in quality management inquiries upon request from the clinical quality analyst.

What are the Responsibilities of Physicians and Care Providers?

You must report the ICD-10-CM diagnosis codes to the highest level of specificity and accurately. This requires accurate and complete medical record documentation. You are required to alert the MA organization of wrong information submitted. You must follow the MA organization's procedures for correcting information. Finally, you must report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

Links to resources for the latest ICD guidelines and MRA resources are available online at mypreferredprovider.com.

CPT and HCPCS Codes

The American Medical Association (AMA) and the CMS update procedure codes quarterly, with the largest volume effective January 1 of each year. CPT and HCPCS codes may be added, deleted or revised to reflect changes in health care and medical practices.

If a claim is submitted with an invalid or deleted procedure code, it will be denied or returned. A valid procedure code is required for claims processing.

We encourage you to purchase current copies of CPT and HCPCS reference guides. You can access CPT, HCPCS and ICD-10 coding resources and materials at the American Medical Association's website, ama-assn.org.

River Valley Entities Supplement

Information Regarding the Use of this Supplement

This supplement applies to covered services rendered to River Valley entities members (does not include MA).

It also applies to care providers who have the following:

1. A UnitedHealthcare participation agreement with:
   - A reference to the River Valley or John Deere Health protocols or guides, or
   - A direct contract with one or more River Valley entities that participate in River Valley entities networks
2. Located in AR, GA, IA, TN, VA, WI or the following Illinois counties: Jo Daviess, Stephenson, Carroll, Ogle, Whiteside, Lee, Mercer, Rock Island, Henry, Bureau, Putnam, Henderson, Warren Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford, McLean.

The following River Valley entities sponsor, issue and administer River Valley benefit plans:

- UnitedHealthcare Services Company of the River Valley, Inc.
- UnitedHealthcare Plan of the River Valley, Inc.
- UnitedHealthcare Insurance Company of the River Valley, Inc.

The River Valley entity is listed on the front of members' ID card (bottom left).

Health care providers who are not subject to this supplement (including care providers in Louisiana, North Carolina, Ohio and South Carolina) can disregard this information. You may work with us when providing services to River Valley members in the same way as you do when providing services to other UnitedHealthcare members.

For protocols, policies and procedures not specified in this supplement, refer to appropriate chapter in the main guide.

Refer to the UnitedHealthcare Community Plan administrative guides available on **UHCCommunityPlan.com** > For Health Care Professionals for policies and procedures relating to the TennCare®, Iowa Medicaid/ hawk-i®, and Secure Plus Complete Medicaid Plans®.

Eligibility

Call the number on the back of the member's ID card to get information about a River Valley member, such as eligibility information and claims status information.

Member ID Cards

When members enroll, they will get a new ID card with a member ID number. The phone number, website and claims address for our core UnitedHealthcare systems are listed on the back. Refer to the section titled *Health Care Identification (ID) Cards* in Chapter 2: Provider Responsibilities, for more guidance regarding ID cards.

How to Contact River Valley

Care providers who practice in Illinois, Iowa and Wisconsin should refer to the "Midwest" references in the following grid. Care providers who practice in Arkansas, Georgia, Tennessee and Virginia should refer to the "Southeast" references in the following grid.

Resource	Where to go
Care Provider Websites:	**UHCprovider.com** and **Link**
Claims Submission (Electronic)	Medical claims payer ID: 87726 Dental claims payer ID: 95378 866-509-1593 or **RVITEDISolutions@uhc.com**
Claims Submission on Paper	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800
Tax ID Numbers (TIN)/ Provider ID Numbers	866-509-1593 or **RVITEDISolutions@uhc.com**
Claim Reconsideration and Appeals	Refer to the *Claim Reconsideration, Appeals Process and Resolving Disputes* section in *Chapter 9: Our Claims Process* for online options, or mail to: UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 **Fax:** 801-938-2100

Resource	Where to go
Electronic Payments and Statements (EPS) If you are enrolled in EPS for UnitedHealthcare Commercial, you'll automatically start receiving direct deposit and online remittance advice for these members. No additional action is required.	**Online:** Optum.com/enroll. If you are signed up for our EFT but not EPS, you will receive paper payments and remittance advices. To continue receiving your payments electronically, enroll in EPS.
United Voice Portal	877-842-3210
Preauthorizations: for procedures and services, except for those otherwise referenced below, including preauthorization for certain DME We accept EDI 278 submissions directly to UnitedHealthcare or through a clearinghouse. Appeals (Urgent)	**Online:** UHCprovider.com/priorauth **Phone:** (Inpatient requests only) 877-842-3210, option 3, or the number on the back of the member's ID card. **Fax:** 866-756-9733 (Include place of service and CPT codes.) **Fax:** 801-994-1083
Mental Health/Substance Use, Vision, or Transplant Services	Illinois/Iowa/Wisconsin: 800-747-1446 Tennessee/Virginia/Arkansas/Georgia: 800-224-6602
Skilled/Extended Care	**Phone:** Midwest: 800-747-1446 Southeast: 800-224-6602 **Fax:** Midwest: 888-534-3258 Southeast: 800-880-5403
Pharmacy Services/Prescription Drugs Requiring Preauthorization **Pharmacy Appeals (Urgent)**	**Phone OptumRx:** 800-711-4555 UHCprovider.com/pharmacy
Preauthorization for End-Of- Life Care and Home Health Care Including Infusion Services	**Phone:** 800-747-1446 Ext: 65212 **Fax:** 800-340-2184 **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive Moline, IL 61265
Notification of Inpatient Admissions	**Phone:** Midwest: 800-747-1446 Southeast: 800-224-6602 **Fax:** Midwest: 888-534-3258 Southeast: 800-880-5403
Case Management/Utilization Management Initiate case management and utilization management	Congenital Heart Disease: 800-747-1446 Kidney Resource Services: 800-747-1446 Transplant Resource Services Fax: 855-250-8157 Ventricular Assist Devices: Fax: 855-282-8929
Disease Management	**Phone:** 800-369-2704, Option # 4 (Mon - Fri., 8 a.m - 4:30 p.m., CT) **Fax:** 866-950-7759, Attn: CMT Coordinator **Email:** MailWebCDM@uhc.com
Cardiology: • Diagnostic Catheterization • Electrophysiology Implants • Echocardiogram and Stress Echocardiogram	**Online:** UHCprovider.com/cardiology; select the *Go to Prior Authorization and Notification* App. **Phone:** 866-889-8054
Radiology/Advanced Outpatient Imaging Procedures: Certain CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online:** UHCprovider.com/radiology; select the *Go to Prior Authorization and Notification* App. **Phone:** 866-889-8054

Use UHCprovider.com and Link to perform secure transactions, including checking member eligibility and benefits as well as managing claims and prior authorization requests.

Reimbursement Policies

Claim payment is subject to reimbursement policies. Find these policies on UHCprovider.com/policies > Commercial Policies > Reimbursement Policies for Commercial. These tools are not available to River Valley members.

Changes to these policies are announced in the Network Bulletin available on UHCprovider.com/news.

Coding edits may also effect reimbursements. We apply coding edits based primarily on the National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare and Medicaid Services (CMS) as well as the CMS' Outpatient Code Editor (OCE). You can find NCCI and OCE edits on cms.gov > Medicare > Coding > National Correct Coding Initiative Edits.

Referrals

Network Referrals

A network referral allows a member enrolled in a primary care coordinator (PCC) plan from a participating care provider other than a PCP at the benefit level. We require one when we are the primary or secondary payer. A referral does not guarantee payment of a claim.

Network Referral Process for Primary Care Coordinator (PCC) Plans

The network PCP must initiate referral requests. Requests may not come from specialists. If the treating specialist feels the member must see another specialist, they must contact the PCP. The PCP makes the final decisions about referrals and must make any new referrals.

Standard Exceptions to the Network Referral Process

- Female members may directly access network OB/GYN providers without a referral.
- Members may directly access network ophthalmologists or contracted vision providers for an annual diabetic dilated eye exam without a referral.
- Members with a split copayment (where they have one copay for PCP visits and a higher copay for specialty visits) do not require a referral to a network specialist.

Process to Facilitate Network Referrals

The PCP decides whether a member needs for a network referral. They communicate this to the member. Then they either mail, call or fax the referral to the specialist. The PCP states the requested services in the referral.

Referral requests must be for services covered under the member's benefit plan to a participating care provider.

To facilitate coordination of care, the PCP should promptly relay clinical information to the specialist. The specialist should also provide written communication to the PCP, describing the rendered health services.

A specialist submits claim(s) for services, providing the PCP's name and UPIN/NPI number in boxes 17 & 17a of the CMS 1500 form. Place the River Valley universal referral number 2009061 RV in Box 23 of the 1500 claim form to serve as authorization for payment at the member's network benefit level.

Out-of-Network Referrals

An out-of-network (OON) referral means a written authorization provided by a participating care provider and approved by us for services to be received from a non-participating care provider. OON referrals must be requested by the member's PCP. If an OON referral is obtained, services received from a non-participating care provider are covered at a network level of benefits under the member's benefit plan. An OON referral is needed when services are not available from a participating care provider and may be needed for various services including, but not limited to, podiatry, chiropractic and mental health/substance use services.

Out-of-Network Referral Approval

A referral to an OON care provider must be approved by us before the services are rendered. We must also give prior approval for modified or expired OON referrals as described in this supplement. We may approve an OON referral when services are needed but not available from a participating care provider. Prior approval of an OON referral is required for each follow-up visit unless we indicate otherwise. A medical director will review requests that do not meet approval criteria.

In the case of emergencies, notify us the first business day following the referral.

Out-of-Network Referral Process

To determine whether an OON referral is necessary under a member's benefit plan, contact us at the number on the back of the member's health care ID card.

Get prior approval by completing an OON referral request form. Then fax it to us with supporting documentation. The OON referral request form can be accessed on uhcrivervalley.com > Providers > Forms > Out-of-Network Referral Form.

- We will make decisions within the time frames required by state and federal law (including ERISA) and in accordance with NCQA standards.
- We will send a letter confirming our approval or denial of a referral to the member and your office
  - If a member requests approval after the fact, advise them this is against policy. Refer them to the following numbers: Illinois/Iowa/Wisconsin: 800-747-1446; Tennessee/Virginia/Arkansas/Georgia: 800-224-6602.

Participating care providers may not refer their own family members to non-participating physicians/facilities due to conflict of interest. If the care provider denies a referral, the care provider must refer the member to their benefit document for any appeal rights. Or have them call:

- Illinois/Iowa/Wisconsin: 800-747-1446;

- Tennessee/Virginia/Arkansas/Georgia: 800-224-6602.

Utilization Management

The term "prior authorization" is also referred to as "Preauthorization."

Our Utilization Management (UM) Program has several parts. These include but are not limited to:

- Preauthorization for various procedures, medical services, treatments, prescription drugs and durable medical equipment (DME).
- Review of the appropriateness of inpatient admissions and ongoing inpatient care coverage.
- Prior approval for referrals to non-participating care providers, if applicable.
- Case management.

Our goal is to encourage the highest quality of care in the right place at the right time from the right care provider.

Care providers must cooperate with our UM program. You will allow us access, in the form we request, to data about covered services provided to our members. You will allow us to collect data to conduct UM reviews and decisions.

Medical Policies, Drug Policies and Coverage Determination Guidelines

River Valley uses UnitedHealthcare's Medical Policies, Drug Policies, Coverage Determination Guidelines, Quality of Care Guidelines, and Utilization Review Guidelines on UHCprovider.com/policies > Commercial Policies > **Medical & Drug Policies and Coverage Determination Guidelines**.

For more information refer to *Medical Policies, Drug Policies and Coverage Determination Guidelines for Commercial Members* in *Chapter 6: Medical Management*.

Preauthorization

Services that Require Preauthorization

We require preauthorization for certain procedures, DME, prescription drugs and other services.

The list of services requiring preauthorization is available on:

- UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > **UnitedHealthcare of the River Valley Advance Notification Procedure Codes**

Submit Adequate Clinical Documentation

You must request preauthorization when required. Provide complete clinical information and supporting medical documentation for each procedure, device, drug or service when you submit your request. That way, we can promptly determine whether the services are covered and medically necessary. We consider additional information provided within the time period allowed for review. However, delayed submissions increase administrative time.

Refer to our Medical Policies, Drug Policies and Coverage Determination Guidelines for what information to provide.

How to Request Preauthorization

Refer to *How to Contact River Valley* in this supplement for how to submit a request for preauthorization.

If you do not get a required preauthorization, the claim may be denied. You cannot bill the member for denied services.

Preauthorization Review Hours of Operation

Staff can review your preauthorization requests Monday through Friday from 8 a.m. until 4:30 p.m. CT. Medical Directors are available to discuss clinical policies or decisions by calling 877-842-3210. The office is closed for national holidays and the day after Thanksgiving.

Clinical Review of a Preauthorization Request

When we receive a preauthorization request, our Clinical Coverage Review Department evaluates the information to determine whether the procedures, devices, drugs or other services are medically necessary and appropriate. Our nursing staff makes decisions to approve care based on specific criteria. Care and/or services that do not fall within the criteria are referred to a medical director or other appropriate reviewer. This may include a board-certified specialty physician or a registered pharmacist. Only physicians and other appropriate care providers may issue a medical necessity denial.

River Valley's staff and our delegates who make these decisions are not rewarded for denying coverage. We do not offer incentives that encourage underutilization of care or services.

The treating physician has the ultimate authority for the member's medical care. The medical management process does not override this responsibility.

Utilization Management Decisions

We make UM decisions within the time frames set by state and federal law (including ERISA). We make UM decisions in accordance with National Committee for Quality Assurance (NCQA) standards.

We also tell care providers and members our decisions according to applicable state and federal law as well as to NCQA standards and River Valley policy. Denial letters explain members' applicable appeal rights, which may include the right to an expedited and/or external review. They also explain the requirements for submitting an appeal and receiving a response. A member may have a health care professional appeal a decision on their behalf. We require a copy of the member's written consent with the appeal.

Facility Utilization Review

Notification of Inpatient Admission Required

Facilities must notify us of an inpatient admission within 24 hours of admission or on the next business day after a holiday or weekend. We need the member's name, ID number, admitting diagnosis and attending physician's name.

Failure to Notify

If the facility does not tell us about an admission as required, claims will be returned as not allowed. The facility may not bill the member for the services. Retrospective reviews may be completed, and any approved services may be re-billed.

Inpatient Review

Our UM activities include inpatient review. We usually begin our review on the first business day following admission. The medical director and clinical staff review member hospitalizations for over- and under-utilization. Then they decide whether the admission and continued stay are medically appropriate and align with evidence-based guidelines.

Where appropriate, River Valley also uses MCG™ Care Guidelines. These are nationally recognized clinical guidelines that help clinicians make informed decisions, on a case-by-case basis, in many health care settings. These settings include acute and sub-acute medical, rehabilitation, skilled nursing facilities (SNF), home health care and ambulatory facilities. Other criteria may be used when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay.

When the guidelines are not met, the medical director considers community resources and the availability of alternative care settings. These include skilled facilities, sub-acute facilities or home care, and the ability of the facilities to provide all necessary services within the estimated length of stay.

Inpatient review also helps us contribute to decisions about discharge planning and case management. In addition, we may identify opportunities for quality improvement and cases appropriate for referral to one of our disease management programs.

If a nurse reviewer believes an admission or continued stay does not meet criteria, you may be asked for more information about the treatment and case management plan. The nurse then refers the case to our medical director. If the medical director determines an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, we tell the facility and the care provider.

You may speak with our medical director within one business day of the request. When decisions require expertise outside the scope of the physician advisor, we have a board-certified physician of the relevant specialty (or similar specialty) review the case. We use external independent review when we decide it is appropriate or by member request, according to applicable law.

Admission to Rehabilitation Units

We require prior authorization for admission for all rehabilitation confinements. We review them concurrently for continued services. Refer to the Skilled/Extended Care row in the How to Contact River Valley section in this supplement for how to submit a preauthorization request.

Admission to Skilled Nursing Units

A member may require inpatient skilled nursing care due to acute illness, injury, surgery, or exacerbation of a disease process.

- We require notification for all admissions to a SNF (or skilled level of care within an acute facility). Refer to How to Contact River Valley in this supplement for how to submit a notification request.
- The facility must submit the care plan along with treatment goals, summary of services to be provided, expected length of stay (LOS), and discharge plan.
- We authorize admission consistent with the level of care required based on the treatment plan.

Concurrent Review

- The skilled facility provider must provide appropriate documentation, including changes in the level of care.
- Approval for additional days of authorized coverage must be obtained before the authorization expires.
- Decisions about levels of care must consider not only the level of service but the member's medical stability.
- Our medical director will speak with the physician managing the member in the skilled facility about disagreements concerning the level of care required. The member or authorized representative can request an appeal when coverage is not approved. We determine whether the admission, stay and care are covered and medically necessary based on the following clinical guidelines, among others:
  - Physicians must order services. The services must be necessary for treatment. They must align with the nature and severity of the illness or injury, medical needs, and accepted medical practice standards. The member must be stable. Clinical and lab findings must have either improved or not changed for the last 24 hours. Diagnosis and initial treatment plan must be established before admission. The services must be reasonable in terms of duration and quantity. The member must require daily (i.e., available on a 24-hour basis, seven days/week) skilled services. If skilled rehabilitation services are not available on this basis, a member whose stay is based on the need for them would meet the daily basis requirement when they need and receive those services at least five days a week. Skilled services, however, are required and provided at least three times per day. How often a

service must be performed does not make it a skilled service.

- We consider the nature and complexity of a service and the skills required for safe and effective delivery when determining whether a service is skilled. Skilled care requires trained medical personnel to frequently review the treatment plan for a limited time. It ends when a condition is stabilized or a predetermined treatment plan is completed. Skilled care moves the member to functional independence.

Observation

Observation helps care providers determine whether a member needs to be admitted to a hospital. It may be needed to monitor or diagnose a condition when testing or treatment exceeds usual outpatient care. Observation is used when physicians need 48 hours or less to determine a member's condition. In some cases, more than 48 hours may be necessary. Members may be admitted when a condition is diagnosed requiring a long-term stay (e.g., acute MI). This condition may involve long-term treatment or further monitoring (e.g., persistent severe asthma).

Notice of Termination of Inpatient Benefits

We may determine that an admission, continued hospital stay, rehabilitation unit or SNF are not covered. These reasons include but are not limited to:

- A medical director determines an admission or continued stay, which was not preapproved at an OON facility, is not medically necessary at the facility's level of care.
- Preauthorization was not obtained for a procedure or service that needed it.
- A medical director determines the member's condition is custodial and is not covered.
- A medical director, upon consulting with the attending physician, determines continued acute inpatient rehabilitation/SNF level of care is no longer medically necessary, but the patient refuses discharge.
- The member has used all inpatient or skilled care benefits under their benefit plan. If a non-coverage determination is made, we provide written notification to the physician, the member and facility that day.

Services Obtained Outside the River Valley Service Area

- We process treatment authorizations as directed by you and the out-of-area (OOA) attending physician.
- With you and the OOA attending physician, we coordinate a member's transfer back to the service area when medically feasible and appropriate.
- We cover OOA urgent or emergent stabilization services according to the member's benefit plan. This includes the time they are stabilized in the emergency room before admission as an inpatient and are discharged.
- We cover post-stabilization care services.
- We cover OOA inpatient services until the member is stable enough to be transferred to a participating hospital. Transfers should happen within 48 hours of that point. Payment for preventive or non-emergent/urgent services performed outside the network varies by benefit plan. Determinations on benefit coverage may include but are not limited to non-covered, covered at a lower benefit level, or covered at the network level with a referral. Call Member Services for questions.

Special Requirements DME

Preauthorization is required for some DME. Refer to the *How to Contact River Valley* section of this supplement for how to submit a preauthorization request.

Subject to the noted exceptions, members must get all DME, orthotics, prosthetics and supply items from a contracted vendor. If an item is not available from a contracted vendor, whether or not preauthorization is required, you must get an OON referral. Otherwise, payment will be denied unless the member has an OON DME benefit.

Note: Even when medically necessary, certain items (e.g., orthotic devices) may not be covered. Others (e.g., prosthetic devices) may be subject to benefits limits.

Contact Member Services for information about a member's plan and preauthorization requirements.

Prescription Drugs

We require preauthorization for some prescription drugs. Refer to the How to Contact River Valley section of this supplement for how to submit a preauthorization request

Some drugs have special rules and require special management services. These include drugs with therapy prerequisites, quantity limitations and/or a multiple copays. A list of some drugs with such rules is on UHCprovider.com/pharmacy.

- If you order and/or administer any medication that requires preauthorization or clinical management services, you may need to get those medications from a participating specialty pharmacy unless we authorize a non-specialty pharmacy.
- Certain drugs are available in quantities up to 90- or 100-day supplies, depending on plan benefit design. A list of drugs on the three-month supply list is on UHCprovider.com/pharmacy.
- River Valley's Prescription Drug Lists (PDL) is on UHCprovider.com/pharmacy.

Not all drugs on a PDL are covered under the pharmacy benefit.

Sleep Studies to Diagnose Sleep Apnea and Other Sleep Disorders

We require preauthorization for laboratory-assisted and polysomnography treatment. We also require it for the site of service (e.g., sleep lab v. portable home monitoring).

Home Health Care (Including Home Infusion Services)

- We require preauthorization for home health care. This may include home infusion services.
- If requested services are required after business hours, notify us within 24 hours or the next business day following a holiday or weekend. Include the member's name, ID number, diagnosis, the attending physician's name and requested services.
- If you do not notify us, we will deny your claim. You may not bill the member for the service.

Assisted Reproduction Program

Most River Valley benefit plans exclude coverage for infertility evaluation or treatment. Some employer groups have a variation or rider to cover these services. Some states, however, require fertility treatment coverage for some groups. Refer to How to Contact River Valley section of this supplement for pre-authorization contact information.

Transplants

- We require preauthorization for transplants. Call the Optum transplant case manager at 888-936-7246. They will request medical records to see whether the transplant is appropriate for a member. We send all information to a physician expert in the related transplantation field for review.
- If authorized, the case manager coordinates referrals and helps select a transplant center based on the member's needs. They also provide information about our transplant management program.
- If a transplant candidate needs home care or is involved with a participating center, the transplant care manager will arrange service.
- Any post-transplant lab or pathology that cannot be performed or interpreted by a network physician can be sent to the transplant center for interpretation. Tell the transplant case manager if you need help making arrangements. Most of these services are covered under the transplant contract. The transplant center should be involved in the member's continuing care.

Post-Transplant Care

- We require preauthorization for all follow-up care. Make requests using the standard River Valley preauthorization process.
- One year after the transplant, members are transferred to their local physician for any other needed care management services.

End-of-Life Care

Some members have end-of-life care benefits, which may include hospice services. These services require preauthorization. Approved care is coordinated by our care managers. Fax requests for end-of-life care to the Home Health Department at 800-340-2184.

Claims Process

Electronic Data Interchange

Use electronic data interchange (EDI) to submit claims and conduct other business with us electronically. To enroll, call EDI customer service at 866-509-1593. Or email RVITEDISolutions@uhc.com.

Claims Transmission

Tell your office software vendor that you want to begin transmitting electronic claims to the River Valley payer ID 87726 for medical claims and 95378 for dental.

We receive all claims through our clearinghouse, OptumInsight. The clearinghouse sets up claims as commercial. Your EDI software vendor must establish connectivity to the clearinghouse. They can make sure you meet the requirements to transmit claims.

EDI Acknowledgment & Status Reports

Your software vendor will give you a report showing an electronic claim left your office. It does not confirm we or the clearinghouse received or accepted the claim.

Clearinghouse acknowledgment reports show the status of your claims. They are given to you after each transmission. This lets you confirm whether a claim reached us, rejected because of an error or needed additional information.

We will also send you status reports providing more data on claims. These include copies of EOBs/remittance advice and denial letters that may request more information.

Carefully review all vendor reports, clearinghouse acknowledgment reports and the River Valley status reports when you receive them.

Paper and Electronic Claims Format

Submit all medical or hospital services claims using, as applicable, the CMS 1500 or UB-04 claim forms. Or use their successor forms for paper claims and HIPAA-standard professional or institutional claim formats for electronic claims. Use black ink when completing a CMS 1500 claim form. This helps us scan the claim into our processing system.

Electronic Claims Submission and Billing

We require you to submit claims electronically, with few exceptions. For electronic claims submission requirements, refer to *Requirements for Complete Claims and Encounter Data Submission* section in Chapter 9: Our Claims Process.

Share this document with your software vendor. We update the Companion Guide regularly, so review it to help ensure you have the most current information about our requirements.

For more information about electronic claims, refer to UHCprovider.com/claims.

Exceptions to Electronic Claims Submission Guidelines

The following claims require attachments. This means they must be submitted on paper:

- Claims submitted for dental pre-treatments for crown lengthening, periodontics, implants and veneers.
- Claims submitted with unlisted procedure codes if sufficient information is not in the notes field.

Modifier 59 helps identify procedures/services commonly bundled together but may be appropriate to report separately. No special rules apply to electronic claims joined using Modifier 59 or for dental pre-treatment claims.

Special Rules for Electronic Submission

- **Corrected Claims** must include the words "corrected claims" in the notes field. Your software vendor can help you with correct placement of all notes.
- **Unlisted Procedure Code Claims** must include details in the notes field. If you cannot, you must submit a paper claim.
- **Claims for Occupational Therapy, Speech Therapy, Physical Therapy, Dialysis, and Mental Health or Substance Use Services** must have the date of service by line item. We do not accept span dates for these types of claims.
- **Secondary Coordination Of Benefits (COB) Claims** must include the following fields:
  - **Institutional:** Payer Prior Payment, Medicare Total Paid Amount, Total Non-Covered Amount, Total Denied Amount.
  - **Professional:** Payer-Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (contractual discount amount of other payer), Patient-Paid Amount (Amount that the payer paid to the member not the care provider).
  - **Dental:** Payer Paid Amount, Patient Responsibility Amount, Discount Amount, Patient Paid Amount.
  - **Span Dates:** We require exact dates of service when the claim spans a period of time. Put the dates in Box 24 of the CMS 1500, Box 45 of the UB-04, or the Remarks field. This will prevent the need for an itemized bill and allow electronic submission.

Requirements for Claims (Paper or Electronic) Reporting Revenue Codes

- We require the exact dates of service for all claims reporting revenue codes.
- If you submit revenue code 270 by itself on an institutional claim for outpatient services, we require a valid CPT or HCPCS code or description.
- If you report revenue code 274, describe the services or include a valid CPT or HCPCS code.
- We require an itemized statement for claims with revenue codes 250-259 if the charges exceed $1,000.
- All claims reporting the revenue codes on the following list require you to report the appropriate CPT and HCPCS codes.

Revenue Codes Requiring CPT® and HCPCS Codes	
260	IV Therapy (General Classification)
261	Infusion Pump
262	IV Therapy/Pharmacy Services
263	IV Therapy/Drug/Supply Delivery
264	IV Therapy/Supplies
269	Other IV Therapy
290	DME (other than renal) (General Classification)
291	DME/Rental
292	Purchase of New DME
293	Purchase of Used DME
300	Laboratory(General Classification)
301	Chemistry
302	Immunology
303	Renal Patient (Home)
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology & Microbiology
307	Urology
309	Other Laboratory
310	Laboratory-Pathology (General Classification)
311	Cytology
312	Histology
319	Other Laboratory Pathological
320	Radiology-Diagnostic (General Classification)
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray
329	Other Radiology-Diagnostic
330	Radiology-Therapeutic and/or Chemotherapy Administration (General Classification)
331	Chemotherapy Administration-Injected
332	Chemotherapy Administration-Oral

Revenue Codes Requiring CPT® and HCPCS Codes	
333	Radiation Therapy
335	Chemotherapy Administration-IV
339	Other Radiology-Therapeutic
340	Nuclear Medicine (General Classification)
341	Diagnostic Procedures
342	Therapeutic Procedures
350	CT Scan (General Classification)
351	CT-Head Scan
352	CT-Body Scan
359	CT-Other
360	Operating Room Services (General Classification)
361	Minor Surgery
362	Organ Transplant-Other Than Kidney
367	Kidney Transplant
369	Other Operating Room Services
400	Other Imaging Services (General Classification)
401	Diagnostic Mammography
402	Ultrasound
403	Screening Mammography
404	Positron Emission Tomography
409	Other Imaging Services
410	Respiratory Services (General)
412	Inhalation Services
419	Other Respiratory Services
460	Pulmonary Function(General Classification)
469	Other-Pulmonary Function
470	Audiology (General Classification)
471	Audiology/Diagnostic
472	Audiology/Treatment
480	Cardiology (General Classification)
481	Cardiac Cath Lab
482	Stress Test

Revenue Codes Requiring CPT® and HCPCS Codes	
483	Echocardiology
489	Other Cardiology
490	Ambulatory Surgical Care (General Classification)
499	Other Ambulatory Surgical Care
610	Magnetic Resonance Technology (MRT) (General Classification)
611	Magnetic Resonance Imaging (MRI)-Brain/Brain Stem
612	MRI-Spinal Cord/Spine
614	MRI-Other
615	Magnetic Resonance Anglogram (MRA)-Head and Neck
616	MRA-Lower Extremities
618	MRA Other
618	Other MRT
623	Surgical Dressing
624	FDA Investigational Devices
634	Erythropoietin (EPO) < 10,000 units
635	Erythropoietin (EPO) > 10,000 units
636	Drugs Requiring Detail Coding
730	EKG/ECG (Electrocardiogram) (General Classification)
731	Holter Monitor
732	Telemetry
739	Other EKG/ECG
740	EEG (Electroencephalogram) (General Classification)
750	Gastro-Intestinal (GI) Services (General Classification)
790	Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
921	Peripheral Vascular Lab
922	Electromyogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
929	Additional Diagnostic Services
940	Other Therapeutic Services (General Classification)

Revenue Codes Requiring CPT® and HCPCS Codes	
941	Recreational Therapy
942	Education/Training (Diabetic Education)
949	Other Therapeutic Services (HRSA-approved weight loss providers)

Claim Reconsideration and Appeals Process and Resolving Disputes

Refer to *Claim Reconsideration, Appeals Process and Resolving Disputes* in *Chapter 9: Our Claims Process* and in the *How to Contact River Valley* section of this supplement.

If you have a question about a pre-service appeal, please see *Pre-Service Appeals* in Chapter 6: Medical Management.

UnitedHealthcare West Supplement

Applicability of This Supplement

This supplement is intended for use by non-capitated physicians, health care professionals, facilities, ancillary care providers and their respective staff. Unless otherwise specified, any references to UnitedHealthcare West in this supplement are intended to apply to any or all of the entities and benefit plans listed below. This information is subject to change.

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, you are paid a set amount for each member assigned to you, whether or not that person seeks care. If you have a UnitedHealthcare West capitation agreement with us, this supplement does not apply to you.

Care providers who participate in the listed benefit plans are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location when applicable. For protocols, policies and procedures not referenced in this supplement please refer to appropriate chapter in the main guide.

You can identify a UnitedHealthcare West member by a reference to "West" on the back of their ID card. Information may vary in appearance or location on the card due to unique benefit plan requirements.

You 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 eligibilityLink.

Benefit Plans Referenced in this Supplement

We offer a wide range of products and services for employer groups, families and individual members. Benefit plan availability may vary. Contact us for more information about benefit plan availability and service areas where each of these products and supplemental benefits are available.

State	Products Offered	Benefits Plans
Arizona	Medicare Advantage (MA)	• AARP MedicareComplete® • UnitedHealthcare® Group Medicare Advantage
California	Commercial and MA	**Commercial:** UnitedHealthcare SignatureValue® family of products including but not limited to: • UnitedHealthcare SignatureValue • UnitedHealthcare SignatureValue Advantage • UnitedHealthcare SignatureValue VEBA • UnitedHealthcare SignatureValue Alliance • UnitedHealthcare SignatureValue Flex • UnitedHealthcare SignatureValue Focus **Medicare:** • AARP MedicareComplete® SecureHorizons® • Sharp® SecureHorizons® Plan by UnitedHealthcare® • UnitedHealthcare® Group Medicare Advantage
Colorado	MA	• AARP MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
Nevada	MA	• AARP MedicareComplete® • UnitedHealthcare® Group Medicare Advantage

State	Products Offered	Benefits Plans
California	Commercial	UnitedHealthcare Core℠* and Core Essential℠ *This UnitedHealthcare West Capitated Supplement does not apply to this benefit plan. Please refer to the main guide for regulations, processes and contact information
Oklahoma	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
Oregon	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP MedicareComplete® • UnitedHealthcare® Group Medicare Advantage
Texas	Commercial and MA	**Commercial:** • UnitedHealthcare SignatureValue® **Medicare:** • AARP MedicareComplete® • AARP MedicareComplete® SecureHorizons® • UnitedHealthcare® Chronic Complete • UnitedHealthcare Dual Complete® • UnitedHealthcare® Group Medicare Advantage
Washington	Commercial and MA	**Commercial:** • UnitedHealthcare® SignatureValue® **Medicare:** • AARP MedicareComplete® • UnitedHealthcare® Group Medicare Advantage

Commercial products

Commercial benefit plans consist of Health Maintenance Organizations (HMOs) or Managed Care Organizations (MCOs). Members access health services through a network primary care physician (PCP). PCPs manage the member's medical history and individual needs. HMOs/MCOs offer minimal paperwork and low, predictable out-of-pocket costs. Members pay a predetermined copayment or a percentage copayment each time they receive health care services.

MA products

Please reference *Chapter 4: Medicare Advantage Products* for a description of Medical Advantage (MA) products offered. You can see a complete list of health plans on UHCprovider.com/plans.

Administrative services are provided by the following affiliated companies: UnitedHealthcare Services, Inc. OptumRx or OptumHealth CareSolutions, Inc.

Behavioral health products are provided by U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California or United Behavioral Health operating under the brand Optum.

MA Special Needs Plans (SNP)

SNPs are part of the MA program. These plans are designed for members with unique health care needs. They offer benefits in addition to those covered under Original Medicare (including Part D prescription drug coverage) and intended to keep the member healthy and as independent as possible. UnitedHealthcare offers two types of MA SNPs within the plans covered by this supplement. These SNPs are currently only available in specific counties in the state of Texas.

UnitedHealthcare West Information Regarding our Care Provider Website

The UHCWest.com website was retired on Nov. 30, 2017 and redirects to UHCprovider.com, our care provider website. The News and Network Bulletin page has the latest information. Certain care providers will also receive notices by mail, where required by state law.

To access Link apps, go to UHCprovider.com and use the Link button in the upper right corner. Sign in with your Optum ID. Information on all available apps is on

UHCprovider.com/Link. We offer several live webinar options; information and registration is available on UHCprovider.com/training. For on-demand videos, go to the UHC On Air app on your Link dashboard and select the UHC News Now channel > Link > Provider Self-Service.

An Optum ID is required to access Link and perform online transactions, such as eligibility verification, claims status, claims reconsideration, referrals, and prior authorizations. To get an Optum ID, go to UHCprovider.com/newuser to register for Link access.

For help with Link, call the UnitedHealthcare Connectivity Helpdesk at 866-842-3278, option 1, Monday through Friday 9 a.m. to 11 p.m. Central Time (CT).

How to Contact UnitedHealthcare West Resources

Resource	Where to go
Helpful Health Plan Service Phone Numbers	UHCprovider.com > scroll down to 'Support and Privacy, Contact Us'> Health Plan Support by State.
Policies and Medical Management Guidelines	**Online:** Benefit Interpretation Policies: UHCPprovider.com/policies > Commercial Policies > UnitedHealthcare SignatureValue/UnitedHealthcare Benefit Plan of California Benefit Interpretation Policies Medical Management Guidelines: UHCPprovider.com/policies > Commercial Policies > UnitedHealthcare SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guidelines.
Provider Website	UHCprovider.com
Preauthorization	To view the most current and complete Advance Notification List, including procedure codes and associated services, go to: **Online:** UHCprovider.com/priorauth, or Prior Authorization and Notification App on Link Arizona & Colorado **Medicare Advantage Phone: 800-746-7405** California, Oregon and Washington: SignatureValue, Medicare Advantage, direct contract network and medical group/IPA carve-out **Phone:** 800-762-8456 Nevada **Medicare Advantage Phone:** 888-866-8297 Texas and Oklahoma: Medicare Advantage, SignatureValue Inpatient Notification/Utilization Management **Phone:** 800-668-8139
Radiology-Advanced Outpatient Imaging Procedures CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online:** UHCprovider.com/radiology; select the Go to Prior Authorization and Notification App. **Phone:** 866-889-8054 Request prior authorization of radiology services as described in *Outpatient Radiology Notification/Prior Authorization Protocol* in Chapter 6: Medical Management.
Cardiology Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram Clinical Trials	**Online:** UHCprovider.com/cardiology; select the Go to Prior Authorization and Notification App. **Phone:** 866-889-8054 Request prior authorization of cardiology services as described in *Outpatient Cardiology Notification/Prior Authorization Protocol* in Chapter 6: Medical Management. See *Chapter 6: Medical Management*
Hospital Inpatient Notification (Non-delegated) Inpatient includes: Acute Inpatient, Skilled Nursing Admission, Long-Term Acute Care, Inpatient Rehabilitation Places of Service.	**Phone:** 800-799-5252 **Fax:** 800-274-0569 Mental health Medicare Advantage: 800-508-0088 Transplant: 866-300-7736 **Fax:** 888-361-0502

Resource	Where to go
EDI Support Encounter Collection, Submission & Controls, including ERA/835 transactions	Password and user ID are not required to review and access EDI information on UHCprovider.com. **Online:** UHCprovider.com/edi > EDI Contact > EDI Transaction Support Form **Phone:** 800-842-1109 (For UnitedHealthcare West ERA/835 questions, select option 4 and then option 2) **Email:** supportedi@uhc.com
Electronic Funds Transfer (EFT) Have claims payments deposited electronically or make changes to an existing EFT enrollment	**Link:** UnitedHealthcare West EFT app on your Link dashboard **Email:** paymentservicesuhcwest@uhc.com with questions about UnitedHealthcare West EFT.
United Voice Portal (Follow prompts to access information)	Commercial & Medicare Advantage HMO/ MCO: • California: 800-542-8789 • Arizona/Colorado/Nevada: 888-866-8297 • Oklahoma/Texas: 877-847-2862 • Oregon: 800-920-9202 • Washington MCO: 800-213-7356
Standard Commercial Member Appeals (Applies only to Commercial UnitedHealthcare Signature Value HMO/ MCO)	*California, Oklahoma, Oregon, Texas, Washington* **Mail:** Mailstop CA124-0160 P.O. Box 6107 Cypress, CA 90630 **Phone:** California: 800-624-8822 Oklahoma/Texas: 800-825-9355 Oregon/Washington: 800-932-3004 **Fax:** 866-704-3420
Medicare Advantage Member Appeals	Mailstop CA124-0157 P.O. Box 6106 Cypress, CA 90630 **Fax:** 888-517 7113 AARPMedicareComplete.com
Expedited Commercial Member Appeals (Applies only to Commercial UnitedHealthcare SignatureValue HMO/ MCO)	*California Oklahoma, Oregon, Texas, Washington* **Phone:** 888-277-4232 **Fax:** 800-346-0930
Urgent Clinical Appeals (medical or pharmacy appeals)	**Fax:** 800-346-0930
Pharmacy Services	Commercial products: UHCprovider.com • UHCprovider.com/specialtyrx • UHCprovider.com/pharmacy Medicare products: UHCMedicareSolutions.com > Our Plans > Medicare Prescription Drug Plans **Phone:** 800-711-4555 **Fax:** 800-527-0531
Mental Health/Substance Use, Vision or Transplant Services	See member's health care ID card for carrier information and contact numbers. You can view the member's health care ID when you verify eligibility on UHCprovider.com.

Resource	Where to go
California Language Assistance Program (applies only to commercial products in California)	**Online:** UHCprovider.com > UnitedHealthcare Links (scroll to bottom right) > Language Assistance **Phone:** 800-752-6096
Health Management and Disease Management Programs	**Phone:** 877-840-4085 **Fax** completed referral form to: 877-406-8212

Care Provider Responsibilities

Electronic Data Interchange

The fastest way for us to talk is electronically. Electronic Data Interchange (EDI) is the preferred method for doing business transactions. You can find more information in *Chapter 2: Provider Responsibilities and Standards*, or go online: **UHCprovider.com/edi**.

Panel Restriction

The issues of confidentiality and objective medical observations are the key in the diagnosis and treatment of our members. Therefore, the care provider or other licensed independent health care professional who is also a UnitedHealthcare member shall not serve as PCP for themselves or their dependents.

Monitor Eligibility

You are responsible for checking member eligibility within two business days prior to the date of service. You may be eligible for reimbursement under the Authorization Guarantee program described in the *Capitation and/or Delegation Supplement* for authorized services if you have checked and confirmed the member's eligibility within two business days before the date of service.

Member Eligibility

You must verify the member's eligibility each time they receive services from you. We provide several ways to verify eligibility:

- **Online:** **UHCprovider.com/eligibility** > eligibilityLink.
- **EDI:** 270/271 transactions through your vendor or clearinghouse
- **Phone:** (See *How to Contact UnitedHealthcare West Non-Capitated Resources* for specific numbers.)
- Electronic eligibility lists (upon request)

You can get more details regarding a specific member's benefit plan in the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage. Benefit plans may be addressed in procedures/protocols communicated by us. Details may include the following:

- Selection of a PCP;
- Effective date of coverage;
- Changes in membership status while a member is in a hospital or skilled nursing facility (SNF);
- Member transfer/disenrollment; or
- Removal of member from receiving services by a PCP

Health Care Identification (ID) Cards

Each member receives a health care ID card with information to help you submit claims accurately. Information may vary in appearance or location on the card due to payer or other unique requirements. Check the member's health care ID card at each visit, and keep a copy of both sides of the card for your records. Sample health care ID cards specific to the member are available when you verify eligibility online.

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

Services Provided to Ineligible Members (does not apply in CA)

If we provide eligibility confirmation indicating that a member is eligible at the time the health care services are provided, and it is later determined that the patient was not in fact eligible, we are not responsible for payment of services provided to the member, except as otherwise required by state and/or federal law. In such event, you are entitled to collect the payment directly from the member (to the extent permitted by law) or from any other source of payment.

California Prohibition Against Care Provider Rescission

California law requires that if:

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

Eligibility Verification Guarantee (TX Commercial)

We reimburse Texas care providers who request a guarantee of payment through the verification process. The verification is based on the participation agreement and the guidelines in Texas Senate Bill SB 418.

We will guarantee payment for proposed medical care or health care services if you provide the services to the member within the required timeframe. We reduce the payment by any applicable copayments, coinsurance and/or deductibles.

You must include the unique UnitedHealthcare West verification number on the claim form (Field 23 of CMS 1500 or Field 63 of UB-04).

You must request eligibility prior to rendering a service. Otherwise, we are not responsible for payment of those services. You are entitled to collect the payment directly from the member to the extent permitted by law or from any other source of payment.

Submit service verification requests to:

- **Phone:** 877-847-2862

  or

- **Mail:** Care Provider Correspondence
  P.O. Box 30975
  Salt Lake City, UT 84130-0975

Access & Availability: Exception Standards for Certain UnitedHealthcare West States

We monitor members' access to medical and behavioral health care to make sure that we have an adequate care provider network to meet the members' health care needs. We use member satisfaction surveys and other feedback to assess performance against standards.

We have established access standards for appointments and after-hours care. Exceptions or additions to those standards are shown in the following table.

Type of Care	Guideline
Regular or routine	UnitedHealthcare Standard: 14 calendar days Exceptions: California Commercial HMO: Members are offered appointments for non-urgent PCP within 10 business days of request, within 15 business days for non-urgent specialist request; Texas: Within three weeks for medical conditions.
Preventive care	UnitedHealthcare Standard: Four weeks Exceptions: California: Preventive care services and periodic follow-up care, including but not limited to standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. Texas: Within two months for child and within three months for adult. Medicare Advantage within 30 days.
Urgent exam (PCP or Specialist)	UnitedHealthcare Standard: Same day (24 hours) Exceptions: California Commercial Members: Within 48 hours when no prior authorization required, within 96 hours when prior authorization required.
In-office wait time	California Members: In-office wait time is less than 30 minutes.
Referral process	Notification to the member should be completed in a timely manner, not to exceed five business days of a request for non-urgent care or 72 hours of a request for urgent care.
Non-urgent ancillary (diagnostic)	15 business days

1. Our members must have access to all physicians and support staff who work for you and must not be limited to particular physicians. We recognize that some substitution between physicians who work out of the same office/building may occur due to urgent/emergent situations.
2. Members must have access to appointments during all normal office hours and not be limited to appointments on certain days or during certain hours.
3. Members must have access to the same time slots as all other patients who are not our members.

4. You must work cooperatively with our Medical Management Department toward*:
   - Managing inpatient and outpatient utilization; and
   - Member care and member satisfaction;
5. Use your best efforts to refer members to our network care providers. You must use only our network laboratory and radiology care providers unless specifically authorized by us.

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

- The timeliness standards require licensed health care providers to offer members appointments that meet the California time frames. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.
- Triage or screening services by phone must be provided by licensed staff 24 hours per day, seven days per week. Unlicensed staff persons shall not use the answers to those questions in an attempt to assess, evaluate, advise or make any decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.
- UnitedHealthcare of California managed care members and covered persons of UnitedHealthcare Insurance Company benefit plans have access to free triage and screening services 24 hours a day, seven days a week through Optum's NurseLine at 866-747-4325.

Notification of Practice or Demographic Changes

All demographic changes, open/closed status, product participation or termination should be reported to us.

For complete information please the *Demographic Changes* section of Chapter 2: Provider Responsibilities and Standards.

California Commercial Benefit Plans—As of July 1, 2016, California Senate Bill 137 requires us to perform ongoing updates to our care provider directories, both online and hardcopy. As a participating medical group, IPA or independent physician, you are required to update UnitedHealthcare within five business days if there are any changes to your ability to accept new patients.

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

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

You shall cooperate with and provide the necessary information to us so we may meet the requirements of Senate Bill 137.

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

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

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

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

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** for the Provider Demographic Change Submission Form and further instructions.

Compliance with the Medical Management Program

Complying with the Medical Management Program includes but is not limited to:

- Allowing our staff to have onsite access to members and their families while the member is an inpatient;
- Allowing our staff to participate in individual case conferences;

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

- Facilitating the availability and accessibility of key personnel for case reviews and discussions with the medical director or designee representing UnitedHealthcare West, upon request; and
- Providing appropriate services in a timely manner.

Benefit Interpretation Policies & Medical Management Guidelines

A complete library of Benefit Interpretation Policies (BIPs), and Medical Management Guidelines (MMGs), is available on UHCprovider.com/policies > Commercial Policies > UnitedHealthcare SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Polices or UnitedHealthcare SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guidelines.

The first calendar day of every month, we publish the BIP and MMG Update Bulletins. These are online resources that provide notice to our network care providers of changes to our BIPs and MMGs. The bulletins are posted on:

- UHCprovider.com/policies > Commercial Policies > UnitedHealthcare SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policies > Benefit Interpretation Policy Update Bulletins, and
- UHCprovider.com/policies > Commercial Policies > UnitedHealthcare SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guidelines > Medical Management Guideline Update Bulletins.

As a supplemental reminder to the detailed policy update summaries announced in the BIP and MMG Update Bulletins, a list of recently approved, revised and/or retired BIPs and MMGs is also included in the monthly Network Bulletin available on UHCprovider.com/news.

Continuity of Care

Continuity of care is a short-term transition period, allowing members to temporarily continue to receive services from a non-participating care provider.

Examples of an Active Course of Treatment Considered for Continuity of Care

- **An Acute Condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services provided for the duration of the acute condition.
- **A Serious Chronic Condition** is a medical condition due to disease, illness, medical problem, mental health problem, or medical or mental health disorder that is serious in nature and that persists without full cure or worsens over an extended period, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services provided for the period necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a network care provider. The active course of treatment is determined by a UnitedHealthcare West or medical group/IPA medical director in consultation with the member, the terminated care provider or the non-network care provider and as applicable, the receiving network care provider, consistent with good professional practice. Completion of covered services for this condition will not exceed 12 months from the participation agreement's termination date, or 12 months after the effective date of coverage for a newly enrolled member.
- **A Terminal Illness** is an incurable or irreversible condition that has a high probability of causing death within one year. Completion of covered services may be provided for the duration of the terminal illness, which could exceed 12 months, provided that the prognosis of death was made by the: (i) terminated care provider prior to the participation agreement termination date, or (ii) non-network care provider prior to the newly enrolled member's effective date of coverage with UnitedHealthcare West.
- **A Pregnancy** diagnosed and documented by the: (i) terminated care provider prior to termination of the participation agreement, or (ii) by the non-network care provider prior to the newly enrolled member's effective date of coverage with UnitedHealthcare West. Completion of covered services provided for the duration of the pregnancy and immediate postpartum period.
- **The Care of a Newborn** service provided to a child between birth and age 36 months. Completion of covered services will not exceed (i) 12 months from participation agreement, termination date, (ii) 12 months from the newly enrolled member's effective date of coverage with UnitedHealthcare West, or (iii) the child's third birthday.
- **Surgery or Other Procedure** Performance of a surgery or other procedure that authorized by UnitedHealthcare West or the member's assigned network care provider. Parts of a documented course of treatment have been recommended and documented by (i) the terminating care provider to occur within 180 calendar days of the participation agreement's termination date, or (ii) the non-network care provider to occur within 180 calendar days of the newly enrolled member's effective date of coverage with UnitedHealthcare West.

Continuity of care does not apply when a member initiates a change of PCP or medical group/IPA. Authorizations granted by the previous medical groups shall be invalid in such situations at the commencement of the member's assignment to the new PCP or medical group/IPA; members shall not be entitled to continuing care unless the member's new PCP or medical group/IPA authorizes that care.

Virtual Visits (Commercial HMO Plans CA only)

UnitedHealthcare of California added a new benefit for Virtual Visits to some member benefit plans in January 2017. We define Virtual Visits as primary care services that include the diagnosis and treatment of low-acuity medical conditions for members through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology.

Virtual Visit primary care services are delivered by the care provider groups covered under professional capitation. Not all UnitedHealthcare West benefit plans will have the Virtual Visit benefit option.

To read more about Virtual Visits, refer to the *Capitation and Delegation Provider Supplement*.

Utilization and Medical Management

Medical Emergencies & Emergency Medical Conditions

For benefit plan definitions of an emergency refer to the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable. Additional definitions are found in our glossary.

Direct the member to call 911, or its local equivalent, or to go to the nearest emergency room. Prior authorization or advance notification is not required for emergency services. However, you should tell us about the member's emergency calling 800-799-5252 between 8 a.m. and 5 p.m. Monday through Friday.

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

Urgently Needed Services

Please check the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable, for the benefit plan definition of urgent care. For our commercial members, you must contact the member's PCP or hospitalist on arrival for urgently needed services. These services should be requested by calling 800-799-5252 between 8 a.m. and 5 p.m., Monday through Friday.

Routine Authorizations

We consider all other services as routine. To request preauthorization, the PCP must enter all the necessary information into UHCprovider.com/priorauth, contact the delegated medical group for approval, or complete and submit the appropriate Preauthorization Request Form. Routine and urgent requests are responded to within the following time frames, if all required clinical information is received:

Product	State	Time frame
Medicare Advantage Urgent	All	72 hours
Medicare Advantage Routine	All	14 calendar days
Commercial Urgent	OR, WA	2 business days
	CA, OK	72 hours
	TX	3 calendar days
Commercial Routine	OR, WA	2 business days; exception: - A delay of decision (DOD) letter
	CA	5 business days; exception: - A delay of decision (DOD) letter
	OK	15 calendar days
	TX	3 calendar days

Authorization Status Determination

Only a physician (or pharmacist, psychiatrist, doctoral-level clinical psychologist or certified addiction medicine specialist, as applicable and appropriate) may determine whether to delay, modify or deny services to a member for reasons of medical necessity.

Prior Authorization Process

A list of services that require prior authorization is available on UHCprovider.com/priorauth.

We will deny payment for services you provide without the required prior authorization. Such services are the care provider's liability, and you cannot bill the member.

Primary Care Services

Most PCP services do not require prior authorization. However, if prior authorization is required, the following guidelines apply:

1. The PCP/requesting care provider is responsible for verifying eligibility and benefits prior to rendering services.
2. To request prior authorization, use our online processes, contact the delegated medical group, or complete and submit the appropriate prior authorization request form (unless the services are required urgently or on an emergency basis). The completed form must include the following information:
   - Member's presenting complaint,
   - Physician's clinical findings on exam,
   - All diagnostic and lab results relevant to the request,
   - Conservative treatment that has been tried,

- Applicable CPT and ICD codes.

3. The fastest way to check the status of a treatment request is online.
4. If approved, the treatment request is given a reference number that can be viewed when you check the status, or by contacting the delegated medical group, or faxed back to the physician office depending on how the PCP/servicing care provider submitted the form.
5. Notate the reference number on the claim when you submit it for payment.
6. All authorizations expire 90 calendar days from the issue date.
7. Participating care providers should refer members to network care providers. Referrals to non-network care providers require prior authorization.
   - If no network care providers can be identified within the member's service area for a necessary service, the PCP/servicing care provider must submit a completed UnitedHealthcare West *Prior Authorization Request Form* to us with the name of the proposed non-network care provider for approval, as appropriate. The *Prior Authorization Request Form* can be found on **UHCprovider.com/priorauth** > scroll down to "Fax Forms."
8. Once the PCP refers a member to a network specialist, that specialist may see the member as needed for the referring diagnosis. The specialist is not required to direct the member back to the PCP to order tests and/or treatment.
9. If a specialist feels a member needs other services related to the treatment of the referral diagnosis, the specialist may refer the member to another participating care provider.

We or our delegates conduct reviews throughout a member's course of treatment. Multiple prior authorizations may be required throughout a course of treatment because prior authorizations are typically limited to specific services or time periods.

Serious or Complex Medical Conditions

The PCP should identify members with serious or complex medical conditions and develop appropriate treatment plans for them, along with case management. Each treatment plan should include a prior authorization for referral to a specialist for an adequate number of visits to support the treatment plan.

Specialty Care (Including Gynecology) in an Office-Based Setting

We send the status of the prior authorization request (approved as requested, approved as modified, delayed, or denied) to the specialist by fax or online. For those services that do not require prior authorization, the PCP sends a referral request directly to the specialists.

1. All specialist authorizations will expire 90 calendar days from the date of issuance.
2. Plain film radiography rendered by a network care provider, or in the specialist's office in support of an authorized visit, does not require prior authorization.
3. Routine lab services performed in the specialist's office, or are provided by a designated participating care provider in support of an authorized visit, do not require prior authorization.
4. Members may self-refer to a gynecologist who is a participating care provider for their annual routine gynecological exams. For women's routine and preventive health care services, female MA members may self-refer to a women's health specialist who is a participating care provider.
5. Female MA members older than 40 years may self-refer to a participating radiology care provider for a screening mammogram.

Note: Mammograms may require prior authorization in California.

Obstetrics

1. A member may self-refer to an obstetrician who is a participating care provider for routine obstetrical (OB) care. If the member is referred by their PCP to a non-participating health care specialist, the specialist must notify us using online tools, or by fax at the number designated on the top of the **Prior Authorization Form**, to help ensure accurate claims payment for ante- and postpartum care.
2. Routine OB care includes office visits and two ultrasounds.
3. Plain film radiography that is performed by a participating care provider or in the obstetrician's office in support of an authorized visit, does require prior authorization.
4. Routine labs performed in the obstetrician's office, or provided by a participating care provider in support of an authorized visit, do not require prior authorization.
5. Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician's office that do not require prior authorization may be performed.

Second Opinions (California Commercial Plans)

We authorize and provide a second opinion by a qualified health care professional for members who meet specific criteria. A second opinion consists of one office visit for a consultation or evaluation only. Members must return to their assigned PCPs for all follow-up care. For purposes of this section, a qualified health care professional is defined as a PCP or specialist who is acting within the scope of practice and who possesses a clinical background, including training and expertise related to the member's particular illness, disease or condition.

The PCP may request a second opinion on behalf of the member in any of the following situations:

- The member questions the reasonableness or necessity of a recommended surgical procedure.
- The member questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, or bodily function or threatens substantial impairment, including, but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt due to conflicting test results.
- The treating care provider is unable to diagnose the condition.
- The member's medical condition is not responding to the prescribed treatment plan within an appropriate period of time, and the member is requesting a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the treatment plan or has consulted with the treating care provider and has serious concerns about the diagnosis or treatment plan.

Turnaround Time for Second Opinion Reviews

We process requests for a second opinion in a timely manner to accommodate the clinical urgency of the member's condition and in accordance with established utilization management procedures and regulatory requirements. When there is an imminent and serious threat to the member's health, we or our delegate will make the second opinion determination within 72 hours after receipt of the request.

An imminent and serious threat includes the potential loss of life, limb, or other major bodily function. It can also be where a lack of timeliness would be detrimental to the member's ability to regain maximum function. For more detailed information and benefit exclusions, refer to UHCprovider.com/policies:

- Medicare Advantage Coverage Summary titled Second and Third Opinions, or
- Member Initiated Second and Third Opinion: CA, or
- Member Initiated Second and Third Opinion: OK, OR, TX, WA

Ventricular Assist Device (VAD)/Mechanical Circulatory Support Device (MCSD) Services/Case Management

We request that you notify the case management department when a member referred for evaluation, authorized for:

- VAD/MCSD and admitted for VAD/MCSD and/or may meet criteria for service denial.
- VAD/MCSD evaluations and surgery should be performed a facility in Optum's VAD Network, or facility approved by UnitedHealthcare West medical directors, to align with heart transplant service centers.

Post-Stabilization Care

Members are covered for post-stabilization services following emergency services.

Post-stabilization care is considered approved if we do not respond within one hour of the request for post-stabilization care or we cannot be contacted for pre-approval.

Extension of Prior Authorization Services

The specialist must request an extension of prior authorization online, by contacting the delegated Medical Group, or by fax, if they desire to perform services:

- Beyond the approved visits;
- Beyond the allotted time frame of the approval (typically 90 calendar days);
- In addition to the approved procedures, and/or diagnostic or therapeutic testing.

The extension must be authorized before care is rendered to the member. The request for extension of services must include the following information:

- Member's presenting complaint;
- Care provider's clinical findings on exam;
- All diagnostic and laboratory results relevant to the request;
- All treatment that has been tried;
- Applicable CPT and ICD codes; and
- Requested services (e.g., additional visits, procedures).

The existing authorization is reviewed by the receiving party, who mails or faxes a response to the care provider and/or makes the information available online There is no need to contact the member's PCP.

Hospital Notifications

Independent from prior authorization, notification by the facility is required for inpatient admissions on the day of admission for urgent/emergent, scheduled/elective, medical, surgical, out-of-area, hospice and obstetrical services.

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

Definition of Facility-Based Outpatient Surgery (CA, OR, WA and NV)

Facility-Based Outpatient Surgery services are defined using CMS Guidelines, CPT/HCPCS coding conventions, as well as clinical and/or proprietary standards. The following denotes services considered Facility-Based Outpatient Surgery services under this definition:

- A procedure with an ASC grouping assigned as of 2007;

- A procedure with a global period of 90 days (according to the care provider fee schedule);
- Core needle biopsies;
- Unlisted or new codes may be considered surgery in the following situations:
  - Unlisted or new code is related to other codes in the same APC group that had an ASC assigned as of 2007, it is considered Facility-Based Outpatient Surgery.
- A procedure with surgical risk or anesthetic risk as determined by clinical review.

Admission Notification

Facilities are responsible for for notifying us of all member inpatient admissions including:

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- SNF admissions
- Admissions following outpatient surgery
- Admissions following observation
- Newborns admitted to Neonatal Intensive Care Unit (NICU)
- Newborns who remain hospitalized after the mother is discharged (notice required within 24 hours of the mother's discharge)

We must receive the admission notification within 24 hours after actual weekday admission (or by 5 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or holiday). For weekend and holiday admissions, we must receive the notification by 5 p.m. local time on the next business day.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within the member's benefit plan, the facility being eligible for payment, compliance with claim processing requirements, and the facility's participation agreement with UnitedHealthcare.

Admission notifications must contain the following details regarding the admission:

- Member name, health care ID number, and date of birth
- Facility name and TIN or NPI
- Admitting/attending physician name and TIN or NPI
- Description for admitting diagnosis or ICD-10-CM diagnosis code
- Actual admission date
- Primary medical group/IPA

For emergency admissions where a member is unstable and not capable of providing coverage information, the facility should notify us by phone or fax within 24 hours (or the next business day, for weekend or holiday admissions) from the time the information is known and communicate the extenuating circumstances.

The following reports must be faxed daily to our Clinical Information Department:

- Census report for all our members;
- Discharge report; and
- Face sheets to report outpatient surgeries and SNF admissions; or
- Inpatient Admission Fax Sheet to report "no UnitedHealthcare West admissions" for that day.

The census report or face sheets must include the following information:

- Primary medical group/IPA
- Admit date
- Member name (first and last) and date of birth
- Bed type/accommodation status/level of care (LOC)
- Expected length of stay (LOS)
- Admitting physician
- Admitting diagnosis (ICD-10-CM)
- Procedure/surgery (CPT Code) or reason for admission
- Attending physician
- Facility
- Address/city/state
- Policy number/member health care ID number
- Other insurance
- Authorization number (if available)
- Discharge report, including member demographic information, discharge date and disposition

Coordination of Care

Facilities are required to assist in the coordination of a member's care by:

- Working with the member's PCP;
- Notifying the PCP of any admissions; and
- Providing the PCP with discharge summaries.

After Hour Admissions/SNF Transfers

- For admissions or transfers after hours or on weekends, the member should be admitted to the appropriate facility at the appropriate level of care. Authorization must be obtained on the next business day.
- Transfers/admissions to SNFs can be admitted directly from the emergency room or home to a SNF.

Out-of-Network Admissions

- A referral/transfer to a non-network facility requires prior authorization. However, in the case of an emergency,

a non-participating hospital may be used without prior authorization.

- After initial emergency treatment and stabilization, we may request that a member be transferred to a network hospital, when medically appropriate.
- If a PCP directs a member to a non-network hospital for non-emergent care without prior authorization, the PCP may be held responsible.

Consultation with Providers During Inpatient Stays

Authorization is not required for a consultation with a participating network care provider during an inpatient stay. However, consultation with a non-network care provider requires prior authorization.

Concurrent Review

We conduct concurrent review on all admissions from the day of admission through the day of discharge. Concurrent review is performed by phone, as well as onsite at designated facilities, by clinical staff. We have established procedures for onsite concurrent review which include: (a) guidelines for identification of our staff at the facility; (b) processes for scheduling onsite reviews in advance; and (c) staff requirements to follow facility rules. If the clinical reviewer determines that the member may be treated at a lower level of care or in an alternative treatment setting, we discuss the case with the hospital case manager and the admitting physician. If a discrepancy occurs, our medical director or designee discusses the case with the admitting physician.

Variance Days

Variance days are days we determine inpatient care coordination and provision of diagnostic services are not medically necessary or are not provided in a timely manner contributing to delays in care. We adjust reimbursement accordingly. Our concurrent review staff attempts to minimize variance days by working with the attending physicians and hospital staff. If a variance is noted in the patient's acute care process, our concurrent review staff discusses the variance with the hospital's medical management/case management representative. If the variance exists after the discussion, our concurrent review staff documents the variance in our utilization records and submits to a UnitedHealthcare concurrent review manager for approval. If approved, the variance is entered into our database as a denial of reimbursement for the variance time period. We mail a letter to the facility stating the variance type and time period. The facility may appeal the variances in writing.

Our medical director will review the appeal and render a decision to overturn or uphold the decision.

Medical Observation Status

We authorize hospital observation status when medically appropriate. Hospital observation is generally designed to evaluate a member's medical condition and determine the need for actual admission, or to stabilize a member's condition and typically lasts less than 48 hours. For MA members, we also follow any applicable CMS guidelines to determine whether observation services are medically appropriate. Typical cases, when observation status is used, include rule-out diagnoses and medical conditions that respond quickly to care. Members under observation status may later convert to an inpatient admission if medically necessary.

Emergency and/or Direct Urgent Admissions (Commercial Plans)

If a hospital does not receive authorization from us within one hour of the initial call requesting authorization, the emergent and/or urgent services prompting the admission are assumed to be authorized and should be documented as such to us until we direct or arrange care for the member. Once we become involved with managing or directing the member's care, all services provided must be authorized by us.

Skilled Nursing Facilities

Before transfer/admit to a SNF, we must approve the member's treatment plan. The member's network physician must perform the initial physical exam and complete a written report within 48 hours of a member's admission to the SNF. We perform an initial review and subsequent reviews as we deem necessary. Federal and state regulations require that members at SNFs be seen by a physician at least once every 30 calendar days.

Discharge Planning

The initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

- Assessment and documentation of the member's needs as compared to those upon admission, including the member's functional status and anticipated discharge disposition, if other than a discharge to home;
- Development of a discharge plan, including evaluation of the member's financial and social service needs and potential need for post-hospital services, such as home health, DME, and/or placement in a SNF or custodial care facility;
- Approved authorizations for necessary post-discharge plan, as required by us;
- Organization, communication and execution of the discharge plan;
- Evaluation of the effectiveness of the discharge plan;
- Referrals to population-based disease management and case management programs, as indicated.

For after-hours or weekend discharges requiring home health and/or DME, facility should arrange the care and obtain authorization on the next business day.

Retrospective Review (Medical Claim Review)

Medical claim review, also known as medical cost review, medical bill review and/or retrospective review, is the examination of the medical documentation and/or billing detail after a service has been provided. Medical claim review is performed to provide a fair and consistent means to retrospectively review medical claims and make sure medical necessity criteria are met, confirm appropriate level of care and length of stay, correct payer source, and identify appropriate potential unbundling and/or duplicate billing occurrences.

The review includes an examination of all appropriate claims and/or medical records against accepted billing practices and clinical guidelines as defined by entities such as CMS, AMA, CPT coding and MCG™ Care Guidelines depending on the type of claims submitted.

Claims that meet any of the following criteria are reviewed before the claim is paid:

- High-dollar claims;
- Claims without required authorization;
- Claims for unlisted procedures;
- Trauma claims;
- Claims for implants that are not identified or inconsistent with the UnitedHealthcare West's Implant Guidelines;
- Claim check or modifier edits based on our claim payment software;
- Foreign country claims; and
- Claims with LOS or LOC mismatch.

To help ensure timely review and payment determinations, you must respond to requests for all appropriate medical records within seven calendar days from receipt of the request, unless otherwise indicated in your agreement.

We may review specific claims based on pre-established retrospective criteria to make sure acceptable billing practices are applied.

For hospital care providers, we may reduce the payable dollars if line item charges have been incorrectly unbundled from room and board charges.

Minimum Content Denials, Delays, or Modification Requests

If we deny, delay delivery, or modify a request for authorization for health care services, our written or electronic notices will, at a minimum, include the following:

- The specific service(s) denied, delayed in delivery, modified or partially approved;
- The specific reference to the benefit plan provisions to support the decision;
- The reason the service is being denied, delayed in delivery, modified, or partially approved, including:
  - Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision;
  - Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based;
  - Clinical reasons for decisions regarding medical necessity; and
  - Contractual rationale for benefit denials.
- Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
- Notification that the member's physician can request a peer-to-peer review;
- Alternative treatment options offered, if applicable;
- Description of any additional material or information necessary from the member to complete the request, and why that information is necessary;
- Description of grievance rights and an explanation of the appeals and grievances processes, including:
  - Information regarding the member's right to appoint a representative to file an appeal on the member's behalf;
  - The member's right to submit written comments, documents or other additional relevant information;
  - Information notifying the member and their treating care provider of the right to an expedited appeal for time- sensitive situations (not applicable to retrospective review);
  - Information regarding the member's right to file a grievance or appeal with the applicable state regulatory agency, including information regarding the independent medical review process, as applicable;
  - Information that the member may bring civil action, under Section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable (Commercial products);
  - For the treating care provider, the name and direct phone number of the health care professional responsible for the decision.

Pharmacy Network

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

A member who obtains a prescription from a non-network pharmacy will not be eligible for reimbursement of any charges incurred unless the prescription received was not available from a participating pharmacy site (e.g., urgent or emergent prescriptions, after hours, out of the service area, or Part D-covered vaccines provided by the care provider).

Mail Service

Each UnitedHealthcare West member with a prescription drug benefit is eligible to use our prescription mail service.

When appropriate, you can write prescriptions for a three-month 90 calendar day supply and up to three additional refills. Only medications taken for chronic conditions should be ordered through the mail. The member may obtain acute prescription needs, such as antibiotics and pain medications, through a network pharmacy site to avoid delay in treatment.

You may also elect to discourage members from using the mail service for medications where large quantities dispensed at one time to the member may pose a problem (e.g., tranquilizer).

Pharmacy Formulary

The UnitedHealthcare SignatureValue formulary includes most generic drugs/medications and a broad selection of brand name drugs/medications. Prescription drugs and medications listed on the formulary are considered a covered benefit. However, select formulary medications may require prior authorization to be covered.

Any prescription for a non-formulary drug is the member's financial responsibility, unless the member meets the criteria for coverage of a non-formulary drug and the care provider requests and receives prior authorization for such drug. Additionally, certain drugs may be excluded from the benefit plan.

Many members have a three-tier pharmacy benefit plan with coverage of formulary generics, formulary brand name drugs, and non-formulary drugs. A prior authorization process may apply to certain non-formulary drugs.

We update the formulary twice a year, in January and July. Care provider requests for formulary review of medications or pre-authorization guidelines are welcome. You can find formulary changes on **UHCprovider.com/pharmacy**, or **UHCprovider.com/priorauth** > Clinical Pharmacy and Specialty Drugs.

Non-Formulary Medications

Non-formulary prescriptions/medications not provided as a plan benefit are the member's financial responsibility, unless the prescribing care provider requests and receives prior authorization for the non-formulary medications and the member meets criteria for coverage.

Commercial plan members may also have coverage when their employer purchases an Open Formulary or Buy-up Plan. The member may be charged the usual and customary cost of the medication or the non-formulary copayment depending on the member's benefit design.

Drug Utilization Review Program

UnitedHealthcare West is dedicated to working with our network care providers to supply information and education needed for effective management in growing cost of pharmaceutical care. Our clinical pharmacists can identify and analyze areas where care providers may be able to prescribe products considered effective as well as economical.

Additionally, our pharmacy staff can help identify when a more detailed review of therapy may improve member care, such as:

- Overuse of controlled substances
- Duplicate therapies
- Drug interactions
- Polypharmacy

Through pharmacist review and information, care providers are given the data needed to better manage the quality of their members' care while also managing pharmacy program costs.

Prior Authorization Process

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

You can request an authorization by:

- Online: OptumRx.com > **Healthcare Professionals** > Prior Authorizations.

This online service enables physicians and health care professionals to submit a real- time prior authorization request 24 hours per day, seven days per week. After logging on at **OptumRx.com** with their unique National Provider Identifier (NPI) number and password, you 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, and
- Fax: 800-853-3844 for injectable/specialty medications.

California Commercial HMO and PPO products: Prescribing providers in California must use the *Prescription Drug Prior Authorization Request Form* when submitting authorization requests to **OptumRx**.

- California Health and Safety Code 1367.241 and California Code of Regulations, Chapter 28, section 1300.67.241. Section 1300.67.241 to Title 28 of the California Code of Regulations (CCR).
- Article 1.2 Section 2218.30 to the California Code of Regulations (CCR) Title 10, Chapter 5, Subchapter 2.

Also, the California utilization management delegates may have contractual responsibilities for payment of certain prescription medications. When the delegate requires prior authorization for use of those drugs prescribed by their care providers, the delegate must also require the use of Optum's *Prescription Drug Prior Authorization Request Form*. The delegate must have a policy and process in place and be able to demonstrate compliance.

Claims Process

Instructions and quick tips for EDI can be found on **UHCprovider.com/edi**.

Claims and Encounters

EDI is the preferred method of claim submission for participating physicians and health care providers. Submit all professional and institutional claims and/or encounters electronically for UnitedHealthcare West and Medicare Advantage HMO product lines.

The payer ID is an identification number that instructs the clearinghouse where to send your electronic claims and encounters. In some cases, the payer ID listed on **UHCprovider.com/edi** may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must validate with your clearinghouse for the appropriate payer ID number or refer to your clearinghouse published Payer Lists.

Please refer to our online **Companion Guides** for the data elements required for these transactions found on **UHCprovider.com/edi**.

For information on EDI claim submission methods and connections, go to **EDI 837: Electronic Claims**.

OptumInsight Connectivity Solutions, UnitedHealthcare's managed gateway, is also available to help you begin submitting and receiving electronic transactions. For more information, call 800-341-6141.

Submit your claims and encounters and primary and secondary claims as EDI transaction 837.
For UnitedHealthcare West encounters, the payer ID is 95958. For claims, the payer ID is 87726. For a complete list of payer IDs, refer to the **Payer List for Claims**.

Do not resubmit claims that were either denied or pended for additional information using EDI or paper claims forms. Use the **ClaimsLink** application on Link.

Electronic Funds Transfer

Now you can enroll or make changes to Electronic Funds Transfer (EFT) and ERA/835 for your UnitedHealthcare West claims using the UnitedHealthcare West EFT Enrollment app. Enrollment in UnitedHealthcare West EFT currently applies to payments from SignatureValue and MA plans only. You'll continue to receive checks by mail until you enroll in UnitedHealthcare West EFT. View our Payer List for ERA **Payer List for ERA** to determine the correct payer ID to use for ERA/835 transactions.

To access the UnitedHealthcare West EFT Enrollment app, **UHCprovider.com/eps**, then click on the UnitedHealthcare West EFT Enrollment App.

For more information go to **UHCprovider.com/claims**, scroll down to "Enroll or Change Electronic Funds Transfer (EFT) for UnitedHealthcare West," and open the UnitedHealthcare West EFT Enrollment App Overview document.

Claims Adjudication

We use industry claims adjudication and/or clinical practices, state and federal guidelines, and/or our policies, procedures and data to determine appropriate criteria for payment of claims. To find out more, please contact your network account manager, physician advocate or hospital advocate or visit **UHCprovider.com/claims**.

Complete Claims Requirements

We follow the *Requirements for Complete Claims and Encounter Data Submission*, as found in Chapter 9: Our Claims Process.

National Provider Identification

We are able to accept the National Provider Identification (NPI) on all HIPAA transactions, including the HIPAA 837 professional and institutional (paper and electronic) claim submissions. A valid NPI is required on all covered claims (paper and electronic) in addition to the TIN. For institutional claims, please include the billing provider National Uniform Claim Committee (NUCC) taxonomy. We will accept NPIs submitted through any of the following methods:

- **Online:** **UHCprovider.com/mypracticeprofile**.
- **Phone:** 877-842-3210 through the United Voice Portal, select the "Health Care Professional Services" prompt. State "Demographic changes." Your call will be directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.

Level-of-Care Documentation and Claims Payment

Claims are processed according to the authorized level of care documented in the authorization record, reviewing all claims to determine if the billed level of care matches the authorized level of care.

If the billed level of care is at a higher level than the authorized level of care, we pay you the authorized level of care. You may not bill the member for any charges relating to the higher level of care. If the billed level of care is at a lower level than authorized, we pay you based on the lower level of care, which was determined by you to be the appropriate level of care for the member.

Level of Specificity — Use of Codes
To track the specific level of care and services provided to its members, we require care providers to utilize the most current service codes (i.e., ICD-10-CM, UB and CPT codes). We also require that you make sure the documented bill type is appropriate for the type of service provided.

Member Financial Responsibility

You can verify the eligibility of our members before you see them and obtain information about their benefits, including required copayments and any deductibles, out-of-pockets maximums or coinsurance that are the member's responsibility.

No Balance Billing
You may not balance bill our members. You may not collect payment from the member for covered services beyond the member's copayment, coinsurance, deductible, and for non-covered services the member specifically agreed on in writing before receiving the service. In addition, you shall not bill a UnitedHealthcare West member for missed office visit appointments.

Claims Status Follow-up

We can provide you with an Explanation of Payment (EOP). If you don't get one, you can follow-up on the status of a claim using one of the following methods:

- **EDI:** 276/277 Claim Status Inquiry and Response transactions are available through your vendor or clearinghouse.
- **Online:** UHCprovider.com/claimsLink; you get real-time data, and it's the quickest method for claim status information.
- **Phone:** See *How to Contact UnitedHealthcare West Non-Capitated Resources* sections for telephone numbers. This system provides a fax of the claim status detail information that is available.

Claims Submission Requirements

You can mail paper CMS 1500 or UB-04s to the address listed on the member's health care ID card. Refer to the *Prompt Claims Processing* section of Chapter 9: Our Claims Process, for more information about electronic claims submission and other EDI transactions. If your claim is the financial responsibility of a UnitedHealthcare West delegated entity (e.g., PMG, MSO, Hospital), then bill that entity directly for reimbursement.

Claims Submission Requirements for Reinsurance Claims for Hospital Providers
If covered services fall under the reinsurance provisions set forth in your agreement with us, follow the terms of the agreement to make sure:

- The stipulated threshold has been met;
- Only covered services are included in the computation of the reinsurance threshold;
- Only those inpatient services specifically identified under the terms of the reinsurance provision(s) are used to calculate the stipulated threshold rate;
- Applicable eligible member copayments, coinsurance, and/or deductible amounts are deducted from the reinsurance threshold computation;
- The stipulated reinsurance conversion reimbursement rate is applied to all subsequent covered services and submitted claims;
- The reinsurance is applied to the specific, authorized acute care confinement; and
- Claims are submitted in accordance with the required time frame, if any, as set forth in the agreement. In addition, when submitting hospital claims that have reached the contracted reinsurance provisions and are being billed in accordance with the terms of the agreement and/or this supplement, you shall:
  - Indicate if a claim meets reinsurance criteria; and
  - Make medical records available upon request for all related services identified under the reinsurance provisions (e.g., ER face sheets).

If a submitted hospital claim does not identify the claim as having met the contracted reinsurance criteria, we process the claim at the appropriate rate in the agreement. An itemized bill is required to compute specific reinsurance calculations and to properly review reinsurance claims for covered services.

Interim Bills

We adjudicate interim bills at the per diem rate for each authorized bed day billed on the claim and reconcile the complete charges to the interim payments based on the final bill.

The following process will increase efficiencies for both us and the Hospital/SNF business offices:

- 112 Interim – First Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 113 Interim – Continuing Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).

- 114 Interim – Last Claim: Review admits to discharge and discharge and apply appropriate contract rates, including per diems, case rates, stop loss/outlier and/or exclusions. The previous payments will be adjusted against the final payable amount.

Reciprocity Agreements

You shall cooperate with our participating care providers and our affiliates and agree to provide services to members enrolled in benefit plans and programs of UnitedHealthcare West affiliates and to assure reciprocity with providing health care services.

If any member who is enrolled in a benefit plan or program of any UnitedHealthcare West affiliate, receives services or treatment from you and/or your subcontracted care providers (if applicable), you and/or your subcontracted care providers (if applicable), agree to bill the UnitedHealthcare West affiliate at billed charges and to accept the compensation provided pursuant to your agreement, less any applicable copayments and/or deductibles, as payment in full for such services or treatment.

You shall comply with the procedures established by the UnitedHealthcare West affiliate and this agreement for reimbursement of such services or treatment.

Overpayments

Please follow the instructions as indicated in the *Overpayments* section of *Chapter 9: Our Claims Process*.

End-Stage Renal Disease

If a member has or develops end-stage renal disease (ESRD) while covered under an employer's group benefit plan, the member must use the benefits of the plan for the first 30 months after becoming eligible for Medicare due to ESRD. After the 30 months elapse, Medicare is the primary payer. However, if the employer group benefit plan coverage were secondary to Medicare when the member developed ESRD, Medicare is the primary payer, and there is no 30-month period.

Medicaid (Applies Only to MA) Please follow the instructions as indicated in the *Member Financial Responsibility* section of *Chapter 10: Compensation*.

The calendar day we receive a claim is the receipt date, whether in the mail or electronically. The following date stamps may be used to determine date of receipt:

- Our Claims Department date stamp
- Primary payer claim payment/denial date as shown on the EOP
- Delegated provider date stamp
- TPA date stamp
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender

Note: Date stamps from other health benefit plans or insurance companies are not valid received dates for timely filing determination.

Time Limits for Filing Claims

You are required to submit to clean claims for reimbursement no later than 1) 90 days from the date of service, or 2) the time specified in your participation agreement, or 3) the time frame specified in the state guidelines, whichever is greater.

If you do not submit clean claims within these time frames, we reserve the right to deny payment for the claim(s). Claim(s) that are denied for untimely filing cannot be billed to a member.

We have claims processing procedures to help ensure timely claims payment to care providers. We are committed to paying claims for which we are financially responsible within the time frames required by state and federal law.

Care Provider Claims Appeals and Disputes

Claims Research and Resolution (Applies to Commercial in Oklahoma & Texas)

The Claims Research & Resolution (CR&R) process applies:

- If you do not agree with the payment decision after the initial processing of the claim; and
- Regardless of whether the payer was UnitedHealthcare West, the delegated medical group/IPA or other delegated payer, or the capitated hospital/provider, you are responsible for submitting your claim(s) to the appropriate entity that holds financial responsibility to process each claim.

UnitedHealthcare West researches the issue to identify who holds financial risk of the services and abides by federal and state legislation on appropriate timelines for resolution. We work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, care provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

Claim Reconsideration Requests (Does Not Apply in California)

You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). All rework requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines. The most efficient way to submit your requests is through the claimsLink app. Learn more on

UHCprovider.com > Service Links > Link Self-Service Tools. You can submit your request to us in writing by using the Paper Claim Reconsideration Form on UHCprovider.com/claims.

Please refer to the chart titled *UnitedHealthcare West Provider Rework or Dispute Process Reference Table* at the end of this section for the address to which your request should be sent.

Submission of Bulk Claim Inquiries

The Claims Project Management (CPM) team handles bulk claim inquiries. Contact the CPM team at the address below to initiate a bulk claim inquiry:

UnitedHealthcare West Bulk Claims Rework Reference Table

Provider's state	Contact information	Notes
Arizona	UnitedHealthcare Attn: WR Claims Project Management P.O. Box 52078 Phoenix, AZ 85072-2078	Submit requests for 20 or more claims.
California	Claims Research Projects CA120-0360 P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 19 or more claims.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983	Submit requests for 20 or more claims.
Nevada	For Medicare Advantage claims: UnitedHealthcare Attn: WR Claims Project Management Claims Research Projects P.O. Box 95638 Las Vegas, NV 89193-5638	The Nevada delegated payer handles bulk claim inquiries received from providers of service. The provider of service should submit the bulk claims with a cover sheet indicating "Appeal" or "Review" to the Claims Research Department at the designated address to initiate a bulk claim inquiry. Submit requests for 10 or more claims.
Oklahoma	Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967	Submit requests for 20 or more claims.
Oregon	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 10 or more claims.
Texas	Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975	Submit requests for 20 or more claims.
Washington	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 10 or more claims.

UnitedHealthcare West's Response
We respond to issues as quickly as possible.

- Reworks/disputes requiring clinical determination: Individuals with clinical training/background who were not previously involved in the initial decision review all clinical rework/dispute requests. We send a letter to you outlining our determination and the basis for that decision.
- Reworks/disputes requiring claim process determination: Individuals not previously involved in the initial processing of the claim review the rework/dispute request.
- Response details: If claim requires an additional payment, the EOP serves as notification of the outcome on the review. If the original claim status is upheld, you are sent a letter outlining the details of the review.

California: If a claim requires an additional payment, the EOP does not serve as notification of the outcome of the review. We send you a letter with the determination. In addition, payment must be sent within five calendar days of the date on the determination letter. We respond to you within the applicable time limits set forth by federal and state agencies. After the applicable time limit has passed, call Provider Relations at 877-847-2862 to obtain a status.

Care Provider Dispute Resolution (CA, OR, and WA Commercial Plans)

If you disagree with our claim determination, you may initiate a care provider dispute. You must submit a care provider dispute, in writing, and with additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement or state law dictate otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

The PDR process is available to provide a fair, fast and cost-effective resolution of care provider disputes, in accordance with state and federal regulations. We do not discriminate, retaliate against or charge you for submitting a care provider dispute. The PDR process is not a substitution for arbitration and is not deemed as an arbitration.

What to Submit
As the care provider of service, 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
- Your contract information

Disputes are not reviewed if the supporting documentation is not submitted with the request.

Where to Submit
State-specific addresses and other pertinent information regarding the PDR process may be found in the *UnitedHealthcare West Provider Rework or Dispute Process Reference Table* at the end of this section.

Accountability for Review of a Care Provider Dispute
The entity that initially processed/denied the claim or service in question is responsible for the initial review of a PDR request. These entities may include, but are not limited to, UnitedHealthcare West, the delegated medical group/IPA/payer or the capitated hospital/care provider.

Excluded From the PDR Process
The following are examples of issues excluded from the PDR process:

- A member has filed an appeal, and you have filed a dispute regarding the same issue. In these cases, the member's appeal is reviewed first. You can submit a care provider dispute after we make a decision on the member's appeal. If you are appealing on behalf of the member, we treat the appeal as a member appeal.
- An Independent Medical Review initiated by a member through the member appeal process.
- Any dispute you file beyond the timely filing limit applicable to you, and you fail to give "good cause" for the delay.
- Any delegated claim issue that has not been reviewed through the delegated payer's claim resolution mechanism.
- Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or capitated hospital/care provider and does not involve an issue of medical necessity or medical management.

UnitedHealthcare West Provider Rework or Dispute Process Reference Table		
Provider's state	**Contact information**	**Notes**
Arizona	PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078	First Review: Request for reconsideration of a claim is considered a grievance. Physicians and health care professionals are required to notify us of any request for reconsideration within one year from the date the claim was processed. Second Review: Request for reconsideration of a grievance determination is also considered a grievance. You are required to notify us of any second level grievance within one year from the date the first level grievance resolution was communicated to the care provider.
California	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	UnitedHealthcare of California acknowledges receipt of paper disputes within 15 business days and within two business days for electronic disputes. If additional information is required, the dispute is returned within 45 business days. A written determination is issued within 45 business days.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983	Upon receipt of a dispute, Colorado Resolution Team: • Acknowledges receipt of the dispute within 30 calendar days of the receipt of the dispute; • Conducts a thorough review of your dispute and all supporting documentation; • Acknowledges receipt, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute; • Processes payment, if necessary, within five business days of the written determination; • Replies to the care provider of service within 30 calendar days if additional information is required. If additional information is required, we will hold the dispute request for 30 additional calendar days.
Nevada	For Medicare Advantage claims: UnitedHealthcare P.O. Box 95638 Las Vegas, NV 89193-5638	All Nevada Medicare Advantage HMO claims are processed by a delegated payer. Therefore, care provider appeals are reviewed primarily by the delegated payer.
Oklahoma	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	
Oregon	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	UnitedHealthcare of Oregon allows at least 30 calendar days for you to initiate the dispute resolution process. We render a decision on care provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we render a decision within 60 calendar days of the complaint.
Texas	UnitedHealthcare West Claims Department P.O. Box 400046 San Antonio, TX 78229	
Washington	UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	UnitedHealthcare of Washington allows at least 30 calendar days for care providers to initiate the dispute resolution process. We render a decision on care provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we render a decision within 60 calendar days of the complaint.

California Language Assistance Program (California Commercial Plans)

UnitedHealthcare of California members who have limited English proficiency have access to translated written materials and oral interpretation services, free of charge, to help them get covered services. For more program information, call 800-752-6096.

If the member's language of choice is not English or they have limited English proficiency, try to arrange for oral interpretive services before the date of service.

Verbal Interpreter/Written Translation Services

The UnitedHealthcare West Call Center is a central resource for both care providers and members. The following information and services are accessible through the call center:

- How to access and facilitate oral interpretation services for members needing language assistance in any language, or
- Request for an in-person interpreter for a member by selecting the appropriate phone number (based on language preference) to speak with a customer service representative and/or to conference in an interpreter:

  UnitedHealthcare SignatureValue (HMO/MCO):
  800-624-8822; Dial 711 TDHI
  Spanish: 800-730-7270; 800-855-3000 TDHI
  Chinese: 800-938-2300

Where to Obtain the Member's Language Preference

The member's preferences for spoken language, written language and eligibility for written language service is displayed in the **eligibilityLink** app on Link.

Documentation of Member Refusal of Interpreter Services

If a member refuses your offer of an interpreter, you must note the refusal in the medical record for that visit. Documenting the refusal of interpreter services in the medical record not only protects you, it also helps ensure consistency. We verify compliance with this documentation when we conduct site reviews of medical records.

If a member wants to use a family member or friend as an interpreter, consider offering a telephonic interpreter in addition to the family member/friend to help ensure accuracy of interpretation. For all Limited English Proficiency (LEP) members, Document the member's preferred language in paper and/or electronic medical records (EMR) in the manner that best fits your practice flow.

Member Complaints & Grievances

Member Satisfaction (California)

In addition to the NCQA CAHPS® survey, we conduct an annual California HMO member Assessment Survey using a sample of members at the care provider organization or medical group level. We summarize the results at the medical group level and use them to identify improvement opportunities. These results are important for the evaluation of member perspectives about access to PCP, specialty and after-hours care. In addition to access, topics include care coordination and interactions with the doctor and the office staff.

We use the results from this survey to support the Integrated Healthcare Association's Pay-for-Performance Program.

Member disputes may arise from time to time with UnitedHealthcare West or with our participating care providers. UnitedHealthcare West respects the rights of its members to express dissatisfaction regarding quality of care or services and to appeal any denied claim or service.

Instructions on how to file a complaint or grievance with us can be found in the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage.

Availability of Grievance Forms

California Commercial HMO members can access grievance forms online. Please direct members to **myuhc.com** > Find a Form. The form accessible in two places: From the California member welcome page or, Library tab page, on the left side, and click on Grievance Form. You and your staff are required to assist the member to obtain a form if the member asks. You can print a form from **myuhc.com** or by provide a number for the member to call Member Services to file the grievance orally. Grievance forms are available in English, Spanish and Chinese.

California Quality Improvement Committee

The California Quality Improvement Committee (CA-QIC) oversees activities specific to members in health plans operating in California to help ensure that state-specific interests are met and the committee activities carried out in collaboration with the West Regional Quality Oversight Committee (RQOC) avoid duplication of effort.

The CA-QIC is chaired by, the senior medical director physician licensed in CA. The committee meets at least quarterly and reports to the UHC of CA BOD and, as needed, to the West RQOC.

UnitedHealthOne Individual Plans Supplement

Applicability of This Supplement

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers individual personal health products, including Golden Rule Insurance Company (GRIC) and some individual products offered by Oxford Health Insurance, Inc.

This supplement applies to services provided to members enrolled in GRIC and UnitedHealthcare Oxford Navigate Individual benefit plans offered by Oxford Health Insurance, Inc.

You are subject to both the main guide and this supplement and the member's benefit plan. This supplement and the member's benefit plan controls if it conflicts with information in the main guide. If additional protocols, policies or procedures are available online, we direct you to that location when applicable. For protocols, policies and procedures not referenced in this supplement, refer to appropriate chapter in the main guide.

How to Contact UnitedHealthOne Resources

Resource	Where to go	Requirements and Notes
GRIC– Group Number 705214		
Notification Admission notification is required for all inpatient services as described in *Chapter 6: Medical Management*.	Call the number on the back of the member's health care ID card or go to **UHCprovider.com/priorauth**.	
Benefits and Eligibility	Call the number on the back of the member's health care ID card, or go to **myuhone.com**.	To inquire about a member's plan benefits or eligibility
Claims	Go to **myuhone.com**.	To view pending and processed claims
Pharmacy Services	**Prior Authorizations:** • **Phone:** 800-711-4555 • **Fax** for non-specialty meds: 800-527-0531 • **Fax** for specialty meds: 800-853-3844 **Benefit Information:** Call the pharmacy number on the back of the member's health care ID card.	For information on the Prescription Drug List (PDL), go to **UHCprovider.com**.
Oxford– Group Number 908410		
Behavioral Health Services	**Online: providerexpress.com** **Phone:** 855-779-2859	Submit admission notification or prior authorization for behavioral health, including substance use and autism.
Cardiology: Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online: UHCProvider.com/cardiology**; select the *Go to Prior Authorization and Notification App.* **Phone:** 866-889-8054	Request prior authorization for services as described in the *Outpatient Cardiology Notification/Prior Authorization Protocol* section of *Chapter 6: Medical Management*.
Chiropractic, Physical and Occupational Therapy	**Online** (clinical submission request): **myoptumhealthphysicalhealth.com**. **Phone:** 888-676-7768	Follow the clinical submission process for chiropractic, physical and occupational therapy as described in *Chapter 6: Medical Management*.
Claims Submission	**Electronic Claims Submission:** Payer ID 37602 **Paper Claims Submission:** Mail to the address listed on the back of the ID card.	

Resource	Where to go	Requirements and Notes
Pharmacy Services	**Prior Authorizations:** • **Phone:** 800-711-4555 • **Fax** for non-specialty meds: 800-527-0531 • **Fax** for specialty meds: 800-853-3844 **Benefit Information:** Call the pharmacy number on the back of the member's health care ID card.	For information on the Prescription Drug List (PDL), go to **UHCprovider.com/pharmacy**.
Prior Authorization and Notification	**Online:** **UHCprovider.com/priorauth** **Phone:** 800-999-3404	Prior authorization and admission notification is required as described in *Chapter 6: Medical Management*. EDI 278A transactions are not available.
Radiology/Advanced Outpatient Imaging Procedures: CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online:** **UHCProvider.com/radiology**; select the *Go to Prior Authorization and Notification App*. **Phone:** 866-889-8054	Request prior authorization for services as described in the *Outpatient Radiology Notification/Prior Authorization Protocol* section of *Chapter 6: Medical Management*.

Health Care ID Card

Members receive health care ID cards with information to help you submit claims accurately. Information varies in appearance or location on the card. However, cards display the same basic information (e.g., claims address, copayment information, and phone numbers).

Be sure to check the member's health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to use the electronic payer ID on the health care ID card.

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

Claims Process

We know that you want to be paid promptly for the services you provide. This is what you can do to help promote prompt payment:

1. Notify us, in accordance with the notification requirements set forth in this supplement.
   - For Navigate referrals, refer to *Chapter 5: Referrals*.
2. Prepare a complete and accurate claim form. For facility (UB-04/8371) claims see number five below.
3. Submit electronic claims using the electronic payer ID on the health care ID card, or submit paper claims to the address listed on the member's health care ID card. GRIC payer ID is 37602.
4. Requirements for claims (paper or electronic) reporting revenue codes:
   - All claims reporting revenue codes require the exact dates of service if they are span dates.
   - If you report revenue code 274, you are required to provide a description of the services or a valid CPT or HCPCS codes.
   - All claims reporting the revenue codes on the following list require that you report the appropriate CPT and HCPCS codes.

Revenue codes requiring CPT® and HCPCS codes
260 IV Therapy (General Classification)
261 Infusion Pump
262 IV therapy/pharmacy services
263 IV therapy/drug/supply delivery
264 IV Therapy/Supplies
269 Other IV therapy
290 Durable Medical Equipment (DME) (other than renal) (General Classification)
291 DME/Rental
292 Purchase of new DME
293 Purchase of used DME
300 Laboratory (General Classification)
301 Chemistry
302 Immunology
303 Renal Patient (Home)
304 Non-Routine Dialysis
305 Hematology
306 Bacteriology & Microbiology
307 Urology
309 Other Laboratory
310 Laboratory-Pathology (General Classification)
311 Cytology Histology
312 Other Laboratory Pathological
319 Radiology–Diagnostic (General Classification)
320 Angiocardiography
321 Arthrography
322 Arteriography
323 Chest X-Ray
324 Other Radiology-Diagnostic
329 Radiology-Therapeutic and/or Chemotherapy Administration (General Classification)
330 Chemotherapy Administration-Injected Chemotherapy Administration-Oral Radiation Therapy
331 Chemotherapy Administration-Injected

Revenue codes requiring CPT® and HCPCS codes
332 Chemotherapy Administration-Oral
333 Radiation Therapy
335 Chemotherapy Administration-IV
339 Other Radiology-Therapeutic
340 Nuclear Medicine (General Classification)
341 Diagnostic Procedures
342 Therapeutic Procedures
350 CT Scan (General Classification)
351 CT-Head Scan
352 CT-Body Scan
359 CT-Other
360 Operating Room Services (General Classification)
361 Minor Surgery
362 Organ Transplant-Other Than Kidney Transplant
367 Other Operating Room Services
369 Other Imaging Services (General Classification)
400 Diagnostic
401 Mammography
402 Ultrasound
403 Screening Mammography
404 Positron Emission
409 Tomography Other Imaging Services
410 Respiratory Services (General)
412 Inhalation Services
419 Other Respiratory Services
460 Pulmonary Function (General Classification)
469 Other-Pulmonary Function
470 Audiology (General Classification)
471 Audiology/Diagnostic
472 Audiology/Treatment
480 Cardiology (General Classification)
481 Cardiac Cath Lab

Revenue codes requiring CPT® and HCPCS codes
482 Stress Test
483 Echocardiology
489 Other Cardiology
490 Ambulatory Surgical Care (General Classification)
499 Other Ambulatory Surgical Care
610 Magnetic Resonance Technology (General Classification)
611 MRI-Brain/Brain Stem
612 MRI-Spinal Cord/Spine
614 MRI-Other
615 MRA-Head and Neck
616 MRA-Lower Extremities
618 MRA Other
618 Other MRT
623 Surgical Dressing
624 FDA Investigational Devices
634 Erythropoietin (EPO) < 10,000 units
635 Erythropoietin (EPO) > 10,000 units
636 Drugs Requiring Detail Coding
730 EKG/ECG (Electrocardiogram) (General Classification)
731 Holter Monitor
732 Telemetry
739 Other EKG/ECG
740 EEG (Electroencephalogram) (General Classification)
750 Gastro-Intestinal (GI) Services (General Classification)
790 Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)
921 Peripheral Vascular Lab
922 Electromyogram
923 Pap Smear
924 Allergy Test
925 Pregnancy Test
929 Additional Diagnostic Services
940 Other Therapeutic Services (General Classification)

Revenue codes requiring CPT® and HCPCS codes
941 Recreational Therapy
942 Education/Training (Diabetic Education)
949 Other Therapeutic Services (HRSA)

Note: Use the payer ID number on the member's health care ID card. The electronic claims submission number does vary. The claim will reject if the correct payer ID is not used.

Claim Adjustments

If you believe your claim was processed incorrectly, please call the number on the back of the member's health care ID card and request an adjustment as soon as possible, in accordance with applicable statutes and regulations. If you or our staff identifies a claim where you were overpaid, send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our request.

If you disagree with our determination regarding a claim adjustment, you can appeal the determination.

Claim Reconsideration, Appeals and Disputes

If you disagree with a claim payment determination, send a letter requesting a review to the following address:

Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0370
Standard Fax: 801-478-5463
Phone: 800-657-8205

If you feel your situation is urgent, request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Expedited Fax: 866-654-6323
Phone: 800-657-8205

Your appeal must be submitted within 12 months from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise.

Please refer to *Claim Reconsideration, Appeals Process and Resolving Disputes* section in Chapter 9: Our Claims Process.

If you disagree with the outcome of the claim appeal, you may file an arbitration proceeding as described in your participation agreement.

Claim reconsideration does not apply to some states based on applicable state legislation (e.g. Arizona, California, Colorado, New Jersey, Texas). For states with applicable legislation, any request for dispute will follow the state specific process.

New Jersey Care Provider Dispute Process

Disputes involving New Jersey (NJ) commercial members are subject to the NJ state-regulated care provider dispute process.

The state regulated provider dispute process does not apply in the following situations:

- Our determination involves a utilization management (UM) denial. UM denials are refusals to pay a claim or to authorize a service or supply because we have determined that the service or supply is:
  - Not medically necessary;
  - Experimental or investigational;
  - Cosmetic;
  - Dental rather than medical; or
  - Treatment of a pre-existing condition.

You can appeal a UM denial by going through the Internal UM Appeals Process described under the Member Complaints and Grievances section. You must submit a completed Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims form to begin the UM appeal process.

- Our determination indicates we denied the service or supply as not covered under the terms of the plan or because the person is not our member.
- The dispute is due to coordination of benefits.
- We have provided you notice that we are investigating this claim (and related ones, as appropriate) for possible fraud.

The process does apply for the following situation:

- The claim was not paid for any reason other than previously listed;
- The claim was paid at a rate you did not expect based on your network contract between or the terms of the plan;
- The claim was paid at a rate you did not expect because of differences in our treatment of the codes in the claim from what you believe is appropriate;
- We required additional substantiating documentation to support the claim, and you believe the required information is inconsistent with our stated claims handling policies and procedures or is not relevant to the claim;
- You believe we failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law and the terms of your network contract, if any;
- Our denial was due to lack of appropriate authorization, but you believe you obtained appropriate authorization from us or another carrier for the services;
- You believe we failed to appropriately pay interest on the claim;
- You believe our statement that we overpaid on one or more claims is erroneous or that the amount we have calculated as overpaid is erroneous;
- You believe we have attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims.

If the dispute is eligible the following process will apply: A written request for appeal must be submitted using the Health Care Provider Application to Appeal a Claims Determination Form created by the New Jersey Department of Banking and Insurance. This request must be submitted within 90 days following receipt of our initial determination notice to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard Fax: 801-478-5463

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

If you are not satisfied with the results of the internal dispute, you may initiate the New Jersey Program for Independent Claims Payment Arbitration (PICPA) process. Submit your requests to Maximus, Inc. within 90 calendar days from receipt of the internal dispute decision. A dispute is eligible if the payment amount in dispute is $1,000 or more. The arbitration decision is binding.

Member Complaints & Grievances

Member disputes may arise from time to time with UnitedHealthOne or with our participating care providers. We respect the rights of our members to express dissatisfaction regarding quality of care or services and to appeal any denied claim or service. Instructions on how to file a complaint or grievance with us are in the member's Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage, or Certificate of Coverage. Please refer to *Member Appeals, Grievances or Complaints* section in Chapter 9: Our Claims Process for detailed information about your role in the member appeal process.

UnitedHealthcare Oxford Navigate Individual - Internal Utilization Management Appeals Process

Internal UM appeals must be initiated by the member or their designee 180 calendar days from receipt of the initial adverse UM determination. UM appeals include denials as not medically necessary, experimental or investigational, cosmetic, dental rather than medical, or excluded as a pre-existing condition.

To initiate the standard internal UM appeal process, write to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard Fax: 801-478-5463

If you feel the situation is urgent, request an expedited (urgent) appeal orally, by fax or in writing to:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Expedited Fax: 866-654-6323
Phone: 800-291-2634

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

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

If the member or designee is not happy with the results of the appeal process, they may pursue an external appeal through an independent Utilization Review Organization (IURO) for final internal UM determinations. You must complete an internal appeal before you can request a review by an IURO, except when:

1. We fail to meet the deadlines for completion of the internal appeals process:
   a. Without demonstrating good cause, or
   b. Because of matters beyond our control, and
   c. While in the context of an ongoing, good faith exchange of information between parties, and
   d. It is not a pattern or practice of noncompliance;
2. We, for any reason, expressly waive our rights to an internal review of an appeal; or
3. The treating care provider and/or member have applied for expedited external review at the same time as applying for an expedited internal review.

To initiate the external appeal, the member or designee must:

1. File a written request with the New Jersey Department of Banking and Insurance within four months of receiving a final determination on an appeal.
2. Sign a release that allows the IURO to review all the necessary medical records related to the appeal; and
3. Send a check or money order in the amount of $25 made payable to: New Jersey Department of Banking and Insurance with the request. The form, release and check must be sent to:

   Department of Banking and Insurance
   Consumer Protection Services
   Office of Managed Care
   P.O. Box 329
   Trenton, NJ 08625-1062
   Phone: 888-393-1062

The IURO completes the review within 45 days of receipt.

The IURO completes its review within 48 hours if the appeal involves:

- Urgent or emergency care
- An admission
- Availability of care
- Continued stay
- Health care services for which the member received emergency services and not yet discharged
- A medical condition that would put the member's life or health in danger when waiting for the normal appeal process

If UnitedHealthcare Oxford Navigate Individual has good cause for not meeting the deadlines of the appeals process, members or their designee and/or their care provider may request a written explanation of the delay. UnitedHealthcare Oxford Navigate Individual must provide the explanation within 10 days of the request and must include a specific description of the bases for which it was determined the delay should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with UnitedHealthcare Oxford Navigate Individual and rejects the request for immediate review, the member has the opportunity to resubmit their appeal.

Internal Administrative Appeal Process

The administrative appeal process is used to appeal an initial determination concerning a claim for benefits or an administrative issue. Issues include but are not limited to:

- Denials based on benefit exclusions or limitations not involving UM decisions;
- Claims payment disputes; and
- Administrative issues concerning other requirements of the health plan. Administrative issues include but are not limited to issues involving:
  - Eligibility;
  - Enrollment issues; and
  - Rescission of coverage.

Please Note: Benefit and administrative issues do not include initial determinations that the service or supply is not medically necessary, experimental or investigational,

cosmetic, dental rather than medical, or treatment of a pre-existing condition. Those determinations are UM decisions.

Administrative appeals must be initiated by the member or their designee in writing unless expedited.

Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis. Expedited administrative appeals are determined within 72 hours from receipt of the appeal. All other appeals are determined within 30 calendar days of receipt of the appeal.

Notice to Texas Providers
To verify benefits for GRIC members, call 800-395-0923.

Tools have been developed by third parties, such as the MCG® Care Guidelines (formerly known as Milliman Care Guidelines®), to assist in administering health benefits making informed decisions in many health care settings, including acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As affiliates of UnitedHealthcare, GRIC and Oxford Health Insurance, Inc. may also use UnitedHealthcare's medical policies as guidance. These policies are available on UHCprovider.com/policies.

Notification does not guarantee coverage or payment (unless mandated by law). The member's eligibility for coverage is determined by the health benefit plan. For benefit or coverage information, please contact the insurer at the phone number on the back of the member's health care ID card.

To obtain a verification as required by 28 TAC §19.1719, please call 800-842-1792.

Important Information Regarding Diabetes (Michigan)
Michigan requires insurers to provide coverage for certain expenses to treat diabetes. It also requires insurers to establish and provide members and participating care providers with a program to help prevent the onset of clinical diabetes. We have adopted the American Diabetes Association (ADA) Clinical Practice Guidelines.

The program for participating care providers emphasizes best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. The Standards of Medical Care in Diabetes and Clinical Practice Recommendations are on care.diabetesjournals.org.

Subscription information for the American Diabetes Journals is available on the website. You can also call 800-232-3472 and select option one, 8:30 a.m. to 8 p.m. ET, Monday through Friday. View journal articles without an online subscription.

Glossary

Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the health insurance plan, improper payment, payment for services that fail to meet professionally recognized standards of care, or medically unnecessary services. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Accreditation: A process that a care provider goes through to be recognized for meeting certain standards such as quality.

Acute Inpatient Care: Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Adjudication: The process of determining the proper payment amount on a claim.

Ambulatory Care: Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term "ambulatory care" usually implies that the patient has come to a location other than their home to receive services and has departed the same day. Examples include: chemotherapy and physical therapy.

Ambulatory Surgical Facility: A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services: Health services ordered by a care provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal: An oral or written request by a member or member's personal representative received by UnitedHealthcare for review of an action.

Authorization: Approval obtained by care providers from UnitedHealthcare for a designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Authorized Care Provider: A care provider who meets UnitedHealthcare's licensing and certification requirements and has been authorized by UnitedHealthcare to provide services.

Balanced Billing: When a care provider bills a member for the difference between billed charges and the UnitedHealthcare allowable charge after UnitedHealthcare pays a claim.

Benefit: The amount of money UnitedHealthcare pays for care and other services.

Capitation: Per person way of payment for medical services. UnitedHealthcare pays a participating capitated care provider a fixed amount for every member he or she cares for, regardless of the care provided.

Care Provider: A person who provides medical or other health care (doctor, nurse, therapist or social worker) or office support staff. A care provider can be a doctor practicing alone, in a hospital setting, or in a group practice. A care provider could work from a remote location, in a public space, or any combination of locations.

Claim: The documentation of the services that have occurred during the course of a visit to a health care provider.

Clinical Laboratory Improvement Amendments of 1988 (CLIA): United States federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research.

Clean Claim: A claim that has no defect, impropriety (including lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

Centers for Medicare & Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services.

Coordination of Benefits (COB): Allows benefit plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance benefit plan has the primary payment responsibility and the extent to which the other benefit plans will contribute when an individual is covered by more than one benefit plan).

Coinsurance: The member's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. Members may pay co-insurance plus any deductibles owed.

Commercial: Refers to all UnitedHealthcare medical products that are not Medicare Advantage, Medicare Supplement, Medicaid, CHIP, workers' compensation, TRICARE, or other governmental programs (except that "Commercial" also applies to benefit plans for the Health Insurance Marketplace, government employees or students at public universities).

Copayment: A fixed amount members may pay for a covered health care service, usually upon receiving the service.

Covered Services: Medically necessary services included in the member's benefit plan. Covered services change periodically and may be mandated by federal or state legislation.

Credentialing: The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare.

Current Procedural Terminology Codes (CPT): American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Deductible: The amount a member owes for health care services the health insurance or benefit plan covers before the health insurance or benefit plan begins to pay.

Delivery System: The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, health care facilities, care provider offices, and home health care.

Dependent: A child, disabled adult or spouse covered by the health benefit plan.

Disallow Amount: Medical charges for which the network provider is not permitted to receive payment from the health benefit plan and cannot bill the member. Examples are:

- The difference between billed charges and contracted rates; and
- Charges for services, bundled or unbundled, as detected by Correct Coding Initiative edits.

Discharge Planning: Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Disease Management: A prospective, disease-specific approach to improving health care outcomes by providing education to members through non-physician.

Disenrollment: The discontinuance of a member's eligibility to receive covered services from a contractor.

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

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS): In November 2006, the Centers for Medicare & Medicaid Services (CMS) approved 10 national accreditation organizations that will accredit suppliers of **durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)** as meeting new quality standards under Medicare Part B.

Electronic Data Interchange (EDI): The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT): The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR): The electronic version of a member's health records.

Emergency Care: The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that sets minimum standards for most voluntarily established pension and health benefit plans in private industry to provide protection for individuals in these benefit plans.

Encounter: An interaction between a patient and health care providers, for the purpose of provider healthcare services or assessing the health status of a patient.

Expedited Appeal: An oral or written request by a member or member's personal representative received by UnitedHealthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Fee for Service: Care providers are paid for each service (like an office visit, test, or procedure).

Fraud: Health care fraud is a crime that involves misrepresenting information, concealing information, or deceiving a person or entity to receive benefits, or to make a financial profit. (18 U.S.C.§1347).

Grievance: An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan.

Health Insurance Portability and Accountability Act (HIPAA) Act of 1996: A federal legislation that provides data privacy and security provisions for safeguarding medical information.

Health Plan Employer Data and Information Set (HEDIS): Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

Home Health Care or Home Health Services: Medical care services provided in the home, often by a visiting

nurse, usually for recovering patients, aged homebound patients, or patients with a chronic disease or disability.

Managed Care: A system designed to better manage the cost and quality of medical services. Managed care products not only offer less member liability but also less member control. Managed care aims to improve accessibility to health care, reduce cost, and improve quality of service. Many managed care health insurance programs work with Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) boards to promote use of specific health treatment procedures. Managed care health insurance benefit plans also educate and work with consumers to improve overall health by addressing disease prevention. The common types of managed care products are HMO, PPO, and Point of Service (POS) benefit plans.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Medically Necessary: To determine medical necessity, we use generally accepted standards of medical practice, based on credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community. We may also use standards based on physician specially recommendations, professional standards of care, and other evidence based, industry recognized resources and guidelines, such as MCG®.

For Medicare Advantage and Medicaid members, we use Medicare guidelines, including National Coverage Determinations and Local Coverage Determinations to determine medical necessity of services requested.

If other nationally recognized criteria contradict MCG, UnitedHealthcare and delegated medical group/IPAs follow the Medicare guidelines for Medicare Advantage members. Individual criteria is provided to you upon request.

Member: Refers to an individual who has been determined UnitedHealthcare eligible and enrolled with UnitedHealthcare to receive services pursuant to the agreement. Other common industry terms: customer, patient, beneficiary, insured, enrollee, subscriber, dependent.

National Provider Identification (NPI): NPI is a unique 10-digit identification number issued to health care providers in the United States by CMS.

Network Care Provider: A professional or institutional care provider who has an agreement with UnitedHealthcare to provide care at a contracted rate. A network care provider agrees to file claims and handle other paperwork for UnitedHealthcare member. A network care provider accepts the negotiated rate as payment in full for services rendered.

Non-network Health Care Provider: A non-network provider does not have an agreement with UnitedHealthcare, but is certified to provide care to UnitedHealthcare members. There are two types of non-network care providers: participating and nonparticipating.

- **Nonparticipating care provider:** A nonparticipating care provider is a UnitedHealthcare-authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to UnitedHealthcare members but who does not have an agreement and does not accept the UnitedHealthcare allowable charge or file claims for UnitedHealthcare members. A nonparticipating care provider may only charge up to 15 percent above the UnitedHealthcare allowable charge.
- **Participating care provider:** A health care provider who has agreed to file claims for UnitedHealthcare members, accept payment directly from UnitedHealthcare, and accept the UnitedHealthcare allowable charge as payment in full for services received. Non-network care providers may participate on a claim-by-claim basis. Participating care providers may seek payment of applicable copayments, cost-shares and deductibles from the member. Under the UnitedHealthcare outpatient prospective payment system, all Medicare participating care providers and hospitals must, by law, also participate in UnitedHealthcare for inpatient and outpatient care.

Nurse Practitioner: A registered nurse who has graduated from a program which prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

Optum: A UnitedHealth Group™ health services and innovation company that designs and implements custom information technology systems, and offers management consulting, in the health care industry nationwide. Optum offers behavioral healthcare programs including integrated behavioral and medical programs, depression management, employee assistance, work/life management, disability support and pharmacy management programs.

Out-Of-Area Care: Care received by a UnitedHealthcare member when they are outside of their geographic territory.

Physician Assistant: A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

Policy: A contract between the insurer and the insured, known as the policyholder, which determines the claims which the insurer is legally required to pay.

Primary Care Provider (PCP): A physician such as a family practitioner, pediatrician, internist, general practitioner, or obstetrician, who serves as a gatekeeper for their assigned members' care. Other providers may be included as primary physicians such as nurse practitioners and physician assistants as allowed by state mandates.

Primary Care Team: a team comprised of a care manager, a PCP, and a Nurse Practitioner or Physician Assistant.

Prior Authorization and Notification: A unit under the direction of the UnitedHealthcare Clinical Services Department that is an essential component of any managed care organization. Prior authorization is the process where health care providers seek approval prior to rendering services as required by UnitedHealthcare policy.

Provider Group: A partnership, association, corporation, or other group of providers.

Provider Manual: This document is referred to as a care provider manual or guide. It may also be referred to as the provider administrative guide or handbook.

Quality Management (QM): A methodology used by professional health personnel to the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Reinsurance: The contract made between an insurance company and a third party to protect the insurance company from losses.

Secondary Payer: A source of coverage that pays after the primary insurance benefit has been applied.

Self-Funded Plan: Self-funded health care also known as Administrative Services Only (ASO) is a self insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds.

Self- Insured: A self-insured group health benefit plan is one in which the employer assumes the financial risk for providing health care benefits to its employees.

Service Area: A geographic area serviced by a UnitedHealthcare contracted provider, as stated in the health care provider's agreement with us.

Skilled Nursing Facility: A Medicare-certified nursing facility that (a) provides skilled nursing services and (b) is licensed and operated as required by applicable law.

Stop-loss: A product that provides protection against catastrophic or unpredictable losses. It is purchased by employers who have decided to self-fund their employee benefit health benefit plans, but do not want to assume 100% of the liability for losses arising from the benefit plans.

Subrogation: A health plan's right, to the extent permitted under applicable state and federal law and the applicable benefit plan, to recover benefits paid for a member's health care services when a third party causes the member's injury or illness.

Subscriber: Person who owns an insurance policy.

Supplemental Benefits: Supplemental insurance includes health benefit plans specifically designed to supplement UnitedHealthcare standard benefits.

Third Party Administrator (TPA): An organization that provides or manages benefits, claims or other services, but it does not carry any insurance risk.

Transitional Care: A program that is designed for members to help ensure a coordinated approach takes place across the continuum of care.

UnitedHealthcare Assisted Living Plan: A Medicare Advantage Institutional-Equivalent Special Needs Plan that:

- Exclusively enrolls special needs individuals who living in a contracted Assisted Living Facility, have Medicare A and B, and meet the local state's criteria for "institutional level of care".
- Is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare's affiliates; and
- Is offered through our UnitedHealthcare Medicare Advantage business unit, as indicated by a reference to Assisted Living Plan name listed on the face of the valid health care ID card.

UnitedHealthcare Nursing Home Plan: A Medicare Advantage Institutional Special Needs Plan that:

- Exclusively enrolls special needs individuals who for 90 calendar days or longer, have had or are expected to need the level of service requiring an institutional level of care (as such term is defined in 42 CFR 422.2);
- Is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare's affiliates; and
- Is offered through our UnitedHealthcare Medicare Advantage business unit, as indicated by a reference to Nursing Home Plan or Erickson Advantage Guardian in the benefit plan name listed on the face of the valid health care ID card.

Us: "Us," "we" or "our" refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Manual.

Utilization Management (UM): The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning and case management.

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

Workers' Compensation: Workers' compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue their employer for the tort of negligence.

You: "You," "your" or "provider" refers to any health care provider subject to this guide, including physicians, health care professionals, facilities and ancillary providers; Except when indicated all items are applicable to all types of providers subject to this Guide.

UnitedHealthcare®

EXHIBIT 40

EXHIBIT 40

FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH

EXHIBIT 41

EXHIBIT 41

FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH

EXHIBIT 42

EXHIBIT 42

FILED UNDER SEAL PURSUANT TO PENDING MOTION TO SEAL FILED CONCURRENTLY HEREWITH