2025 UnitedHealthcare Care Provider Administrative Guide for Commercial, Individual Exchange and Medicare Advantage

United Healthcare®

Welcome to UnitedHealthcare

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

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

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

1. Keys CTRL+F
2. Type in the keyword
3. Press enter

This 2025 UnitedHealthcare Care Provider Administrative Guide (this "guide") applies to covered services you provide to our members or the members of our affiliates* through our benefit plans insured by or receiving administrative services from us, unless otherwise noted.

This guide is effective April 1, 2025, for physicians, health care professionals, facilities and ancillary health care providers currently participating in our commercial and MA networks. It is effective now for health care providers who join our network on or after Jan. 1, 2025. This guide is subject to change. We frequently update content in our effort to support our health care provider networks.

Terms and definitions as used in this guide:

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

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

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

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

If there is inconsistency between the terms of your Agreement and this guide, your Agreement controls. The exception to this rule is when your Agreement defines a protocol that is specific to one of our affiliates and is inconsistent with a protocol in the corresponding affiliate supplement to this guide. In that situation, the protocol in the applicable affiliate supplement to this guide controls.

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

Quick reference guide

Join our network and credentialing	If you are interested in joining our network, visit **UHCprovider.com/join** to view our credentialing policies and procedures. **Credentialing application:** Check on your application status by visiting **UHCprovider.com** > Sign In and clicking the chat icon in the lower right corner.
Digital solutions	**UHCprovider.com: UHCprovider.com** is your home for health care provider information with 24/7 access to the UnitedHealthcare Provider Portal, medical policies and news bulletins. The website offers great resources to support administrative tasks, including eligibility, claims, referrals, and prior authorizations and notifications. **UHCprovider.com/digitalsolutions:** Going digital means less paper and more automation, faster workflow between applications and quicker claims submission process to get you paid faster. Our 3 digital solutions — Electronic Data Interchange (EDI), Application Programming Interface (API) and the UnitedHealthcare Provider Portal — help to make that a reality, and it's not a one-size-fits-all solution. There's flexibility to choose the best approach for your practice and integrate with the practice management systems you use today. This webpage helps you choose the right solution to fit your practice's needs. **UnitedHealthcare Provider Portal:** Access patient- and practice-specific information 24/7 within the UnitedHealthcare Provider Portal. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information — all at no cost without calling. **UHCprovider.com/edi:** Submit and receive data using HIPAA Electronic Data Interchange (EDI) X12 transactions for claim submissions and claim attachments, eligibility and benefits, claim status, authorizations, referrals, hospital admission, discharge and observation stay notifications, and electronic remittance advice. You can submit single or batch transactions for multiple members and payers without manual data entry or logging in to multiple payer websites. **UHCprovider.com/api:** Application Programming Interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer. This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions, more detail at the link above.
Healthcare professional education and training	We provide a full range of training resources, including interactive self-paced courses and instructor-led sessions at **UHCprovider.com/training**. The training content is organized by categories to make it easier to find what you need.
Provider Portal access and new user registration	In order to access the UnitedHealthcare Provider Portal, you'll need to create a One Healthcare ID. Visit **UHCprovider.com/access**.

UnitedHealthcare communications	**Network News:** Find health care provider news and updates for national and state commercial, Medicare and Medicaid plans at **UHCprovider.com/news**. **Policy and protocol updates:** News and updates regarding policy, product or reimbursement changes are posted online at **UHCprovider.com/news**. Updates are posted at the beginning of each month. Sign up to receive notification of these updates by email at **UHCprovider.com/subscribe**.
Contact UnitedHealthcare	**Online:** Most questions can be answered using one of our secure digital solutions – API, EDI and the UnitedHealthcare Provider Portal. To learn more, visit **UHCprovider.com/digitalsolutions**. For state-specific contact information, visit **UHCprovider.com** > **Contact us**. **Provider Services / Provider Services (Individual Exchange Plans) / Prior Authorizations / Prior Authorizations (Individual Exchange Plans):** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. **Optum Pay™ Helpdesk: 1-877-620-6194** **UnitedHealthcare Web Support: 1-866-842-3278** **Participation Agreement questions:** Contact your Network Management representative. To identify your Network Management representative, go to **UHCprovider.com** > Contact us > **State-specific health plan and network support** and select your state. **Provider Advocate:** To find your health care provider advocate, go to **UHCprovider.com** > Contact us > **State-specific health plan and network support** and select your state.
Find a health care provider	**UHCprovider.com/findprovider** • Search for doctors, clinics or facilities by plan type • Find dental providers by state, network or location • Locate mental health or substance use disorder services
Eligibility	Access benefit, coverage and identification card information **EDI:** 270/271 transaction | **UHCprovider.com/edi270** **Online:** **UHCprovider.com** > Sign In > Eligibility **Information:** **UHCprovider.com/eligibility** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. **API:** scheduled automatic data transfer | **UHCprovider.com/api**

Advance notification/prior authorization, admission notification, discharge notification, observation stay notification and referrals	To notify us or request prior authorization: **API:** Submit claims through API in a standard X12 format **EDI:** Transactions **278 and 278N** • Submit prior authorization requests and referrals using EDI 278 transactions. Go to **UHCprovider.com/edi278** for more information. • Submit hospital admission, discharge and observation stay notifications using EDI 278N transactions. Go to **UHCprovider.com/edi278n** for more information. • Check the status of prior authorization requests and notifications using EDI 278I. Go to **UHCprovider.com/edi278i** for more information. **Online: UHCprovider.com** > Sign In > Prior Authorizations **Use the Prior Authorization and Notification tool in the UnitedHealthcare Provider Portal to:** • Determine if notification or prior authorization is required • Complete the notification or prior authorization process • Upload medical notes or attachments • Check request status **Information: UHCprovider.com/priorauth** **Phone:** Only where telephonic submission is permitted, call the Care Coordination number on the member's ID card (self-service after hours) and select Care Notifications
Claims	**API:** Submit claims through API in a standard X12 format **EDI: UHCprovider.com/edi837** – Learn more about submitting claims through EDI **UHCprovider.com/edi** – View our Claims Payer list to identify Payer IDs, payers accepting COB claims electronically and if Smart Edits apply **Online: UHCprovider.com** > Sign In > Claims & Payments **Information: UHCprovider.com/claims** **Chat:** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus** **Reimbursement policies:** **UHCprovider.com** > Resources > Health plans, policies, protocols and guides > For Commercial Plans > **Reimbursement Policies for UnitedHealthcare Commercial Plans** **UHCprovider.com** > Resources > Health plans, policies, protocols and guides > For Individual Exchange Plans > **Reimbursement Policies for UnitedHealthcare Individual Exchange Plans** **UHCprovider.com** > Resources > Health plans, policies, protocols and guides > For Medicare Advantage Plans > **Reimbursement Policies for Medicare Advantage Plans** **UHCprovider.com** > Resources > Health plans, policies, protocols and guides > For Community Plans > **Reimbursement Policies for Community Plan** Reimbursement policies may be referred to in your Agreement as "payment policies." Refer to the Medicare Advantage policies for D-SNP members.

Claim reconsiderations and appeals	**API:** Submit reconsiderations and appeals with attachments using our API solution. Visit the **API Marketplace** for more details. **Online: UHCprovider.com** > Sign In > Claims & Payments Report escalated or unresolved issues to your Provider Advocate by email. Submit an appeal as a final resolution. **Medical policies:** Get copies of the medical policies and guidelines at **UHCprovider.com/policies**.
Timely filing guidelines	Refer to your internal contracting contact or Participation Agreement for timely filing information.
Care provider or group demographic information update forms	**Online: UHCprovider.com** > Sign In > Practice Management > My Practice Profile **Information: UHCprovider.com/mypracticeprofile** Visit the Provider Data Updates and Attestation page on **UHCprovider.com** to view ways to update and verify your provider demographic data.
Preferred lab network	**UHCprovider.com** > Our network > **Preferred Lab Network**
Specialty Pharmacy Program (commercial and exchange)	Specialty Pharmacy Program provides focused support to help better manage rare and complex chronic conditions. Find details about the Specialty Pharmacy Program online at **UHCprovider.com** > Resources > Drug lists and pharmacy > **Specialty Pharmacy - Medical Benefit Management (Provider Administered Drugs)**. Commercial medical benefit specialty prior authorizations are managed under the Specialty Guidance Program. **Phone: 1-888-397-8129** **Email: specialtyguidanceprogram@optum.com**

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Chapter 1: Introduction

Manuals and benefit plans referenced in this guide

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

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

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

If a member presents a health plan ID card with a product name you are not familiar with, go to **UHCprovider.com** > Sign In > Eligibility to quickly find information on the plan. You can also connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

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

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

Benefit plans subject to this guide

Plan name	Location of most members subject to additional guides	Location of plan information
Empire Plan	All markets outside of NY* and national health care providers; primary concentrations in: AZ, CA, CT, DE, FL, GA, MA, MD, NC, NJ, NV, PA, SC, TN, TX, VA Health plan ID card indicates NYSHIP, The Empire Plan and references UnitedHealthcare logo on the back	**Empire Plan supplement** to this guide **UHCprovider.com**
Exchanges	AL, AZ, FL, GA, IA, IL, IN, KS, LA, MD, MI, MO, MS, NC, NE, NJ, NM, OH, OK, SC, TN, TX, VA, WA, WI, WY	**Chapter 4: Individual Exchange plans** to this guide
Medicare Advantage (including Dual Special Needs Plans)	Multiple states	**Chapter 5: Medicare products** to this guide
MDIPA: MD Individual Practice Association, Inc.	DC, DE, MD, VA, WV Some counties in: Southeastern PA	**Mid-Atlantic Regional supplement** to this guide **UHCprovider.com**

* In the NY markets, there are a limited number of health care providers with The Empire Plan specifically added to their UnitedHealthcare Agreement. Otherwise, we have a separate health care provider network for Empire Plan members in NY.

Plan name	Location of most members subject to additional guides	Location of plan information
Capitated and/or Delegated Providers (commercial and Medicare Advantage)	All markets	**Capitation and/or delegation supplement** to this guide
NHP: Neighborhood Health Partnership, Inc.	FL	**Neighborhood Health Partnership supplement** to this guide **UHCprovider.com**
OCI: Optimum Choice Inc.	DC, DE, MD, VA, WV Some counties in: PA	**Mid-Atlantic Regional supplement** to this guide **UHCprovider.com**
OneNet PPO	DC, DE, FL, GA, MD, NC, PA, SC, TN, VA, WV	**OneNet PPO supplement** to this guide **UHCprovider.com**
Oxford: • Oxford Health Plans, LLC • Oxford Health Insurance, Inc. • Investors Guaranty Life Insurance Company, Inc. • Oxford Health Plans (NY), Inc. • Oxford Health Plans (NJ), Inc. • Oxford Health Plans (CT), Inc. • Oxford Level Funded Plans (NJ, CT)	CT, NJ, NY (except upstate) Some counties in: PA	**Oxford commercial supplement** to this guide For commercial and Medicare benefits: **UHCprovider.com**
Peoples Health	LA	**Peoples Health supplement** to this guide
Preferred Care Network	FL counties: Broward and Miami-Dade	**Preferred Care Network supplement** to this guide **UHCprovider.com**
Preferred Care Partners	FL counties: Broward, Miami-Dade and Palm Beach	**Preferred Care Network supplement** to this guide **UHCprovider.com**

Plan name	Location of most members subject to additional guides	Location of plan information
River Valley: • UnitedHealthcare Services Company of the River Valley, Inc. • UnitedHealthcare Plan of the River Valley, Inc. • UnitedHealthcare Insurance Company of the River Valley	Parts of AR, GA, IA, IL, TN, VA, WI Your UnitedHealthcare contract specifically references River Valley or John Deere Health protocols or guides; and You are located in AR, GA, IA, TN, VA, WI or these counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Mercer, Whiteside, Lee, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford, McLean; and You are providing services to a River Valley Commercial member and not a River Valley Medicare Advantage, Medicaid or CHIP member. Note: River Valley also offers benefit plans in LA, NC, OH and SC, but the River Valley Additional Guide does not apply to those benefit plans.	**River Valley entities supplement** to this guide **UHCprovider.com**
Sierra or Health Plan of Nevada: • Sierra Health and Life Insurance Co., Inc. • Health Plan of Nevada, Inc. • Sierra Healthcare Options, Inc.	Outside NV only: The health plan ID card identifies the Sierra or Health Plan of Nevada members who access the UnitedHealthcare network outside of Nevada, and includes the following reference: UnitedHealthcare Choice Plus Network Outside Nevada	Services rendered outside of Nevada to Sierra or Health Plan of Nevada members with the ID card reference described in this row are subject to your UnitedHealthcare Agreement and to this guide unless you are in Arizona or Utah and have a contract directly with Sierra or Health Plan of Nevada
UMR: • UMR • UnitedHealthcare Shared Services (UHSS)	All markets	**UMR supplement** to this guide **umr.com**
UnitedHealthcare Level Funded	All markets	**UnitedHealthcare Level Funded supplement** to this guide **UHCprovider.com**

Plan name	Location of most members subject to additional guides	Location of plan information
UnitedHealthcare West: (formerly referenced in this guide as PacifiCare) • UHC of California DBA UnitedHealthcare of California (hereinafter referred to as UnitedHealthcare of California) • UnitedHealthcare of Oklahoma, Inc. • UnitedHealthcare of Oregon, Inc. • UnitedHealthcare Benefits of Texas, Inc.*	AZ, CA, OK, OR, TX, WA	**UnitedHealthcare West supplement** to this guide **UHCprovider.com**
UnitedHealthOne: • Golden Rule Insurance Company Group #705214 • Oxford Health Insurance, Inc. Group #908410	All markets New Jersey	**UnitedHealthOne Individual Plans supplement** to this guide **UHCprovider.com** and **myuhone.com**
UnitedHealthcare Freedom Plans	NH, ME, VT	**UHCprovider.com**
UnitedHealthcare Student Resources	All states	**Student Resources supplement** to this guide **uhcsr.com** and **UHCprovider.com**

*PacifiCare of Arizona is now referenced as UnitedHealthcare Benefits of Texas, Inc.

Benefit plans not subject to this guide

Plan name	Location of most members subject to additional guides	Additional guide/website
Rocky Mountain Health Plan (RMHP)	CO	**Rocky Mountain Provider Manual** **Rocky Mountain Behavioral Health Provider Manual**
Sierra: Sierra Health and Life Insurance Co., Inc. Sierra Healthcare Options, Inc. Health Plan of Nevada, Inc. Health Plan of Nevada Medicaid/ Nevada Check Up	NV	Benefit plans for Sierra Health and Life Insurance Company, Inc.: **sierrahealthandlife.com/provider** Benefit plans for Sierra Healthcare Options, Inc.: **sierrahealthcareoptions.com** Benefit plans for Health Plan of Nevada, Inc.: **healthplanofnevada.com/provider** **myhpnmedicaid.com/provider**
UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured	Multiple states	UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicaid, CHIP or Uninsured **UHCprovider.com/communityplan** and **UHCprovider.com**

Obligation to do business with UnitedHealthcare electronically

Going digital is fast and efficient, and supports a paperless work environment. This means, where allowed by law, UnitedHealthcare requires you to use digital tools where available when conducting business with UnitedHealthcare. This includes claims, appeal, reconsideration, prior authorization, and to accept claim related documents electronically, and make inquiries.

The benefits of going digital

Our digital tools offer a more direct path to the information you need. This means:

- **24/7 access** – Our website, portal and chat windows never close
- **Complete common and complex tasks quicker** – Self-serve first for everyday tasks. This includes:
  - Completing and tracking credentialing requests in real time with Onboard Pro
  - Viewing claim status
  - Verifying benefits and eligibility
  - Submitting prior authorizations
  - Viewing ID cards
  - Verifying and attesting to your demographic data accuracy
- **Reliable routing, faster decisions and better documentation** – Online requests and submissions are routed to the right people, right away – all with a digital trail. This includes:
  - Prior authorizations
  - Reconsiderations
  - Pre- and post-service appeals

- **Streamlined submissions** – We're always adding new digital capabilities and portal enhancements to simplify your workflow and resolve your claims faster. Added features include:
  - Online attachment capabilities
  - More detailed remark codes
  - Automation to reduce rekeying
  - Smart features that make verifying your identity easier than over the phone

Learn more about going digital by viewing our **Digital Solutions Comparison Guide**.

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online; get updates on claims, reconsiderations, appeals and payment detail; submit prior authorization requests; check eligibility; and update your practice demographic information — all at no cost without calling.

Application Programming Interface (API)

API is the newest digital method for health care professionals and business partners to exchange information in a timely and effective manner. API is a common programming interface that interacts between multiple applications. Our API solutions allow you to electronically receive detailed data on claims status and payment, eligibility and benefits, claim reconsiderations and appeals (with attachments), referrals and documents. It requires technical coordination with your IT department, vendor or clearinghouse. The data is in real time and can be programmed to be pulled repetitively and transferred to your practice management system or any application you prefer. To learn more about the benefits of API, visit **UHCprovider.com/api**.

Electronic Data Interchange (EDI)

EDI is regulated by HIPAA and is the computer-to-computer exchange of data between business partners. Electronic transactions are generated from and to your computer system through a clearinghouse.

The following are EDI transactions available to health care providers:

- Claims (837)
- Eligibility and benefits (270/271)
- Unsolicited claim attachments (275)
- Claims status (276/277)
- Referrals and authorizations (278)
- Hospital admission, discharge and observation stay notifications (278N)
- Electronic remittance advice (ERA/835)

To learn more about the benefits of EDI, visit **UHCprovider.com/edi**.

Getting started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system
- Contact clearinghouses to review which electronic transactions can interact with your software system. Visit **UHCprovider.com/edi** > **EDI Clearinghouse Options** for more information.
- Point of Care Assist

When made available by UnitedHealthcare, you will do business with us electronically. Point of Care Assist™ integrates members' UnitedHealthcare health data within the electronic medical record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca**.

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, quality programs, network news and more. You'll also find information about our electronic workflow solutions, including EDI, API and the UnitedHealthcare Provider Portal.

UnitedHealthcare Provider Portal

The UnitedHealthcare Provider Portal allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks, such as submitting prior authorization requests, checking claim status, submitting appeal requests, and locating copies of PRAs and letters in Document Library. All at no cost to you and without needing to pick up the phone. Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online; get updates on claims, reconsiderations, appeals and payment detail; submit prior authorization requests; check eligibility; and update your practice demographic information — all at no cost without calling.

To access the portal, you will need to **create or sign in using a One Healthcare ID.** To use the portal:

- If you already have a One Healthcare ID, simply go to **UHCprovider.com** > Sign In to access the portal
- If you need to set up an account on the portal, follow **these steps** to register

Use the UnitedHealthcare Provider Portal to access information for the following:

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

Available benefit plan information varies for each of our UnitedHealthcare Provider Portal tools.

Here are the most frequently used tools:

- **Eligibility and benefits** – View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims** – Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Chat support** – Have a question? **Connect with us 24/7 from the UnitedHealthcare Provider Portal. For chat options and contact information, visit UHCprovider.com/contactus.**
- **Prior authorization and notification** – Submit notification and prior authorization requests. For more information, go to **UHCprovider.com** > Sign In > **Prior Authorizations**.
- **Specialty pharmacy transactions** – Submit notification and prior authorization requests for certain medical injectable drugs. For more information, go to **UHCprovider.com** > Resources > Drug lists and pharmacy > **Specialty Pharmacy – Medical Benefit Management (Provider Administered Drugs)**.
- **My Practice Profile** – View and update your health care provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library** – Access reports and correspondence from many UnitedHealthcare plans for viewing, printing or download. For more information, go to **UHCprovider.com/documentlibrary**.
- **Paperless delivery options** – In Document Library, you can manage email notifications to alert you when we add new letters to your Document Library. With our delivery options, you decide when and where the emails are sent for each type of correspondence. This tool is available to One Healthcare ID Primary Access Administrators only.

Visit **UHCprovider.com/portal** to learn more about these and other UnitedHealthcare Provider Portal tools that can simplify your administrative workflow.

We provide a full range of training resources, including interactive self-paced courses and instructor-led sessions at **UHCprovider.com/training**. The training content is organized by categories to make it easier to find what you need.

UnitedHealthcare web support

For chat options and contact information, visit **UHCprovider.com/contactus**.

Online resources and how to contact us

Online resources and how to contact us	Where to go
How to join our network	For instructions on joining the UnitedHealthcare provider network, go to **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for online tools and other helpful information.
UnitedHealthcare provider website	**UHCprovider.com** **Resources:** • Administrative guides for network health care providers • Plan-specific policies, protocols and guidelines • Health plans by state • News, regulatory and practice updates • Guidance on common member- and claim-related tasks, including eligibility and benefit verification, prior authorization and referral requirements, and claims submissions and payments • Information on our electronic workflow solutions, including EDI, API and the UnitedHealthcare Provider Portal
Advance notification, prior authorization and admission, discharge and observation stay notification (to submit and get status information)	EDI: Submit prior authorization requests and referrals using EDI 278 transactions. Go to **UHCprovider.com/edi278** for more information. Submit hospital admission, discharge and observation stay notifications using EDI 278N transactions. Go to **UHCprovider.com/edi278n** for more information. **Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Air ambulance nonemergency transport	**Online: UHCprovider.com/findprovider**
Appeal – (clinical) urgent submission (commercial members) (Medicare Advantage – follow the directions in the customer decision letter)	An expedited appeal may be available if the time needed to complete a standard appeal could seriously jeopardize the member's life, health or ability to regain maximum function. **Urgent medical fax:** 1-801-994-1083 **Urgent pharmacy fax:** 1-801-994-1058 **Urgent appeal fax:** 1-866-654-6323 For Individual Exchanges: **Urgent medical fax:** 1-888-808-9123 **Urgent appeal fax:** 1-888-808-9123 **Urgent pharmacy fax:** 1-877-239-4565

Online resources and how to contact us	Where to go
Application programming interface (API)	**Online: UHCprovider.com/api** and follow the Get Started prompts to schedule a meeting with an API consultant to learn more.
Cardiology and radiology Notification/Prior Authorization – Submission and Status	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Phone** (only where telephonic submission is permitted): **1-866-889-8054**
Chiropractic, physical therapy, occupational therapy and speech therapy providers (contracted with Optum Physical Health, a UnitedHealth Group company)	**Online: myoptumhealthphysicalhealth.com** **Phone: 1-800-873-4575**
Claims (Filing, payments, reconsiderations)	**EDI: UHCprovider.com/edi837** to learn more about the types of claims you can file using EDI and view our claims payer list to identify the correct payer ID. **Online: UHCprovider.com** > Sign In > Claims & Payments **Information: UHCprovider.com/claims** **Chat:** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Demographics	Visit the Provider Data Updates and Attestation page on **UHCprovider.com** to view ways to update and verify your provider demographic data.
Optum Pay™	**Online: optum.com/optumpay** **Help Desk: 1-877-620-6194**

Online resources and how to contact us	Where to go
Electronic data interchange (EDI) and EDI support	**Online:** UHCprovider.com/edi **Help:** UHCprovider.com/edi > EDI support and resources **Phone: 1-800-842-1109** (Monday–Friday, 7 a.m.–9 p.m. CT) **UnitedHealthcare EDI Support** **Online:** EDI Transaction Support Form **Email:** supportedi@uhc.com **Phone: 1-800-842-1109** **UnitedHealthcare Community Plan EDI Support** **Online:** EDI Transaction Support Form **Email:** ac_edi_ops@uhc.com **Phone: 1-800-210-8315**
Fraud, waste and abuse (Report potential fraud, waste or abuse concerns)	**Online:** uhc.com/fraud, select the "Report a concern" button. **Phone: 1-844-359-7736** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. For more information on fraud, waste and abuse prevention efforts, refer to **Chapter 17: Fraud, waste and abuse**.
Genetic and molecular testing	**Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need.
Member/customer care	**Online:** myuhc.com Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Mental health and substance use disorder services	See ID card for carrier information and contact numbers.
Outpatient injectable chemotherapy and related cancer therapies	**Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Phone: 1-888-397-8129**
Pharmacy services	**Online:** professionals.optumrx.com **Phone: 1-800-711-4555**

Online resources and how to contact us	Where to go
Provider advocates For participating hospitals, health care and ancillary providers; locate your physician or hospital advocate	**Online: UHCprovider.com/contact-us** > State-specific health plan and network support
Provider directory	**UHCprovider.com/findprovider**
Radiation therapy prior authorization	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Phone** (only where telephonic submission is permitted): **1-888-397-8129** (8 a.m.–5 p.m. local time Monday–Friday)
Referral submission and status You can determine if a member's benefit plan requires a referral when you view their eligibility profile.	**EDI:** Submit referral requests using EDI 278 transactions. Go to **UHCprovider.com/edi278** for more information. **API: API Marketplace** **Online: UHCprovider.com** > Sign In > Referrals **Information: UHCprovider.com/referrals** **Note:** Submitted referrals are effective immediately but may not be viewable for 48 hours.
Skilled nursing facilities (Free-standing)	**Online: UHCprovider.com/skillednursing** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Subrogation	**Online: subroreferrals.optum.com** **Fax:** 1-800-842-8810 **Mail:** Optum 11000 Optum Circle MN102-0300 Eden Prairie, MN 55344
Transplant services	See ID card for carrier information and contact numbers.
Vision services	See ID card for carrier information and contact numbers.

Chapter 2: Provider responsibilities and standards

Verifying eligibility, benefits and your network participation status

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

- Helps ensure you submit the claim to the correct payer
- Allows you to collect copayments
- Determines if a referral, prior authorization or notification is required
- Reduces denials for noncoverage

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

There are 4 easy ways to verify eligibility and benefits as shown in the **Obligation to do business with UnitedHealthcare electronically** in **Chapter 1: Introduction**.

Eligibility grace period for Individual Exchange plan members

When individuals enroll in a health benefit plan through the Health Insurance Marketplace (also known as Individual Exchange), the plans are required to provide a 3-month grace period before terminating coverage. The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least 1 full month's premium within the benefit year. Additionally, for individuals who do not receive federal subsidy assistance, plans are required to provide a grace period consistent with state law (typically 30 or 31 calendar days) before terminating coverage.

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

Refer to **Chapter 4: Individual Exchange plans** for more information.

Understanding your network participation status

Your network status is not returned on 270/271 transactions. Know your status prior to submitting 270 transactions. As our product portfolio evolves and new products are introduced, it is important for you to confirm your network status for the medical or pharmacy benefit plan (and tier status for commercial tiered benefit plans) online at **UHCprovider.com** > Sign In > Eligibility or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus** (Individual Exchange plans). If you are not participating in the member's benefit plan or are outside the network service area for the benefit plan, the member may have higher costs or no coverage.

Commercial only

For more information about tiered benefit plans, visit **UHCprovider.com/plans** > Select your state > Commercial > UnitedHealthcare Tiered Benefit Plans.

Health plan identification (ID) cards

Commercial: We are moving toward eliminating physical ID cards, and members may not have one if not required by law.

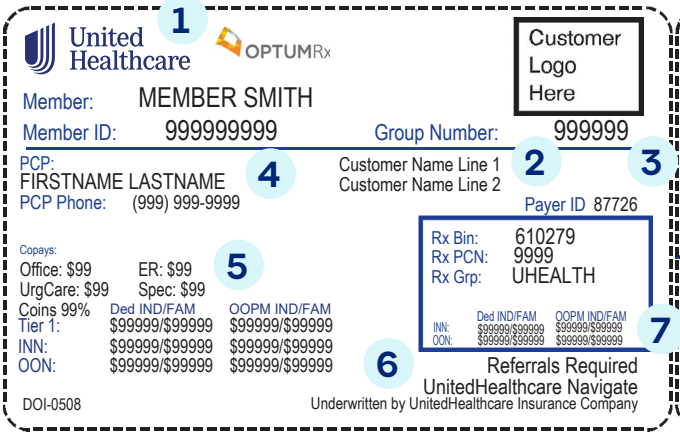
Medicare Advantage (MA): We are required to send physical ID cards to all MA members, and we also provide access to a digital version of the member ID card for both members and providers.

To view and download a digital ID card and access member-specific information around plan benefits and requirements, visit **UHCprovider.com** > Sign In > Eligibility. You can also view member eligibility and benefits through an API solution.

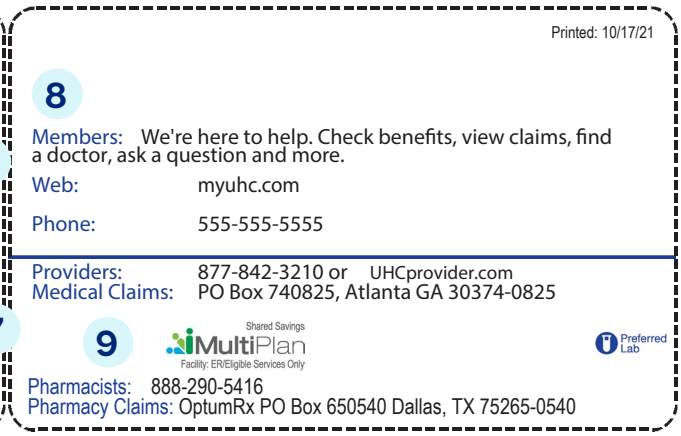
You may download and keep a copy of both sides of the health plan ID card for your records. Possession of a physical ID card is not proof of eligibility.

Commercial health plan ID card legend

Front



Back

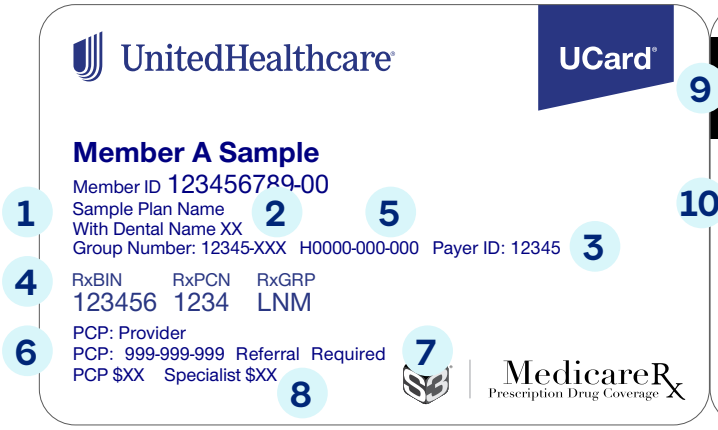


1. **UnitedHealthcare brand:** This includes UnitedHealthcare, UnitedHealthcare Level Funded, UnitedHealthcare Oxford Level Funded, Golden Rule, UnitedHealthcare Oxford, UnitedHealthcare Student Resources, UnitedHealthOne, UMR and UnitedHealthcare Shared Services (UHSS), UnitedHealthcare Freedom Plans
2. **Member plan identifier:** This is a customized field to describe the member's benefit plan (e.g., Individual Exchange, Tiered Benefits, ACO)
3. **Payer ID:** Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary
4. **PCP name and phone number:** Included for benefit plans that have PCP selection requirements – may not appear on all cards. For Individual Exchange Members PCP required is listed in place of the PCP name and number. This section may also include Laboratory, Preferred Lab Network and Radiology participant codes.
5. **Copay information:** If this area is blank, the member is not required to make a copay at the time of service
6. **Benefit plan name:** Identifies the applicable benefit plan name
7. **Referral requirements identifier:** Identifies plans with referral requirements. Requires PCP to send electronic referrals.
8. **For members section:** Lists benefit plan contact information and, if applicable, referrals and notifications information
9. **For providers section:** Includes the prescription plan name

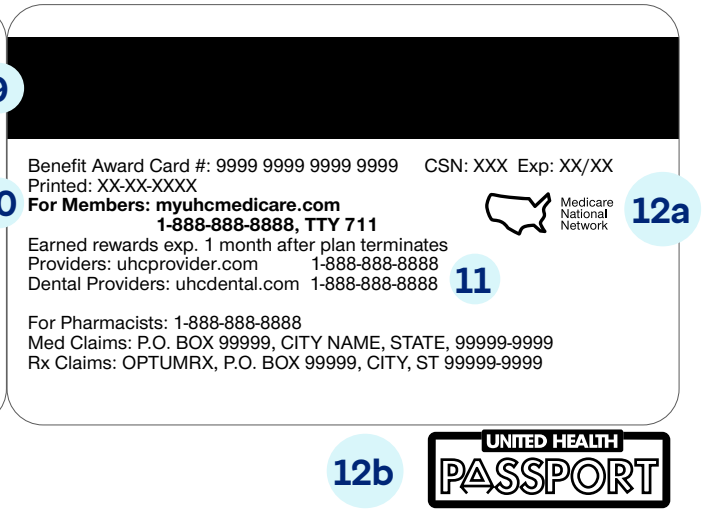
Sample member ID cards are for illustration only; actual information varies depending on payer, plan and other requirements.

Medicare Advantage (MA) member ID card legend

Front



Back



1. **Benefit plan name:** Identifies the applicable benefit plan name
2. **Dental benefits:** Included if routine dental benefits are part of the benefit plan and/or if the member purchased an optional supplemental dental benefit rider
3. **Payer ID:** Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.
4. **Prescription information:** If the benefit plan includes Part D prescription drug coverage, the Rx BIN, PCN and Group code are visible. If Part D coverage is not included, this area lists information for Medicare Part B Drugs
5. **Plan ID number:** Identifies the plan ID number that corresponds to CMS filings
6. **PCP:** Indicates member's PCP selection for the plan. Some plans do not display the PCP name on the ID card.
7. **Referral required:** Indicates a plan with referral requirements. Some plans with referral requirements do not display this wording on the ID card. Refer to the **Medicare Advantage referral plans** section in **Chapter 6: Referrals** for more detailed information.
8. **Copay information:** Select plans do not list copay information or may have a variance
9. **Payment type:** Most plan cards have a swipe-able magnetic stripe for members to purchase approved products. A smaller number of plan cards have a bar code instead.
10. **For members:** Lists benefit plan contact information for the member
11. **Providers:** Lists benefit plan contact information for the health care provider

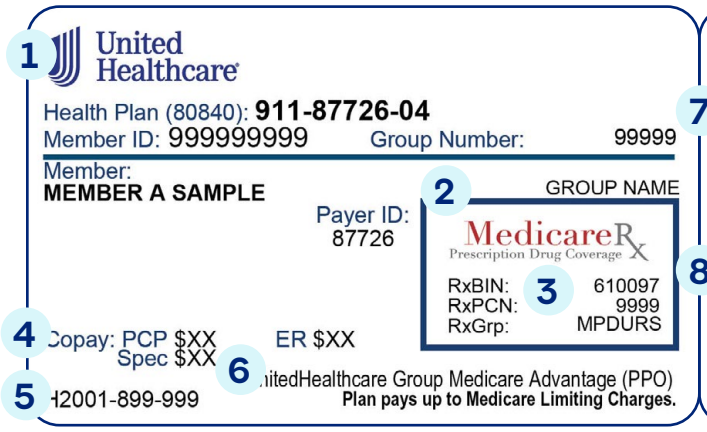
12a. **Network logo:** If the Medicare National Network logo is present, the member has access to the national network

12b. **UnitedHealth Passport logo:** If the UnitedHealth Passport logo is present, the member's plan has the Passport travel benefit

Sample member ID cards are for illustration only; actual information varies depending on payer, plan and other requirements.

Medicare Advantage (MA) Employer Group plans member ID card legend

Front



Back

1. **UnitedHealthcare brand:** Present on a UnitedHealthcare ID card
2. **Group name:** Identifies the name of the employer group
3. **Prescription information:** If the benefit plan includes Part D prescription drug coverage, the Rx Bin, PCN and Group code are visible. If Part D coverage is not included, this area lists information for Medicare Part B drugs.
4. **Copay information:** Includes PCP, specialist and ER copays
5. **Plan ID number:** Identifies the plan ID number that corresponds to Centers for Medicare & Medicaid Services (CMS) filings
6. **Benefit plan name:** Identifies the applicable benefit plan name
7. **For members:** Lists benefit plan contact information for the member
8. **For providers:** Lists benefit plan contact information for the health care provider

Note: In 2025, some employer group plans will have the UnitedHealthcare UCard instead of the standard member ID card shown above. The UCard will look similar to the one used for individual plans on the previous page and will additionally display some employer group specific content. Please refer to the **Medicare Advantage (MA) member ID card legend** for a sample copy of the UCard.

Sample member ID cards are for illustration only; actual information varies depending on payer, plan and other requirements.

Access standards

Covering physician

PCPs must arrange for 24 hours a day, 7 days per week coverage of our members. If arranging a substitute health care provider, use those who are in-network with the member's benefit plan.

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

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

Appointment standards

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

Type of service	Standard
Preventive care	Within 30 calendar days
Regular/routine care appointment	Within 14 calendar days
Urgent care appointment	Same day
Emergency care	Immediate
After-hours care	24 hours/7 days a week for PCPs

These are general UnitedHealthcare guidelines. State or federal regulations may require standards that are more stringent. Go to **uhc.com/legal** and select your state to find additional information about timely access to care.

After-hours phone message instructions

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

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

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

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

Timely access to nonemergency health care services (applies to commercial in California)

- The timeliness standards require licensed health care providers to offer members appointments that meet the California time frames. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable:
  - Is acting within the scope of their practice and consistent with professionally recognized standards of practice
  - Has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the member's health
- Licensed staff must triage or screen services by phone 24 hours a day, 7 days a week. Unlicensed staff shall not use the answers to those questions to assess, evaluate, advise or make any decision regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional.
- UnitedHealthcare of California managed care members and covered persons under UnitedHealthcare benefit plans have access to free triage and screening services 24 hours a day, 7 days a week by calling the Optum NurseLine number on the back of their ID card. If a member is unable to obtain a timely referral to an appropriate

health care provider, refer to the **Out-of-network provider referrals (Commercial HMO and Medicare Advantage)** section for further details. If still unable to obtain a timely referral to a health care provider after following these steps, contact the following:

- For members with Department of Managed Healthcare regulated plans: 1-888-466-2219
- For members with California Department of Insurance regulated plans: 1-800-927-4357

Telehealth services

Under certain benefit plans, we provide coverage for telehealth services regardless of whether the member is located at a CMS-designated originating site. For more information on telehealth services, see the **Telehealth services protocol** in **Chapter 9: Specific protocols**.

Provider privileges

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

Cultural competency

Provide services in a culturally competent manner. This includes members with limited English proficiency, and those with diverse backgrounds and/or disabilities. For more information, go to **UHCprovider.com** > Resources > Resource library > Patient care resources for health care professionals > Patient health and safety > **Cultural Competency**.

Translation/interpretation/auxiliary aide services

You must provide language services and auxiliary aides, including, but not limited to, sign language interpreters, to members as required, to provide members with an equal opportunity to access and participate in all health care services. Download the **I Speak language assistance card** to help your patients identify their preferred language and arrange for interpretation services.

If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member.

Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

Any materials you have a member sign and any alternative check-in procedures (like a kiosk) must be accessible to an individual with a disability.

If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing so they receive them prior to the Virtual Visit.

Primary care provider responsibilities

PCPs are responsible to provide medically necessary primary care services. They are the coordinator of our members' total health care needs. They are responsible for seeing all members on their panel who need assistance, even if the member has never been in for an office visit. Some benefit plans require PCPs to submit electronic referrals for the member to see another network physician. Go to **Chapter 6: Referrals** for detailed information on referral requirements.

Providers may not be selected as their own assigned PCP and may not be listed as immediate family members PCP. Immediate family member means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild or grandchild's spouse.

Civil rights

Nondiscrimination

You must not discriminate against any patient regarding quality of service or accessibility of services because they are our member. You must not discriminate against any patient based on any of the following:

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

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

Complying with laws and regulations for individuals with disabilities

You must comply with applicable laws, which include, but are not limited to, the Americans with Disabilities Act (ADA) and Section 504 or 508 of the Rehabilitation Act.

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

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

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

- Accessibility to your office or facility
- The methods you or your staff use to communicate with members with disabilities. This may also include any electronic communications.
- The training your staff receives to learn and implement these guidelines

Care for members who are deaf or hard of hearing

You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.

Confidentiality, use of Licensed Marks, publicity

Consolidated Appropriations Act, 2021 (CAA) prohibition on gag clauses

Your participation agreement may include a confidentiality provision that describes information that neither party may disclose to a member, other health care provider or other third party except as required by an agency of the government, court order or other third party. You agree the CAA constitutes such a requirement by an agency of the government, and nothing in your participation agreement will be interpreted to supersede or conflict with the CAA. Specifically, your participation agreement will not be interpreted to directly or indirectly restrict us (as a health insurance issuer offering group and individual health insurance coverage) or a group health plan from:

1. Providing provider-specific cost or quality of care information to referring health care providers or current and potential members
2. Electronically accessing de-identified claims and encounter information for each member in the plan or coverage, upon request and consistent with the privacy regulations related to section 264(c) of the Health Insurance Portability and Accountability Act (HIPAA), the amendments made by the Genetic Information Nondiscrimination Act of 2008 and American with Disabilities Act of 1990. This includes, on a per claim basis, the following:
   - Financial information
   - Provider information
   - Service codes
   - Any other data included in claim or encounter transactions
3. Sharing information with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with HIPAA, the amendments made by the Genetic Information Nondiscrimination Act of 2008 and the Americans with Disabilities Act of 1990

Use of Licensed Marks, publicity

Except as required by applicable law or as provided herein, you will not have any right to use the names, logos, trademarks, trade names or other marks of United (collectively, "United Marks"), including in connection with any advertising, sales promotions, press releases and other publicity matters.

During the term of the Agreement, you are granted a limited, non-sublicensable, nontransferable, and nonexclusive license to use within the United States the UNITEDHEALTHCARE name and logo (the "Licensed Marks") solely for the limited purposes of (i) using or displaying the Licensed Marks alongside names or logos of other insurance carriers with whom you have a network participation agreement, or (ii) communicating verbally or in writing to your prospective or existing patients that you have an agreement with us to provide health care services to our members. The use of the Licensed Marks cannot be expanded beyond what is allowed under the Agreement or this guide. You will only use the trademark and logo files provided to you by the United Brand Team (you must contact the United Brand Team at **brand.team@uhc.com**). You will comply with all requirements made available by United regarding use of United Marks and Licensed Marks. We may at any time withdraw our permission for you to use any Licensed Marks, effective upon written notice to you, and you shall promptly comply with our instructions provided in such notice. All other uses of United Marks will require our advance written consent.

If either you or we intend to issue a press release or other public disclosure pertaining to our business relationship, the issuing party will ensure the material does not:

- Mischaracterize the nature of the relationship between us,
- Suggest any endorsement or promotion of the other party, or
- Disclose or describe information subject to the confidentiality obligations embedded in our Agreement

You will not issue a press release or other public disclosure pertaining to our Agreement without receiving our advanced written consent.

Consolidated Appropriations Act, 2021 (CAA) requirements

Continuity of Care

Health insurance issuers, plan sponsors and/or health care providers are required to comply with the Continuity of Care requirements under the CAA unless your participation agreement states otherwise.

Continuity of Care is provided in the following circumstances:

1. Your participation agreement with us or between you and a downstream provider is terminated by us, a payer, you or a downstream provider
2. The terms of your network participation with us or a payer changed, and that change leads to certain members no longer receiving in-network coverage for your care
3. A fully insured group contract between us and a group health plan terminated and that termination leads to members no longer receiving in-network coverage for your care

Under the CAA, Continuity of Care must be offered to members in your care or the care of your downstream contracted providers who are:

1. Undergoing treatment for a serious and complex medical condition
2. Undergoing inpatient or institutional treatment
3. Scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery
4. Pregnant and receiving treatment related to the pregnancy
5. Terminally ill per the Social Security Act and receiving treatment for the terminal illness

In accordance with the CAA, you must accept payment from us or a payer based on your participation agreement and negotiated rates for any services rendered pursuant to the Continuity of Care requirements under the CAA. Any care you render to a member under Continuity of Care is subject to our or any payer's applicable policies, procedures and quality standards.

You also acknowledge additional rights for Continuity of Care may be required under state or local law or as specifically required in your participation agreement with us.

Provider directory

Consistent with the CAA, we will verify information in our provider directory. You will provide us with accurate information and respond to our questions when you receive them. You will respond within any time period listed in the communication we send to you. We may remove health care providers and facilities from the provider directory if we can't verify information.

Cooperation with quality improvement and patient safety activities

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

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

Demographic changes

If you have access and editing rights to My Practice Profile, you can make demographic updates right in the tool. For more information, go to **UHCprovider.com/mypracticeprofile** or **UHCprovider.com/demographics**.

Provide timely notice of demographic changes

Every quarter, you or an entity delegated to handle credentialing activities on behalf of us (a "delegate"), are expected to review, update and attest to the health care provider information available to our members. If you or the delegate cannot attest to the information, you must correct it online (as described below). You or the delegate must tell us of changes to the information at least 30 calendar days before the change is effective. This includes adding new information and removing outdated information, as well as updating the information listed in the following paragraph.

You or the delegates are required to update all health care provider information, such as the following:

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

Delegates are responsible for notifying us of these changes for all the participating health care providers credentialed by the delegate. If you or a delegate fails to (1) update records or (2) give 30 days prior notice of changes or (3) attest to the information, you or the participating health care providers credentialed by the delegate may experience delays in processing claims or denial of claims payment until the records are reviewed and attested to or updated.

If a health care provider leaves your practice, notify us immediately. This allows us to timely notify impacted members as may be required. If the healthcare provider leaving your practice is a PCP, then, when possible, the notice should identify the PCPs who will assume the membership previously assigned to the departing PCP. A tier 1 PCP should be provided if a member is on a tiered benefit plan.

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

To update your practice information

You can make demographic updates to your practice information by:

- Using Provider Directory Snapshot within CAQH Provider Data Portal
- Using My Practice Profile within the UnitedHealthcare Provider Portal (**UHCprovider.com** > Sign In > Practice Management > My Practice Profile)

For nonparticipating providers: Please submit your claim for reimbursement with the most updated information, and your demographic updates will be addressed at the point of claims processing.

To add or remove a physician or healthcare provider

To add a physician or other healthcare provider to your existing Agreement, submit a request through Onboard Pro (**UHCprovider.com** > Sign In > Practice Management > Onboard Pro).

If you need to remove a physician or other healthcare provider from your Agreement, submit a request through My Practice Profile (**UHCprovider.com** > Sign In > Practice Management > My Practice Profile).

Unless otherwise approved by UnitedHealthcare, the effective date for removal of a PCP from your agreement will be the last day of a month.

Physician panel status

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

Follow these definitions:

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

If you wish to change your panel status (i.e., open to new patients, open to existing patients only, or closed), the request must be made in writing 30 days in advance. Changes to panel status apply to all patients for all lines of business (LOB) and products for which a health care provider is participating. If you feel that exceptional circumstances exist, you may request to have a different panel status for an LOB or product. Include the exception in the written request. Approval is at our discretion. We may notify you in writing of changes in our panel status including closures based on state and/or federal requirements, current market dynamics and patient quality indicators. For more information, go to **UHCprovider.com/mypracticeprofile**.

Primary care physicians (PCPs) are responsible for monitoring office capacity based on member assignments and for notifying us if they have reached maximum capacity. A self-reporting tool is available to generate a PCP panel roster report using **UHCprovider.com/reports**.

Provider directory suppression

We are committed to making sure members and prospective members have access to the most accurate provider information in our directories. We strive to ensure provider location information includes only those locations where the member can make an appointment with the provider.

Using internal and external resource data, we periodically analyze and identify provider locations where the member would not be able to make an appointment with the provider at the location identified. When found, the provider location will be suppressed from the directory. In ongoing analysis, if a provider is later found to be available for appointments at a suppressed location, the suppression will be removed.

This activity has no impact on billing or claims payment. The provider record will not be changed beyond suppressing the provider location from the directory.

Physician/health care professional verification outreach

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

Your office may receive a call from us asking to verify your data currently on file in our provider database.

Notice of certain events

Notify us within 10 calendar days if any of these situations occur:

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

Notice must be sent in the manner and method required by your Agreement to the notice address identified in your Agreement or any subsequently updated address.

For Preferred Care Network and Preferred Care Partners, you must contact their Network Management department by email, **pcp-networkmanagementservices@uhcsouthflorida.com**, or call **1-877-670-8432**. Changes should not be made in the UnitedHealthcare Provider Portal.

Notification of practice or demographic changes (applies to commercial benefit plans in California)

California Senate Bill 137 requires us to perform ongoing updates to our health care provider directories, both online and hard copy. Participating medical groups, Independent Practice Associations (IPAs) or independent physicians are required to update UnitedHealthcare within 5 business days if there are any changes to their ability to accept new patients.

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 health care provider directory to:

- UnitedHealthcare for additional assistance in finding a health 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 health care providers, including but not limited to, contracted medical groups or IPAs on an annual basis and independent physicians every 6 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 health care provider directory after 10 business days.

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

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

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

For delegated providers – the designated submission pathway, which includes CAQH Provider Data Portal for Groups, Demographic API, or My Practice Profile for Groups.

For nondelegated providers – visit **UHCprovider.com** for further instructions.

Administrative terminations for inactivity

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

- Administratively terminate Agreements for health care providers who have not submitted claims for 1 year
- Inactivate any TIN under which there have been no claims submitted for 1 year

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

We administratively terminate a health care provider if:

- We get oral notice that a practitioner is no longer with a practice
- We make 3 attempts to obtain documentation confirming the practitioner's departure but do not receive the requested documentation
- The practitioner has not submitted claims under that practice's TIN(s) for 6 months prior to our receipt of oral notice the practitioner left the practice or the effective date of departure provided to us, whichever is sooner. This does not apply to Preferred Care Network and Preferred Care Partners.

Continuity of care following termination of your participation

If your Agreement ends for any reason, you may be required to help our members find another participating health care provider. You may need to provide services at our contracted rates during the continuation period, per your Agreement and any applicable laws. We are ready to help you and our members with the transition. We tell affected members at least 30 calendar days (45 days for MA) prior to the effective date of your participation termination, or as required under applicable laws.

Member dismissals initiated by a PCP (Medicare Advantage)

We recognize there are certain instances a PCP may choose to terminate a patient relationship. While we will not interfere with the PCP's decision, PCPs who wish to terminate their relationship with an MA member and have a member reassigned must:

- Comply with all applicable legal and regulatory requirements
- Send a certified letter to the member (evidence that the letter was mailed is acceptable even if a letter comes back as undeliverable as addressed)
- Provide continuity of care as required by applicable laws and regulations
- Provide us written notice

Required information from the PCP

For member reassignment or termination, we require the following information from the PCP:

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

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

Medicare opt-out

We follow, and require our health care providers to follow, Medicare requirements for physicians and other practitioners who opt out of Medicare. If you opt-out of Medicare, you may not accept federal reimbursement. Health care providers who opt out of Medicare (and those not participating in Medicare) are not allowed to bill Medicare or its MA benefit plans during their opt-out period for 2 years from the date of official opt-out. For our MA membership, we and our delegated entities do not contract with, or pay claims to, health care providers who have opted out of Medicare. Exception: In an emergency or urgent care situation, if you have opted out of Medicare, you may treat an MA beneficiary and bill for the treatment. In this situation, you may not charge the member more than what a nonparticipating health care provider is allowed to charge. You must submit a claim to us on the member's behalf. We pay Medicare-covered items or services furnished in emergency or urgent situations.

Additional Medicare Advantage requirements

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

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

- You may not discriminate against members in any way based on health status
- You must allow members direct access to screening mammography and influenza vaccination services
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services
- You must provide female members with direct access to a women's health specialist for routine and preventive health care services
- You must make sure members have adequate access to covered health services
- You must make sure your hours of operation are convenient to members
- You must make sure medically necessary services are available to members 24 hours a day, 7 days a week
- PCPs must have backups for absences
- You must adhere to CMS marketing regulations and guidelines. This includes, but is not limited to, the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge or attempt to persuade Medicare beneficiaries to enroll or disenroll in a specific plan based on the health care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must ensure that services are provided in a culturally competent manner and to promote equitable access to all members, including people:
  - With limited English proficiency or reading skills
  - Of ethnic, cultural, racial or religious minorities
  - With disabilities
  - Who identify as lesbian, gay, bisexual or other diverse sexual orientations
  - Who identify as transgender, nonbinary and other diverse gender identities or people who were born intersex
  - Living in rural areas and other areas with high levels of deprivation
  - Otherwise adversely affected by persistent poverty or inequality
- You must cooperate with our procedures to tell members of health care needs that require follow-up and provide necessary training to members in self-care
- You must document in a prominent part of the member's medical record whether they have executed an advance directive

- You must provide covered health services in a manner consistent with professionally recognized standards of health care
- You must make sure any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards
- You must comply with all applicable federal and Medicare laws, regulations and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including but not limited to, applicable provisions of federal criminal law, The False Claims Act and the Anti-Kickback Statute; and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164
- The payments you receive from us or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage
- You must comply with our processes for notifying members if your participation agreement terminates
- You must submit all **Risk adjustment data** (see definition in glossary) and other MA program and commercial insurance related information we may request within the time frames specified and in a form that meets MA program requirements as well as state and federal commercial insurance requirements. By submitting data to us you represent to us, and upon our request you shall certify in writing that the data is accurate, complete and truthful, based on your best knowledge, information and belief.
- You must comply with our MA medical policies, quality improvement programs and medical management procedures
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators as specified by CMS
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within 2 hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.
- You must comply with the Medicare Advantage Regulatory Requirements Appendix in your Provider Agreement

Member communication (CMS approval required)

Member communications require CMS approval. This includes:

- Anything with the MA and/or the AARP name or logo, including MA dual special needs plans (D-SNP)
- Correspondence that describes benefits
- Marketing activities

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

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

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

In addition to making sure the letter is approved by the governing regulatory body, we direct the letter to the correct audience. For example, we may need to distinguish a mailing to MA plan individual members versus Medicare employer group plan members, as their benefits are distinctly different.

Part C reporting requirements

MA organizations are subject to additional reporting requirements. We may request data from you. This data is due by 11:59 p.m. PT on our established reporting deadline.

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

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

Filing of a lawsuit by a member

Lawsuits against a health care provider

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

We consider a transfer if:

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

Lawsuits against a medical group/IPA

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

Note: If you receive notification of a member's plan to sue, notify your health care provider advocate online at **UHCprovider.com** > **Contact us** > State-specific health plan and network support.

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

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

Chapter 3: Commercial products

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

Individual Exchange plans

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

For Individual Exchange in AL, AZ, FL, GA, IA, IL, IN, KS, LA, MD, MI, MO, MS, NE, NJ, NM, NC, OH, OK, SC, TN, TX, VA, WA, WI, WY, refer to **Chapter 4: Individual Exchange plans**.

Understanding your network participation status

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

Commercial networks

Each commercial product has a network of health care providers we work with to provide more affordable, quality health care. The following benefit plans include a subset of our commercial network care providers: Charter, Compass, Core, Doctors Plan, Individual Exchange, Navigate, NexusACO and Select. A list of participating health care providers by benefit plan is on **UHCprovider.com/findprovider**. Your Agreement requires you to coordinate care with other participating network providers. Do not engage non-network providers in a member's care.

Commercial product overview table

Product name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Choice and Choice Plus	Members can seek care from any Choice network physician or health care professional without a referral and without designating a PCP. In some instances, you may see the PCP on the member's ID card. UnitedHealthcare Choice Plus provides out-of-network benefits. UnitedHealthcare Choice does not cover out-of-network services (except for emergency services).	No, members have open access to a national network of Choice health care providers.	Yes, on selected procedures as described in **Chapter 7: Medical management** of this guide.

Product name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Doctors Plan and Doctors Plan Plus	Members choose, or are assigned, a Doctors Plan network PCP for each family member. Members are encouraged to see their PCP to coordinate their care, but are not required to see that PCP, or to obtain a referral from a PCP when accessing a Doctors Plan network specialist or facility for care. UnitedHealthcare Doctors Plan Plus provides out-of-network benefits. UnitedHealthcare Doctors Plan does not cover out-of-network services (except for emergency services).	No, members have open access to a limited network of Doctors Plan health care providers available nationally.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.
UnitedHealthcare Select and Select Plus	Members choose, or are assigned, a Select network PCP for each family member. Members are encouraged to see their PCP to coordinate their care, but are not required to see that PCP, or to obtain a referral from a PCP when accessing a Select network specialist or facility for care. UnitedHealthcare Select Plus provides out-of-network benefits. UnitedHealthcare Select does not cover out-of-network services (except for emergency services).	No, members have open access to a national network of Select health care providers.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.
UnitedHealthcare Options PPO	Members can seek care from any Choice network physician or health care professional without a referral and without designating a PCP. In some instances, you may see the PCP on the member's ID card. Options PPO provides out-of-network benefits.	No, members have open access to a national network of Options PPO health care providers.	This may be the obligation of the provider or the member and will depend on the member's benefit plan.
UnitedHealthcare Indemnity	Members can choose any physician or health care professional.	No, members have open access to any health care provider.	No, members are responsible for notifying us using the phone number on their health plan ID card.

Product name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Core and Core Essential	Members can choose any Core network physician or health care professional without a referral and without designating a PCP. Core provides out-of-network benefits. Core Essential does not (except for emergency services).	No, members have open access to a limited network of health care providers available nationally.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.
UnitedHealthcare Freedom Plans **Granite Advantage/Saver EPO, Granite Advantage EPO OA and Granite Advantage/Saver PPO OA**	Members must select a PCP for the EPO plan and have electronic referrals submitted to UnitedHealthcare by their PCP before seeing another Freedom network physician. For EPO OA and PPO OA plans, members can choose to see any network physician without a referral or designating a PCP. The PPO OA plan provides out-of-network benefits. The EPO plans do not (except for emergency services).	No, referrals are not required on Granite Advantage EPO OA and Granite Advantage/Saver PPO OA plans. Yes, referrals are required on Granite Advantage/Saver EPO plans. An electronic referral from the member's PCP is required prior to receiving services from a participating physicians in the Freedom network. **See Chapter 6: Referrals** of this guide.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.
UnitedHealthcare Navigate, Navigate Balanced **Navigate Plus**	Members must see their PCP and have electronic referrals submitted to UnitedHealthcare by their PCP before seeing another UnitedHealthcare Navigate® network physician. Navigate Balanced® and Plus benefit plans provide additional network coverage, at a higher member cost-share, for services from a Navigate network physician other than the member's PCP without a referral. Navigate Plus® provides out-of-network benefits.[3] Navigate and Navigate Balanced do not (except for emergency services).	Yes, an electronic referral from the member's PCP is required prior to receiving services from a Navigate physician participating in this limited Navigate network. **See Chapter 6: Referrals** of this guide.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.

Product name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare Charter, Charter Balanced, Charter Plus	Members must see their PCP and have electronic referrals submitted by their PCP before seeing another UnitedHealthcare Charter® network physician to receive the highest level of coverage. Charter Balanced® and Charter Plus® benefit plans provide additional network coverage, at a higher member cost-share, for services from a Charter network physician other than the member's PCP without a referral. Charter Plus provides out-of-network benefits. Charter and Charter Balanced do not (except for emergency services).	Yes, an electronic referral from the member's PCP is required prior to receiving services from a Charter health care provider participating in this limited Charter network. **See Chapter 6: Referrals** of this guide.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.
UnitedHealthcare Compass, Compass Balanced, Compass Plus	Members must see their PCP and have electronic referrals submitted by their PCP before seeing another Compass network physician within the Compass network service area to receive the highest level of coverage.[4] Compass Balanced and Plus benefit plans provide network coverage at a higher member cost-share for services from a network physician other than the member's PCP without a referral. Compass Plus provides out-of-network benefits. Compass and Compass Balanced do not (except for emergency services).	Yes, an electronic referral from the member's PCP is required prior to receiving services from a Charter health care provider participating in this limited Charter network. **See Chapter 6: Referrals** of this guide.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.
Individual Exchange Plans	Plans are sold on the Exchange marketplace. Members choose, or are assigned, a network PCP for each family member. Members must see a network PCP to coordinate care. In some states, members must obtain a referral from a PCP when accessing a network specialist for care. Individual Exchange plans do not provide out-of-network benefits (except for emergency services) and members must stay within a defined service area to access care. See **Chapter 4** for more information on Individual Exchange plans.	Referrals are required in some states.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.

Product name[1]	How do members access physicians and health care professionals?[2]	Is a referral required from the member's PCP to the network specialist?	Is the treating network physician and/or facility required to give notification when providing certain services?
UnitedHealthcare NexusACO OA **NexusACO OAP**	NexusACO OA® is a tiered benefit plan where members choose, or are assigned, a network PCP for each family member. The member is encouraged to see their PCP to coordinate their care, but is not required to see that PCP, or obtain a referral when accessing other network providers. NexusACO OAP® is a tiered benefit plan and provides out-of-network benefits. NexusACO OA does not cover out-of-network services (except for emergency services). All NexusACO benefit plans are tiered.	No, members have open access to a national network of health care providers.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.
UnitedHealthcare NexusACO R **UnitedHealthcare NexusACO RB** **NexusACO RP**	NexusACO R® is a tiered benefit plan where members must see their assigned network PCP and have electronic referrals submitted by their PCP before seeing another network specialist to receive the highest level of coverage. NexusACO RB® benefits are reduced without a referral. NexusACO RP® provides out-of-network benefits.[3] NexusACO R and RB do not (except for emergency services). All NexusACO benefit plans are tiered.	Yes, an electronic referral from the member's PCP is required prior to receiving services from a Charter health care provider participating in this limited Charter network. **See Chapter 6: Referrals** of this guide.	Yes, on selected procedures, as described in **Chapter 7: Medical management** of this guide.

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

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

[3] The benefit level for nonemergency services from out-of-network physicians and other health care providers is generally less than that for services from network physicians and other health care providers.

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

Benefit plan types

Open access benefit plans

No referral or PCP approval is required for members to see other network providers. Prior authorization and notifications are required for certain services, described in **Chapter 7: Medical management**, with the exceptions noted in the previous table. Benefit plans vary in the type of coverage offered based on network and tier status (for tiered benefit plans only).

Gated benefit plans

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

Tiered benefit plans

Plans define tier 1 health care providers differently. Check your tier status by visiting **UHCprovider.com** > Sign In > Eligibility. Some of our commercial products feature tiered benefits. NexusACO is always offered as a tiered benefit plan. Members may have lower out-of-pocket costs for services provided by a tier 1 health care provider or facility. Members with a tiered benefit plan have a Tiered Benefits identifier on the front of their ID card.

W500 additional network benefits

Some benefit plans include additional network benefits referred to as W500 Emergent Wrap. We contract with network providers, whose agreements exclude them from some products, to provide network coverage for urgent, emergent and network gap exception services. This extends the network of health care providers available to members outside their primary network for these services. Members with additional network benefits display W500 on the back of their ID card.

PCP selection

A PCP is a physician in family practice, internal medicine, pediatrics or general practice. Other specialties may be included if required by state law. The PCPs designated by the member and enrolled dependent(s) do not need to be the same person or affiliated with the same group. The member and enrolled dependent(s) must select a PCP within the geographic area where the subscriber lives.

Members in a gated plan,* and the open access products of Doctors Plan, NexusACO OA and Select choose a network PCP at the time of their enrollment. If a PCP is not selected by a member, we assign one. Members in nongated plans may be able to select a PCP during enrollment or one may be assigned. This does not alter the product rules or administration processes in nongated plans.

Care providers may not be selected as their own assigned PCP and may not be listed as immediate family members' PCP. Immediate family member means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild or grandchild's spouse.

You can verify a member's PCP when you verify their eligibility, as shown in the **Verifying eligibility, benefits and your network participation status** section in **Chapter 2: Provider responsibilities and standards**.

Consumer-driven health benefit plans

Consumer-driven health benefit plans are made to help members:

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

These benefit plans are listed on the ID card and by visiting **UHCprovider.com** > Sign In > Eligibility. These plans include an account that helps members pay their out-of-pocket costs on a pretax basis. The account can either be a health savings account (HSA) or a health reimbursement account (HRA).

HRAs and HSAs are similar in many ways:

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

*Subject to specific benefit designs.

HRAs and HSAs differ in that:

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

Chapter 4: Individual Exchange plans

UnitedHealthcare offers plans both on and off the Health Insurance Marketplace (Exchange). This chapter applies to the plans we offer on the Health Insurance Marketplace for the states listed in the following table. Individual Exchange Benefit Plans are also referred to as Individual and Family Plans. Participating providers for the Exchange Plans are subject to this chapter in addition to topics described elsewhere in this guide. For purposes of Individual Exchange Benefit Plans, this chapter controls if it conflicts with information elsewhere in the main guide.

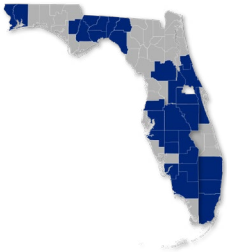
Additional plans may be offered in Nevada (administered by Sierra/Health Plan of Nevada) and Colorado (administered by UnitedHealthcare under Rocky Mountain Health Plan license). Those plans follow a separate administrative guide, as indicated in the **Benefit plans not subject to this guide** section in **Chapter 1: Introduction**.

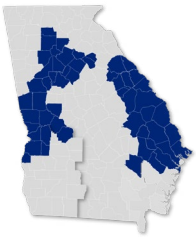
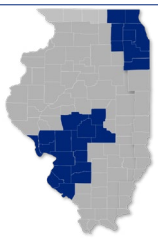
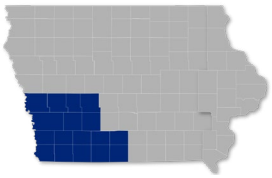
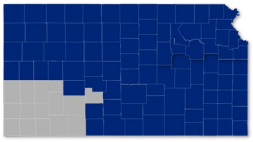
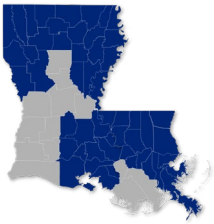
Individual Exchange plans offered in New York (Compass) and Massachusetts (Navigate) will follow the commercial plan guidelines listed elsewhere in this guide and are not subject to this chapter.

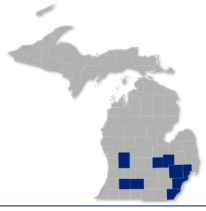
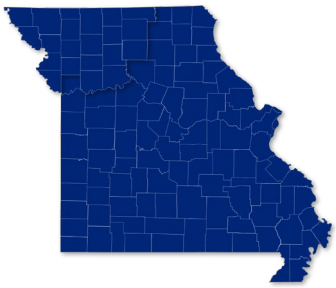
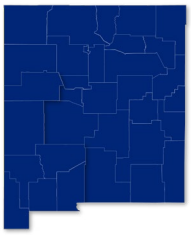
UnitedHealthcare participation in Exchanges

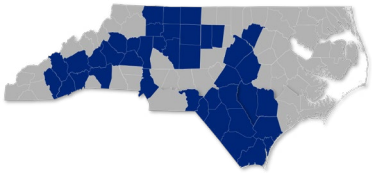
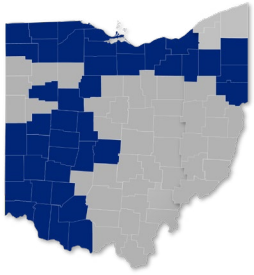
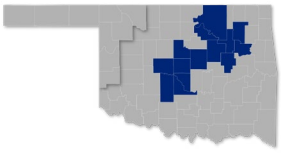
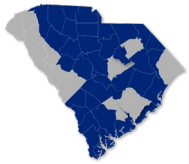
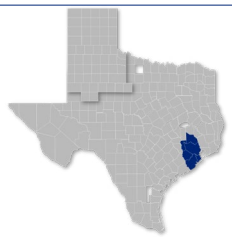
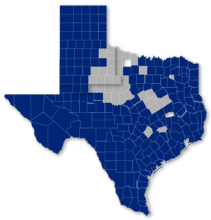
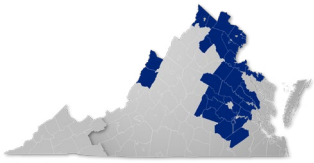
UnitedHealthcare evaluates each Exchange opportunity according to our ability to provide value, and honor commitments to our existing local customers, members and health care providers. In 2024, we participated in Alabama, Arizona, Colorado, Florida, Georgia, Illinois, Kansas, Louisiana, Maryland, Michigan, Mississippi, Missouri, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin. In 2025, we will add 4 additional states: Indiana, Iowa, Nebraska and Wyoming.

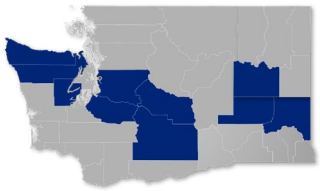
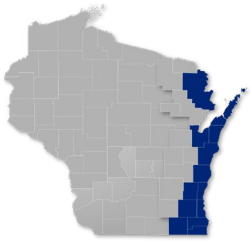
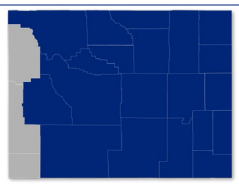
2025 Exchange footprint

State	Service area	Network	Marketplace
Alabama	56 counties	Individual Exchange Benefit Plan	Individual Exchange
Arizona	Gila, La Paz, Maricopa, Mohave, Pima and Pinal counties	Individual Exchange Benefit Plan	Individual Exchange
Florida	32 counties. Coverage not offered in Pinellas county for 2025. 	Individual Exchange Benefit Plan	Individual Exchange

State	Service area	Network	Marketplace
Georgia	53 counties 	Individual Exchange Benefit Plan	Individual Exchange
Illinois	24 counties 	Individual Exchange Benefit Plan	Individual Exchange
Indiana	Boone, Hamilton, Hancock, Hendricks, Henry, Howard, Johnson, Madison and Marion counties	Individual Exchange Benefit Plan	Individual Exchange
Iowa	Adair, Adams, Audubon, Cass, Clarke, Decatur, Fremont, Guthrie, Harrison, Mills, Montgomery, Page, Pottawattamie, Ringgold, Shelby, Taylor and Union counties 	Individual Exchange Benefit Plan	Individual Exchange
Kansas	91 counties 	Individual Exchange Benefit Plan	Individual Exchange
Louisiana	51 counties 	Individual Exchange Benefit Plan	Individual Exchange
Maryland	Statewide	Individual Exchange Benefit Plan	Individual Exchange

State	Service area	Network	Marketplace
Michigan	Calhoun, Genesee, Kalamazoo, Kent, Macomb, Monroe, Oakland, Shiawassee and Wayne counties 	Individual Exchange Benefit Plan	Individual Exchange
Mississippi	69 counties	Individual Exchange Benefit Plan	Individual Exchange
Missouri	Statewide 	Individual Exchange Benefit Plan	Individual Exchange
Nebraska	Statewide	Individual Exchange Benefit Plan	Individual Exchange
New Jersey	Statewide	Oxford Metro	Individual Exchange
New Mexico	Statewide 	Choice Network	Individual Exchange

State	Service area		Network	Marketplace
North Carolina	37 counties. Coverage not offered in Buncombe, McDowell and Transylvania counties for 2025.		Individual Exchange Benefit Plan	Individual Exchange
Ohio	42 counties		Individual Exchange Benefit Plan	Individual Exchange
Oklahoma	14 counties		Individual Exchange Benefit Plan	Individual Exchange
South Carolina	33 counties. Coverage not offered in Berkeley, Dorchester and Horry counties for 2025.		Individual Exchange Benefit Plan	Individual Exchange
Tennessee	87 counties		Individual Exchange Benefit Plan	Individual Exchange
Texas (Kelsey-Seybold plans only)	Brazoria, Fort Bend, Galveston, Harris and Montgomery counties		Kelsey-Seybold Anchor Individual Exchange Benefit Plan	Individual Exchange
Texas	209 counties. Coverage is discontinued in Aransas, Bee, Jim Wells, Kaufman, Kleberg, Live Oak, Nueces, Refugio and San Patricio counties for 2025.		Individual Exchange Benefit Plan	Individual Exchange
Virginia	30 counties and 11 independent cities		Individual Exchange Benefit Plan	Individual Exchange

State	Service area	Network	Marketplace
Washington	Adams, Clallam, Jefferson, King, Kittitas, Lincoln, Mason, Pierce, Whitman and Yakima counties 	Charter	Individual Exchange
Wisconsin	Brown, Door, Kenosha, Kewaunee, Manitowoc, Marinette, Milwaukee, Ozaukee, Racine, Sheboygan, Walworth, Washington and Waukesha counties 	Individual Exchange Benefit Plan	Individual Exchange
Wyoming	20 counties 	Individual Exchange Benefit Plan	Individual Exchange

Expanded coverage in certain states

Unlike many other commercial products, the Individual Exchange plans do not have a national network. Members do not have out-of-area benefit coverage, with the following exceptions as described in the table below. Members in certain states will have access to participating providers in certain counties of a neighboring state. For plan year 2025, members may cross the border to participating providers in the following counties:

Type of service	Coverage	Border counties
AL members may access	FL participating providers located in	Escambia, Santa Rosa
AL members may access	GA participating providers located in	Coweta, Muscogee, Troup
AL members may access	MS participating providers located in	Clarke, George, Harrison, Jackson, Kemper, Lauderdale, Lee, Newton, Stone
AL members may access	TN participating providers located in	Bedford, Giles, Hamilton, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Wayne
FL members may access	AL participating providers located in	Baldwin, Mobile
GA members may access	SC participating providers located in	Beaufort, Jasper
IL members may access	MO participating providers located in	Jefferson, Ste Genevieve, St Charles, St Louis, St Louis City
IL members may access	WI participating providers located in	Kenosha, Racine, Milwaukee
KS members may access	MO participating providers located in	Buchanan, Cass, Clay, Jackson, Platte
KS members may access	NE participating providers located in	Buffalo, Dundy, Fumas, Franklin, Gage, Harlan, Hitchcock, Jefferson, Lancaster, Nuckolls, Red Willow, Thayer, Webster
KS members may access	OK participating providers located in	Creek, Okmulgee, Osage, Pawnee, Rogers, Tulsa, Wagoner
LA members may access	MS participating providers located in	Claiborne, Hancock, Harrison, Jefferson, Lamar, Marion, Pearl River, Pike, Walthall, Warren
MD members may access	VA participating providers located in	Arlington, Fairfax, Fairfax City, Loudoun
MI members may access	OH participating providers located in	Lucas
MO members may access	IL participating providers located in	Madison, Monroe, St Clair
MO members may access	KS participating providers located in	Atchison, Bourbon, Cherokee, Crawford, Doniphan, Jackson, Johnson, Leavenworth, Linn, Miami, Wyandotte

Type of service	Coverage	Border counties
MO members may access	TN participating providers located in	Dyer, Shelby
MS members may access	AL participating providers located in	Baldwin, Jefferson, Mobile
MS members may access	LA participating providers located in	Concordia, E Baton Rouge, Franklin, Jefferson, Madison, Orleans, St Tammany, Tangipahoa, Tensas
MS members may access	TN participating providers located in	Fayette, Hardeman, McNairy, Shelby, Tipton
NM members may access	AZ participating providers located in	Maricopa
NM members may access	CO participating providers located in	La Plata
NM members may access	TX participating providers located in	El Paso, Lubbock, Potter
OH members may access	MI participating providers located in	Monroe
SC members may access	GA participating providers located in	Richmond
TN members may access	AL participating providers located in	Colbert, Jefferson, Lauderdale, Lawrence, Limestone, Madison, Morgan
TN members may access	MS participating providers located in	Benton, DeSoto, Lee, Marshall, Tate, Tippah, Tunica, Union
TX members may access	OK participating providers located in	Beaver, Beckham, Bryan, Canadian, Choctaw, Cimarron, Cleveland, Cotton, Ellis, Grady, Greer, Harmon, Harper, Jackson, Jefferson, Lincoln, Logan, Love, Marshall, McClain, McCurtain, Oklahoma, Roger Mills, Texas, Tillman
VA members may access	MD participating providers located in	Frederick, Prince George, Montgomery
WI members may access	IL participating providers located in	Lake

State specific plan coverage available on **UHCprovider.com**

Plan coverage and metal levels

Essential health benefits

Individual Exchange health insurance plans are required to cover essential health benefits or essential care and services as defined by each state. To learn more about essential health benefits, go to healthcare.gov.

Metal level plans

Plans offered on the Exchange are grouped into 4 metal levels based on the actuarial value: Bronze, Silver, Gold and Platinum. Each level covers the same set of essential health benefits but differs by how much the member pays in premium and total cost share. UnitedHealthcare offers Bronze, Silver and Gold plans. We do not offer Platinum plans.

	Bronze	Silver	Gold	Platinum
Monthly premium	$	$$	$$$	$$$$
Cost per visit/ prescription	$$$$	$$$	$$	$
Plan pays	60%	70%	80%	90%
Member pays	40%	30%	20%	10%

Identifying metal levels

The ID card will identify the metal level and plan name. See the **Health plan ID card** section of this chapter.

Premium tax credits and cost-sharing reduction subsidies

People who purchase coverage on the Individual Exchange may qualify for financial assistance to help lower their premium or cost-share amounts depending on their household income. As a member's qualifications change, so does eligibility for financial assistance or other government programs like Medicaid. These changes can occur within the same calendar year. Individuals must inform their state Exchange when financial changes occur, so the government can adjust their subsidy accordingly. You should verify eligibility at the point of service to confirm coverage and benefits.

3-month grace period

Individual Exchange members will have a premium they are responsible to pay each month to maintain coverage. The Patient Protection and Affordable Care Act (ACA) requires health insurers to provide a 3-month grace period before terminating coverage for people who have not paid their premium. The grace period applies to those who receive an advanced premium tax credit and have paid at least 1 full month's premium within the benefit year. Members are required to pay the first month's premium before coverage goes into effect. Additionally, for individuals who do not receive federal subsidy assistance, plans are required to provide a grace period consistent with state law (typically 30 or 31 days) before terminating coverage.

How the 3-month grace period works*	
Month 1	UnitedHealthcare processes the claims.
Month 2	UnitedHealthcare pends the claims and sends a letter to the health care provider advising them of the delinquency. The member receives a copy of the letter. You may not balance bill the member at this time. Reminders are sent to the member to complete payment.
Month 3	UnitedHealthcare pends the claims and sends a letter to the health care provider advising of the delinquency. The member receives a copy of the letter. You may not balance bill the member at this time. If the premium is paid in full by the end of the grace period, claims are released. OR If the premium is not paid in full by the end of the grace period, the member's coverage will terminate to the end of the first month. Any claims received during the second and third month will be processed and denied. You may bill the member for any unpaid amounts at the end of the grace period.

* Certain states (Texas) may require payers to pay all claims during the grace period. If a member does not pay their premium after the grace period has expired, coverage is terminated retrospectively and previously paid claims will be recouped.

Identifying members in a grace period

There are 3 ways to verify if the member is in a grace period:

1. **EDI 271 Response Transactions** – we return the following information:
   - Coverage Status
     - First month: Active
     - Second month: Active – Pending Investigation
     - Third month: Active – Pending Investigation
   - Period Start – First day of the first month of the grace period
   - Period End – Last day of the third month of the grace period
   - MSG – Individual Exchange grace period

If the service date is 1 month after the claim eligible through date, the member is in the second grace period month.

2. **UnitedHealthcare Provider Portal**
   The online secure UnitedHealthcare Provider Portal will indicate if the member is within a grace period and at what month. The portal also includes an informational icon message where the user can hover to understand what each period means to them and the member. If additional assistance is needed, you will be able to chat with a provider advocate from within the UnitedHealthcare Provider Portal.
3. **Contact Us**
   Verify member eligibility by calling Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

UnitedHealthcare benefit plans for Individual Exchanges

Plans are grouped into 5 product families

Plan name	Description	Plan sub-type
Required*	Also called standard plans, CMS and/or state-based marketplaces require all carriers to offer these plans Plan designs and cost-shares are prescribed, allowing consumers to more easily shop on price, network and product extras Available in all states where we offer Individual Exchange plans	Bronze, Silver and Gold plans
Value*	Flagship plan with moderate deductible but lower premium Mix of copays and coinsurance Typically includes some pre-deductible coverage with copay, including low-cost generics	Bronze, Silver and Gold plans
Advantage*	Lower deductible plan with higher premium Copay cost shares for many services	Silver and Gold plans
Copay Focus*	Plan provides first dollar coverage through $0 medical deductibles and most commonly accessed services have copays to provide price transparency	Bronze, Silver and Gold plans
Essential*	Lean plan design, low-cost offering Leverages a higher deductible but lower premium Available Off-Exchange only in AZ, CO, MD, OH and TX	Bronze plans

*A "+" sign indicates plan includes embedded adult dental and vision coverage.

Plan requirements

State	PCP required	Referral required	Prior auth required	Out-of-network/ area coverage
Alabama	Yes	No, not required for member to have coverage	Yes	No*
Arizona	Yes	Yes, for the member to have coverage	Yes	No*
Florida	Yes	Yes, for the member to have coverage	Yes	No*
Georgia	Yes	Yes, for the member to have coverage	Yes	No*
Illinois	Yes	As of Jan. 1, 2025, no, not required, for the member to have coverage	Yes	No*
Indiana	Yes	No, not required for the member to have coverage	Yes	No*
Iowa	Yes	No, not required for the member to have coverage	Yes	No*
Kansas	Yes	No, not required for the member to have coverage	Yes	No*
Louisiana	Yes	No, not required for the member to have coverage	Yes	No*
Maryland	Yes	Yes for gated plan; No for nongated plan	Yes	No*
Michigan	Yes	As of Jan. 1, 2025, no, not required, for the member to have coverage	Yes	No*
Mississippi	Yes	No, not required for the member to have coverage	Yes	No*
Missouri	Yes	No, not required for the member to have coverage	Yes	No*
Nebraska	Yes	No, not required for the member to have coverage	Yes	No*
New Jersey	Yes	No, not required for the member to have coverage	Yes	No*

*Except for emergency services and related authorized admissions.

State	PCP required	Referral required	Prior auth required	Out-of-network/ area coverage
New Mexico	Yes	No, not required for the member to have coverage	Yes	No*
North Carolina	Yes	No, not required for the member to have coverage	Yes	No*
Ohio	Yes	As of Jan. 1, 2025, no, not required for the member to have coverage	Yes	No*
Oklahoma	Yes	No, not required for the member to have coverage	Yes	No*
South Carolina	Yes	No, not required for the member to have coverage	Yes	No*
Tennessee	Yes	No, not required for the member to have coverage	Yes	No*
Texas	Yes	Yes, for the member to have coverage	Yes	No*
Texas – Kelsey-Seybold Narrow Network	Yes, Kelsey-Seybold Clinic PCPs	Yes, for specialists outside of Kelsey-Seybold Clinic	Yes	No*
Virginia	Yes	As of Jan. 1, 2025, no, not required for the member to have coverage	Yes	No*
Washington	Yes	As of Jan. 1, 2025, no, not required for the member to have coverage	Yes	No*
Wisconsin	Yes	As of Jan. 1, 2025, no, not required for the member to have coverage	Yes	No*
Wyoming	Yes	No, not required for the member to have coverage	Yes	No*

*Except for emergency services and related authorized admissions.

Understanding your network participation

Check your participation agreement to determine if you are participating for the Individual Exchange Benefit plans in your state. You may have also received a notice letter or amendment from us clarifying your participation status. If you have questions, please contact your Network Manager. To locate your Network Manager, visit **UHCprovider.com/contact-us**. For Individual Exchange Benefit Plan and Charter Exchange networks, you must also have a location in the network service area to be eligible for in-network coverage.

As a participating health care provider, you agree to give UnitedHealthcare members equal access to the treatment they need. This includes service or treatment for any Exchange member with plans in which you participate.

Access to services/appointment wait time

CMS, which governs Exchanges, requires that members receive access to services in a timely manner. Participating providers must adhere to the following average wait times for appointments:

Provider specialty type appointments must be available within:

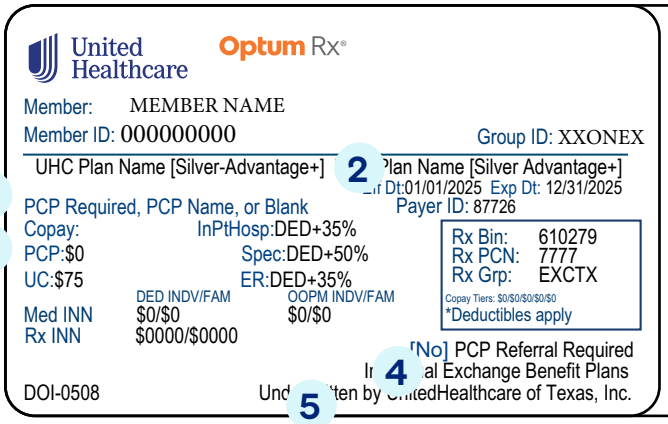
- Behavioral health – 10 business days
- Primary care (routine) – 15 business days
- Specialty care (nonurgent) – 30 business days

Reimbursement

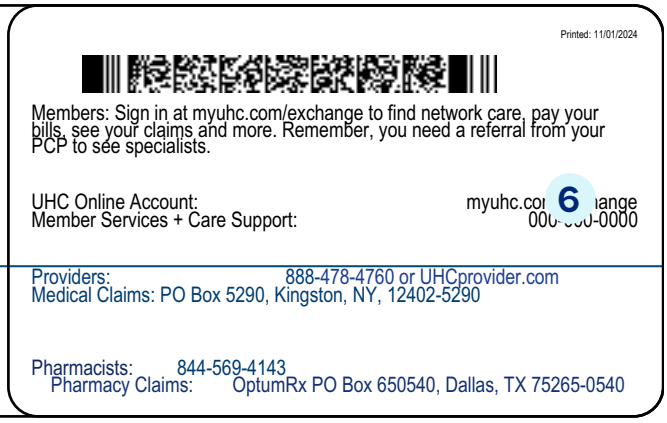
Reimbursement for Individual Exchange plans is the same as your commercial rates, unless your Agreement includes a specific Payment Appendix for the network name (Individual Exchange Benefit Plan, Charter, Oxford, Choice).

Health plan ID card

Front



Back



1. **Plan name** – includes the metal level – bronze, silver, gold, platinum
2. **Group number** – ONEX – plans offered on the Exchange, OFEX – plans offered off the Exchange
3. **PCP name** – PCP Required or blank
4. **Referral required indicator** (if applicable)
5. **Member's network name**
6. The word **exchange** indicates an Exchange plan

Sample member ID cards are for illustration only; actual information varies depending on payer, plan and other requirements.

Verifying eligibility and benefits

Check the member's eligibility and benefits before providing care. Health plans and coverage can change within a single enrollment year.

When checking eligibility, be sure you:

1. Verify your network participation in the member's health plan by going to **UHCprovider.com** > Sign In > Eligibility
2. Confirm whether the member is in the grace period
3. Know the member's financial liabilities at the time of service

Plan requirements/features

PCP selection

Members enrolled in Individual Exchange benefit plans, otherwise known as Individual and Family Plans, must select a PCP at the time of enrollment to manage their health care needs. If the member does not select a PCP within the first month, one will be assigned for them. Members may change their PCP by calling the Member Services number listed on the back of their ID card or through their online account at **myuhc.com/exchange**. This process is outlined in **Chapter 3: Commercial products**.

Care providers may not be selected as their own assigned PCP, and may not be listed as immediate family members' PCP. Immediate family member means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild or grandchild's spouse.

Out-of-network benefit coverage

Individual Exchange Benefit Plan members do not have out-of-network benefit coverage, except for emergency services and related admissions, unless specifically approved by UnitedHealthcare. Members must receive eligible services at participating health care provider locations within the service area to be covered. Members may be responsible for full cost of services rendered by out-of-network providers. Members can search for in-network health care providers by logging into their online account at **myuhc.com/exchange**.

Specialist referral requirements

Some Individual Exchange Benefit Plans will require a specialist referral. Where applicable, the PCP must submit referrals on the UnitedHealthcare Provider Portal when the member needs additional care by a network specialist. Any eligible service provided by a specialist, in any setting, requires a referral to a participating network specialist. Once the referral end date has passed, or the number of visits is exhausted, the member must contact their PCP to request a new referral before receiving additional care. Specialists should confirm a valid referral is on file before each office visit. Members seen without a valid referral on file may have no coverage. Refer to the benefit plan grid for specific plan details by state.

Referral impacts on hospital claims

Individual Exchange benefit plans that require specialist referrals also apply to planned inpatient and outpatient procedures where the specialist is the admitting physician. The member must have a referral on file to see a network specialist for planned services in any setting, including in the hospital. The specialist referral requirement is in addition to notification requirements.

Members without a valid referral on file with the admitting physician for planned inpatient or outpatient services will have no coverage for both the admitting physician's claim and the hospital claim. This does not apply to nonphysician hospital services, such as radiology and lab testing.

Eligible services that do not require a referral

- Services from PCPs within the same tax ID as the member's assigned PCP. Note: Specialists within the same TIN as the member's assigned PCP require referrals.
- Services from network OB/GYNs, including perinatologists
- Services rendered in network urgent care centers or convenience care clinics
- Routine refractive eye exams performed by a network provider
- Mental health disorder services from network behavioral health clinicians
- Services from a network pathologist, network radiologist, network anesthesiologist or network dentist
- Services performed by a designated virtual care network provider for primary or urgent care needs
- Emergency room or emergency ambulance
- Physician services for emergency/unscheduled admissions or emergency ambulance services
- Services from network, facility-based inpatient/outpatient consulting physicians, assisting surgeons, co-surgeons or team surgeons
- Indian Health Services
- Nonphysician services, including but not limited to acupuncture, durable medical equipment (DME), family planning, home health, prosthetic devices, hearing aids, nutritionist, outpatient lab, X-ray or diagnostics, midwifery, doula, podiatry, physical therapy, speech therapy, occupational therapy, chiropractic care, pulmonary rehabilitation services, cardiac rehabilitation services, post cochlear implant aural therapy, cognitive rehab – with the exception of vision therapy (e.g., physician services). Services performed by a specialist will require a referral.
- Other network services for which applicable laws do not require a referral

Important facts about referrals

1. Unless otherwise allowed by law, electronic referrals are required
2. Referrals can be backdated up to 5 days prior to the date of entry
3. Referrals are valid for up to 6 months or 6 visits, whichever comes first
4. The PCP may submit up to 6 visits. Unused visits expire after 6 months. For members with the following chronic conditions, the PCP may submit up to 99 visits per 6-month referral: AIDS/HIV, anemia, cancer, cystic fibrosis, schizophrenia spectrum and other psychotic disorders, Parkinson's disease, amyotrophic lateral sclerosis, multiple sclerosis, epileptic seizure, myasthenia gravis, glaucoma.

Prior authorizations

Prior authorization and notification requirements apply to Individual Exchange members and are posted at **UHCprovider.com**. Click Prior Authorization > Advance notification > **Exchange Plans Advanced Notification/Prior Authorization Requirements**. Make sure you and your staff are familiar with the Exchange-specific prior authorization list.

You must submit prior authorizations electronically unless otherwise allowed by law. We will not accept them by phone or fax. We will not accept prior authorization or notification requests that also require a referral unless a completed referral is on file. If you do not meet the referral requirements, we may deny the physician's and hospital's claim for planned inpatient admissions. Additionally, admission notification is not a guarantee of coverage or payment (unless mandated by law).

Note: Prior authorization is not required for chiropractic services. Go to **UHCprovider.com/exchanges** for state-specific information. In addition, in-network behavioral health providers may submit prior authorization requests via Optum Forms (**Providerexpress.com**). Behavioral health providers may also submit prior authorization requests by fax or by calling the provider services phone number listed on the back of the member's ID card.

Care coordination and case management

Complex care management (CCM) and case management (CM)

UnitedHealthcare case managers are registered nurses who engage the appropriate internal, external or community-based resources to support the specific Individual Exchange member's needs. Our complex care nurses are trained to identify and assist individuals with complex medical conditions who need long-term care support, have unmet access or who have care plan, psychosocial or knowledge needs.

Our broader case management team will collaborate, evaluate and coordinate requested change to post-transition of care needs for Individual Exchange members who are at risk of rehospitalization or frequent users of high-cost services.

Members must meet program criteria to receive complex care management.

Helping members stay in the network

You play a leading role in helping members stay within their plan's network. This helps members get the best level of coverage for the highest quality of care. Remember to:

- Use the online provider directory to find other in-network providers when members require additional care. Go to **UHCprovider.com/findprovider**.
- Submit electronic referrals at **UHCprovider.com/referrals**
- Refer patients to participating lab providers. For more information, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.
- Search for in-network health care providers at **myuhc.com/exchange**

Coordinating care for new patients

We understand there can be challenges when a member changes their plan or PCP assignment while undergoing treatment. Here is how you can help:

- Help the individual become an established patient in your practice
- Issue referrals for care that requires immediate attention, especially for those undergoing treatment or who have previously scheduled procedures
- Check online to confirm network participation status for the member's plan by visiting **UHCprovider.com** > Sign In > Eligibility
- Secure valid referrals and/or prior authorizations before each visit
- Partner with UnitedHealthcare regarding member referrals, requests for information or case management opportunities
- An out-of-network provider may continue to treat the patient under certain circumstances if preapproved by UnitedHealthcare

Coordinating care between medical and behavioral health care

To support coordination of medical and behavioral services, our CCM nurses are trained to identify and assist individuals with complex medical conditions who may also have behavioral health conditions that need follow-up with a behavioral health provider. Additionally, our Live and Work Well website is available to all members as a resource to support individual self-management and to educate and assist members in accessing medical and behavioral services. Learn more at **liveandworkwell.com**.

Transition of care

Transition of care (TOC) allows newly enrolled members the option to request an extension of care from a currently treating out-of-network provider as required by the Exchange benefit plans. To request TOC, please

contact Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

- TOC request must be received within 30 days from a member's enrollment effective date
- TOC request can be submitted by a member or provider via phone or fax
- Transition to a contracted provider will be required within 90 days if TOC request is approved

Health risk assessments

Upon enrollment in our Individual Exchange plan, we will ask members to complete an annual health risk assessment (HRA). The purpose of the HRA is to identify and engage members with high-risk needs or conditions to connect them with programs and benefits that will help them navigate care and manage their health. Encourage your patients to complete their HRA. HRA are only offered online.

Member dismissal initiated by a PCP

We recognize there are certain instances a PCP may choose to terminate a patient relationship. While we will not interfere with the PCP's decision, PCPs who wish to terminate their relationship with an Exchange member and have a member reassigned must:

- Comply with all applicable legal and regulatory requirements
- Send a certified letter to the member (evidence that the letter was mailed is acceptable even if a letter comes back as undeliverable as addressed)
- Provide continuity of care as required by applicable laws and regulations
- Provide us written notice

Required information from the PCP

For member reassignment or termination, we require the following information from the PCP:

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

Each dismissal should be carefully considered based on the facts and circumstances specific to the member. We use good faith efforts to reassign the member to another PCP within 90 days of receipt of request. Changes will not be applied retroactively.

Government inspections and audits

You must permit access by the Secretary of the U.S. Department of Health and Human Services (HHS) and the Office of Inspector General or their designees, in the case of Federally Facilitated Exchange business, or comparable state regulators, in the case of State Exchange business, in connection with their right to evaluate through audit, inspection or other means, your books, contracts, computers or other electronic systems, including medical records and documentation, relating to the UnitedHealthcare obligations as a QHP Issuer in accordance with federal standards under 45 CFR §156.340, as it may be amended from time to time, until 10 years from the final date of your Agreement period or such lesser or greater period, which may be specified in state law for State Exchanges.

You agree to cooperate with these entities and to allow access to and the right to audit, inspection or other means, your books, contracts, computers or other electronic systems, including medical records and documentation. If you refuse to allow access, this will constitute a breach of your Agreement.

Telemedicine and virtual care

The term telemedicine refers specifically to the treatment of various medical conditions without seeing the member in person. Providers will use telehealth platforms like live video, audio or instant messaging to address a patient's concerns and diagnose their condition remotely. Virtual care is a broad term that encompasses all of the ways that health care providers remotely interact with their patients. It encompasses all of the ways that patients and doctors can use digital tools to communicate in real time.

Individual Exchange plans include access to telehealth and virtual care. Members can use telehealth for urgent or primary care services. Virtual visits through a designated virtual provider may have a separate defined cost share. Members may access telehealth services from their online account at **myuhc.com/exchange** or by connecting with local in-network health care providers who offer virtual care.

Individual Exchange members may also use telehealth to access behavioral health services. With this benefit, members can talk to a participating licensed therapist or psychiatrist for the evaluation and treatment of behavioral health conditions such as depression and anxiety. Members can schedule their appointment online with some providers or call the health care provider directly to schedule.

Billing for telehealth or virtual care services

UnitedHealthcare will consider reimbursement for eligible virtual care services when they are given by audio and video with a place of service POS 02 or POS 10. The Distant Site is where the rendering health care provider is housed during a virtual care encounter and is reported on the claim with POS 02 or POS 10 in Box 24B on the 1500 claim form.

We do not require you to report one of the virtual care-associated modifiers (GT, GQ, G0 or 95) when performing a service, but modifiers are accepted as informational if reported on a claim with eligible virtual services. For additional coding guidelines, refer to **Telehealth and Telemedicine Policy, Professional - Exchange** (**UHCprovider.com**). Additional modalities may be allowed for virtual behavioral health services. Please refer to the Optum **Telemental Health** policy located on Optum - Provider Express.

Pharmacy

For information about pharmacy benefits for the Exchanges, go to **UHCprovider.com/exchanges**.

- View and search the Prescription Drug List (PDL)
- Learn about prior authorization, step therapy protocols and utilization management edits
- Learn how to request a prior authorization or exception
- Access Pre-Check MyScript to get real-time prescription coverage information
- Find a network pharmacy

To request authorization of outpatient self-administered medications, call **1-800-711-4555** or request online at **professionals.optumrx.com**.

For authorization of provider-administered medications, go to **UHCprovider.com** > Sign In > Prior Authorizations.

- For noncancer-related medications, after logging in, go to: Create a new prior authorization submission > Select prior authorization type for submission, and select Specialty pharmacy from the drop down menu
- For cancer-related medications, after logging in, go to: Create a new prior authorization submission > Select prior authorization type for submission, and select Oncology from the drop down menu

Members can access pharmacy benefit information, including PDLs, drug costs and in-network pharmacies within their online account at **myuhc.com/exchange**.

Specialty services (hearing, vision, dental, transplant, behavioral health, chiropractor, skilled nursing facility)

Follow the standard processes for specialty services for Individual Exchange members. See the following **Quick reference guide** for contact information.

Claims process

Refer to **Chapter 10: Our claims process** for more information about our claims process, including claim submission tips, claim reconsiderations and appeals processes and more. For the Individual Exchange plans included in this chapter, use the following electronic payer ID.

Initial submissions:

Please submit claims electronically using Electronic Payer ID: 87726.

Provider appeals and reconsiderations:

Please submit electronically using the process outlined in **Chapter 10: Our claims process**. If you are unable to submit electronically, use the following fax numbers.

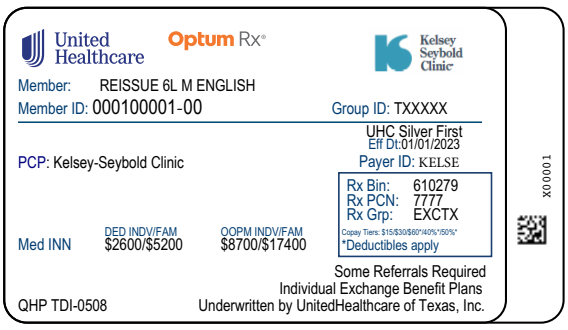
Fax: 1-888-404-0949 (standard requests)
1-888-808-9123 (expedited requests)
1-877-239-4565 (Pharmacy appeals and reconsiderations – standard and expedited)

Policies and protocols

For policies and protocols, go to **UHCprovider.com** > Resources > Health plans, policies, protocols and guides > **For Individual Exchange Plans**.

Kelsey-Seybold Narrow Network Individual Exchange plans offered in 5 counties in Texas

UnitedHealthcare is partnering with Kelsey-Seybold Clinic in Texas to offer Individual Exchange plans using a fully capitated, narrow network anchored by Kelsey-Seybold Clinics in Brazoria, Fort Bend, Galveston, Harris and Montgomery counties. Members enrolled in a Kelsey-Seybold plan will receive a customized ID card and will have open access to Kelsey-Seybold Clinic PCPs who will help them to manage their care. Members with Kelsey-Seybold plans will receive a customized ID card as shown below:



All members with these plans will be assigned to the Kelsey-Seybold Clinic. A referral is not needed to see a Kelsey-Seybold Clinic specialist. However, a referral is needed to any participating specialists outside of Kelsey-Seybold Clinic.

If you are not a participating provider in the Kelsey-Seybold Clinic network, and a member presents with this ID card, please redirect these members back to Kelsey-Seybold, as they are capitated for these members' care and claims payment.

We are excited to be able to offer these plans again in the Houston area in 2025. For more information on Capitation and Delegation requirements, please refer to the Capitation and/or Delegation Supplement near the end of this guide.

Quick reference guide

Resource	Where to go
Ambulatory infusion suites national providers	**Accredo** **Phone:** 1-800-803-2523 accredo.com **Infusion Express (IVX Health)** **Phone:** 1-800-746-8147 infusionexpress.com **Option Care** **Phone:** 1-844-624-4584 optioncarehealth.com **Promptcare** **Phone:** 1-877-776-6782 promptcare.com **Vital Care** **Phone:** 1-800-447-4095 vitalcare.com **Vivo Infusion (aka MPP Infusion Centers)** **Phone:** 1-855-478-1528 vivoinfusion.com
Breast pump national providers†	**Acelleron Breast Pumps** **Phone:** 1-877-932-6327 **Fax:** 1-978-738-9801 acelleron.com **AdaptHealth** **Phone:** 1-844-PCS-MOMS (727-6667) adapthealth.com **AeroflowHealthcare** **Phone:** 1-844-867-9890 aeroflowbreastpumps.com **Byram Healthcare** **Phone:** 1-877-773-1972 byramhealthcare.com (mail order) **Edgepark Medical Supplies** **Phone:** 1-855-504-2099 edgepark.com (mail order) **Synapse Health** **Phone:** 1-888-336-9363 synapsehealth.com **Pumping Essentials** **Phone:** 1-866-688-4203 pumpingessentials.com
Cardiology Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/cardiology** **Phone: 1-866-889-8054** Request prior authorization for services as described in the **Outpatient cardiology prior authorization protocol** section of **Chapter 7: Medical management**.

† May be subject to change without notice.

Resource	Where to go	
Claims submission	**Electronic claims submission** **Payer ID:** 87726 **Reconsideration and appeals** Please submit electronically as per process outlined in **Chapter 10**.	
Continuous glucose monitors national providers	**AdaptHealth** **Phone:** 1-844-727-6667 adapthealth.com **Advanced Diabetic Supply** **Phone:** 1-866-422-4866 northcoastmed.com **Byram Healthcare** **Phone:** 1-877-902-9726 byramhealthcare.com	**Edgepark** **Phone:** 1-800-321-0591 edgepark.com **MiniMed/Medtronic** **Phone:** 1-800-646-4633 medtronic.com
Convenience care clinics national providers	**The Little Clinic** (located in Kroger stores) solvhealth.com/company/the-little-clinic **Minute Clinic** **Phone:** 1-866-389-2727 cvs.com/minuteclinic	
Dental	**uhcdental.com** **Provider Services: 1-800-822-5353** **Electronic Payer ID:** 521337971 In network only plan with Options PPO 20 network	**Claims address:** UnitedHealthcare Dental - Claims Unit P.O. Box 30567 Salt Lake City, UT 84130-0567
Dialysis national providers	**American Renal Associates (ARA)** **Phone:** 1-978-922-3080 **DaVita Dialysis** **Phone:** 1-800-424-6589 davita.com **Dialysis Clinic, Inc** **Phone:** 1-833-602-2199 dciinc.org	**Fresenius** **Phone:** 1-866-434-2597 fmcna.com **Home Dialysis Service (HDS)** **Phone:** 1-608-833-8033 homedialysis.org **US Renal Care** **Phone:** 1-800-550-9664 usrenalcare.com
Demographic maintenance	**Provider data updates and attestation**	

Resource	Where to go
DME/cardiac, respiratory and commodity services national providers†	**AbleNet, Inc.** Speech Generating Device **Phone:** 1-651-414-6539 **AdaptHealth** Standard DME **Phone:** 1-844-727-6667 adapthealth.com **Advanced Respiratory** Respiratory high-frequency chest compression vest **Phone:** 1-800-426-4224 respiratorycare.hill-rom.com **Apria Healthcare** Standard DME **Phone:** 1-800-227-4288 apria.com **Bioventus** Bone growth stimulator **Phone:** 1-800-396-4235 bioventus.com **Cranial Technologies** Cranial helmets **Phone:** 1-844-447-5894 cranialtech.com **DJO** Bone growth stimulator **Phone:** 1-800-321-9549 djoglobal.com **DynaSplint Systems** Dynamic splinting, braces, orthotics **Phone:** 1-800-638-6771 dynasplint.com **EBI** Bone growth stimulator **Phone:** 1-800-526-2579 biomet.com **ElectroMed** Respiratory high-frequency chest compression vest **Phone:** 1-800-462-1045 smartvest.com **Electrostim Medical Services** TENS units **Phone:** 1-800-588-8383 wecontrolpain.com

†May be subject to change without notice.

Resource	Where to go
DME/cardiac, respiratory and commodity services national providers[†] (continued)	**Ethos Therapy Solutions** High-end hospital beds and support systems **Phone:** 1-888-861-8612 ethosoutcomes.com **Gordian Medical** Wound care supplies (SNF only) **Phone:** 1-800-568-5514 amtwoundcare.com **Hoveround Corp.** POV and power wheelchairs **Phone:** 1-800-701-5781 or 1-800-771-6565 hoveround.com **InfuSystem, Inc.** Ambulatory infusion pumps **Phone:** 1-800-962-9656 infusystem.com **Insulet Corporation** Omnipod and supplies **Phone:** 1-800-591-3455, #4 myomnipod.com **KCI USA** Negative pressure wound pump **Phone:** 1-800-275-4524 3m.com **Kestra Medical** AED – wearable life vest **Phone:** 1-833-692-7787 kestramedical.com **Kinex Medical** CPM, ThermoComp, TENS **Phone:** 1-800-845-6364 kinexmedical.com **Liberator Medical Supply** Incontinence, ostomy and urologic supplies liberatormedical.com **Lincare** Standard DME **Phone:** 1-727-530-7700 lincare.com **Linkia Orthotics and Braces** (aka Hanger) Orthotics/braces **Phone:** 1-877-754-6542 linkia.com **National Biological Corporation** Ultraviolet light therapy **Phone:** 1-216-831-0600 natbiocorp.com **National Seating and Mobility** Technology mobility products, custom wheelchairs nsm-seating.com/find-a-branch **Novocure** Optune brain stimulator novocure.com **Numotion** Mobility products, custom wheelchairs **Phone:** 1-888-232-1333 numotion.com/locations **Orthofix** Bone growth stimulator **Phone:** 1-800-535-4492 orthofix.com **Otto Bock Healthcare** CPM **Phone:** 1-800-736-8276 ottobockus.com **PHM Logistics** (aka Quipt Home Medical) Standard DME and Respiratory Equipment **Phone:** 1-859-441-8876 quipthomemedical.com **Prentke Romich** Speech-generating devices **Phone:** 1-800-268-5224 prentrom.com **RespirTech** Respiratory high-frequency chest compression vest **Phone:** 1-800-793-1261 respirtech.com

[†] May be subject to change without notice.

Resource	Where to go
DME/cardiac, respiratory and commodity services national providers† (continued)	**Rotech Healthcare** Standard DME **Phone:** 1-877-254-1725 rotech.com **Synapse Health** CPAP/BiPAP/CPM/standard DME/diabetic supplies **Phone:** 1-888-336-9363 synapsehealth.com **Tactile Systems** Pneumatic compression devices **Phone:** 1-866-435-3948 tactilemedical.com **Talk to Me Technologies** Speech-generating devices **Phone:** 1-877-392-2299 **Tobii Dynavox** Speech generating device **Phone:** 1-866-588-4548 tobiidynavox.com **Wound Care Concepts** (aka Gentell) Wound care devices **Phone:** 1-800-840-9041 **ZOLL LifeVest** AED – wearable defibrillator **Phone:** 1-800-543-3267 zoll.com
EDI support	**Online: UHCprovider.com/edi** **Phone: 1-800-842-1109**
Eligibility and benefits	**API:** Eligibility and benefits available. Visit the **API Marketplace** for more details. **EDI:** Use the Eligibility and Benefit Inquiry (270) and Response (271) transactions. For more information, go to **UHCprovider.com/edi270**. **Online: UHCprovider.com** > Sign In > Eligibility **Information: UHCprovider.com/eligibility**
Enteral national providers	**AdaptHealth** **Phone:** 1-844-727-6667 adapthealth.com **APRIA Healthcare** **Phone:** 1-800-277-4288 apria.com **Aveanna Healthcare Medical Solutions** **Phone:** 1-713-956-5288 aveannamedicalsolutions.com **Byram Healthcare** **Phone:** 1-877-773-1972 byramhealthcare.com **Edgepark Medical Supplies** **Phone:** 1-800-321-0591 edgepark.com **Lincare** **Phone:** 1-727-530-7700 lincare.com **PHM Logistics** (aka Quipt Home Medical) **Phone:** 1-859-441-8876 quipthomemedical.com **Synapse Health** **Phone:** 1-888-336-9363 synapsehealth.com
Hearing	**Provider Services:** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

† May be subject to change without notice.

Resource	Where to go	
Home health services national providers†	**Bayada Home Health Care** **Phone:** 1-800-305-3000 bayada.com **Brookdale Home Health** brookdaleliving.com **Encompass Health Home Health** encompasshealth.com **Heartland Healthcare** **Phone:** 1-800-736-4427 gentivahs.com	**Maxim Health Care Services** **Phone:** 1-800-899-9525 maximhomecare.com **PSA Healthcare** **Phone:** 1-770-441-1580 aveanna.com
Home infusion and specialty pharmacy national providers† *ambulatory infusion suites	**Accredo** **Phone:** 1-800-803-2523 accredo.com **Basic Home Infusion** **Phone:** 1-888-822-7428 basichomeinfusion.com **Biologics** **Phone:** 1-800-856-1984 biologicsinc.com **Caremark** **Phone:** 1-877-287-1234 cvsspecialty.com **Eversana** **Phone:** 1-866-336-1336 eversana.com **Freedom Fertility Pharmacy** **Phone:** 1-800-660-4283 freedomfertility.com **Genoa Healthcare** **Phone:** 1-800-519-1139 genoahealthcare.com	**Option Care Health*** **Phone:** 1-866-827-8203 optioncare.com **Optum Infusion Services*** **Phone: 1-877-306-4036** **specialty.optumrx.com/infusion** **Optum Pharmacy** **Phone: 1-866-218-7398** **specialty.optumrx.com** **Optum Women's and Children's Health** **Phone: 1-800-950-3963** **optum.com** **Orsini Pharmaceutical** **Phone:** 1-800-672-0869 orsinihealthcare.com **PANTHERx** **Phone:** 1-855-726-8479 pantherxrare.com **Walgreen's Specialty Pharmacy** **Phone:** 1-888-282-5166 walgreenshealth.com
Insulin pumps and supplies national providers†	**AdaptHealth** **Phone:** 1-855-404-6727 pcs.adapthealth.com **Byram Healthcare** **Phone:** 1-877-902-9726 byramhealthcare.com **Edgepark Medical Supply** **Phone:** 1-800-321-0591 edgepark.com	**Insulte Corporation** **Phone:** 1-800-591-3455 myomnipod.com **MiniMed Distribution Group** (Medtronic) **Phone:** 1-800-933-3322 minimed.com **Tandem Diabetes Care** **Phone:** 1-877-801-6901 tandemdiabetes.com

† May be subject to change without notice.

Resource	Where to go
Medical supply national providers[†] Disposable supplies, ostomy, urological, incontinence supplies	**180 Medical** **Phone:** 1-877-688-2729 180medical.com **AdaptHealth** **Phone:** 1-844-727-6667 adapthealth.com **Atos Medical** **Phone:** 1-800-217-0025 atosmedical.com **Byram Medical** **Phone:** 1-877-902-9726 byramhealthcare.com **Comfort Medical** **Phone:** 1-800-719-1663 comfortmedical.com **Edgepark Medical** **Phone:** 1-888-394-5375 edgepark.com **Liberator Medical Supply** **Phone:** 1-888-244-0789 liberatormedical.com **Synapse Health** **Phone:** 1-888-336-9363 synapsehealth.com
Mental health and substance use disorder Prior authorization	**Online: Providerexpress.com** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Optum care solutions Physical, occupational, speech therapy and chiropractic services Acupuncture services in the states of CO, MD, WA and NM Naturopathy in the state of WA	**Online: myoptumhealthphysicalhealth.com** **Phone: 1-800-873-4575** **Fax:** 1-248-733-6070
Optum Rx Pharmacy services and self-administered medications benefit information	**Phone: 1-800-711-4555** **Online: professionals.optumrx.com**
Preferred Lab Network	**Online: UHCprovider.com/findprovider** > **Preferred Lab Network**
Prior authorization and notification (includes provider-administered medications)	**EDI:** Submit prior authorization requests using EDI 278 and 278n. Go to **UHCprovider.com/edi278** and **UHCprovider.com/edi278n** for more information. **Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/priorauth**

[†] May be subject to change without notice.

Resource	Where to go
Provider advocates For participating hospitals, health care and ancillary providers	**Online: UHCprovider.com** > **Contact us** > State-specific health plan and network support
Provider Services	**Online: UHCprovider.com** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. Confirm member eligibility, provide care coordination notification, check claim status, update facility/practice data.
Radiation therapy prior authorization	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need **Phone** (only where telephonic submission is permitted): **1-888-397-8129** 8 a.m.–5 p.m. local time, Monday–Friday
Radiology/advanced outpatient imaging procedures CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/radiology** **Phone: 1-866-889-8054** Request prior authorization for services as described in the **Outpatient radiology prior authorization protocol** section of **Chapter 7: Medical management**
Referrals (if plan requires)	**EDI:** Submit referrals using the EDI 278 transaction. Go to **UHCprovider.com/edi278** for more information. **Online: UHCprovider.com** > Sign In > Referrals **Information: UHCprovider.com/referrals**
Skilled nursing facilities (free-standing)	**Online: UHCprovider.com/skillednursing** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Transplant resource services and ventricular assist devices Request prior authorization	**Phone: 1-888-936-7246** **Fax:** 1-855-250-8157
Urgent care national providers	**Concentra** (American Current Care) concentra.com/urgent-care-centers **Dispatch Health** (mobile urgent care) dispatchhealth.com **MedExpress** medexpress.com

Resource	Where to go
Vision	**Online:** spectera.com **Electronic Payer ID:** 00773 **Phone: 1-800-638-3120** (Monday–Friday, 8 a.m.–11 p.m. ET; Saturday 9 a.m.–4:30 p.m. ET) **Claims address:** UnitedHealthcare P.O. Box 30978 Salt Lake City, UT 84130

Chapter 5: Medicare products

Visit **UHCprovider.com**, **aarpmedicareplans.com** or **uhc.com/medicare** for more information about our Medicare products in your area.

UnitedHealthcare Medicare products offer Medicare Advantage (MA) benefit plans for Medicare-eligible individuals and employer group retirees. If a member presents an ID card with a product name with which you are not familiar, verify the member's eligibility and benefits in the UnitedHealthcare Provider Portal by going to **UHCprovider.com** > Sign In > Eligibility. To view your practice's accepted health insurance plans and effective dates, go to **UHCprovider.com** > Sign In > My Practice Profile. For more information, go to **UHCprovider.com/mypracticeprofile**.

Product lists provided for your convenience are subject to change at any time.

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

Medicare product overview tables

Medicare Advantage – Products for individuals

In 2025, UnitedHealthcare Medicare Advantage plan names include a unique identifier code for each plan. Please refer to the **2025 Medicare Advantage Benefit Plan Names** resource on **UHCprovider.com** for a complete list of the plan names.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
HMO plans • UHC MedicareMax Medicare Advantage • UHC Preferred Medicare Advantage **HMO-POS plans** • AARP Medicare Advantage CareFlex from UHC • AARP Medicare Advantage Essentials from UHC • AARP Medicare Advantage Extras from UHC • AARP Medicare Advantage from UHC • AARP Medicare Advantage Giveback • AARP Medicare Advantage Patriot No Rx • AARP SecureHorizons Medicare Advantage • Peoples Health Choices 65 • Peoples Health Choices Gold • Peoples Health Medicare Advantage Giveback • Peoples Health Medicare Advantage Patriot No Rx	Members who are Medicare eligible for Part A and B, and reside in the plan's service area.	Members choose a PCP from the Medicare network of providers who can help coordinate their care. HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.	A referral may or may not be required to see a specialist, depending on the benefit plan.** For further information, go to **Medicare Advantage referral plans**, or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.	Yes, see guidelines in **Chapter 7: Medical management**.

** Most services rendered to members in referral plans require referrals and/or authorizations from the PCP or physician hospital organization, dependent upon contractual arrangement.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
HMO-POS plans (continued) • UHC Medicare Advantage • UHC Medicare Advantage Patriot No Rx • UHC Northern Light Health UHC Rocky Mountain • UHC Sharp Medicare Advantage • UHC Sharp Medicare Advantage ValueRx • UHC The Villages Medicare Advantage		HMO-POS benefit plans provide out-of-network coverage for some covered benefits.*	Have the member ID and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	
Local PPO and Regional PPO (RPPO) plans • AARP Medicare Advantage Access from UHC • AARP Medicare Advantage Essentials from UHC • AARP Medicare Advantage Extras from UHC • AARP Medicare Advantage from UHC • AARP Medicare Advantage Giveback • AARP Medicare Advantage Patriot No Rx • Peoples Health Choices • Peoples Health Patriot • UHC Medicare Advantage • UHC Medicare Advantage Essentials • UHC Medicare Advantage Patriot No Rx	Members who are Medicare eligible for Part A and B, and reside in the plan's service area.	Members should choose a PCP from the Medicare network of providers who can help coordinate their care. PPO benefit plans provide out-of-network coverage for all covered network benefits.*	No, a referral is not needed.	Yes, see guidelines in **Chapter 7: Medical management**.

* The plan will cover services from in-network and out-of-network providers, as long as the services are covered benefits and medically necessary. However, a member's cost-share may be higher for covered out-of-network services.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
Institutional Special Needs Plans (HMO, HMO-POS, PPO) • UHC Care Advantage • UHC Nursing Home Plan	Members reside in a contracted skilled nursing facility (UHC Nursing Home Plan) or they reside in a community setting and require an institutional level of care (UHC Care Advantage).	Members choose a PCP from the Medicare network of providers who can help coordinate their care. HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis. PPO and HMO-POS benefit plans provide out-of-network coverage.*	No, a referral is not needed.	Yes, see guidelines in **Chapter 7: Medical management**.

* The plan will cover services from in-network and out-of-network providers, as long as the services are covered benefits and medically necessary. However, a member's cost-share may be higher for covered out-of-network services

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
Dual Special Needs Plans **HMO** • UHC Dual Choice • UHC Dual Complete • UHC MedicareMax Dual Complete • UHC Preferred Dual Complete • UHC Rocky Mountain Dual Complete • UHC Senior Care Options (Massachusetts) **HMO POS** • Peoples Health Dual Complete • Peoples Health Secure Complete • Peoples Health Secure Health • UHC Dual Complete • UHC MedicareMax Dual Complete • UHC Preferred Dual Complete **PPO, RPPO** • UHC Dual Choice • UHC Dual Complete	Members who are both Medicare and Medicaid eligible.	Members choose a PCP from the Medicare network of providers, who can help coordinate their care. HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis. HMO-POS and PPO benefit plans provide out-of-network coverage.*	A referral may or may not be required to see a specialist, depending on the benefit plan.** For further information, go to **Medicare Advantage referral plans**, or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. Have the member ID card and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	Yes, see guidelines in **Chapter 7: Medical management**.

* The plan will cover services from in-network and out-of-network providers, as long as the services are covered benefits and medically necessary. However, a member's cost-share may be higher for covered out-of-network services.

** Most services rendered to members in referral plans require referrals and/or authorizations from the PCP or physician hospital organization, dependent upon contractual arrangement.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
Chronic Special Needs Plans **HMO** • UHC Complete Care Support • UHC MedicareMax Complete Care • UHC Preferred Complete Care **HMO-POS** • Peoples Health Complete Care • UHC Complete Care • UHC Complete Care Support **PPO, RPPO** • UHC Complete Care • UHC Complete Care Support	Members who have one or more of the following qualifying chronic conditions: diabetes, chronic heart failure and/or cardiovascular disorders.	Members choose a PCP from the Medicare network of providers who can help coordinate their care. HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis. HMO-POS and PPO benefit plans provide out-of-network coverage.*	A referral may or may not be required to see a specialist, depending on the benefit plan.** For further information, connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. Have the member ID card and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	Yes, see guidelines in **Chapter 7: Medical management**.

*The plan will cover services from in-network and out-of-network providers, as long as the services are covered benefits and medically necessary. However, a member's cost-share may be higher for covered out-of-network services.

** Most services rendered to members in referral plans require referrals and/or authorizations from the PCP or physician hospital organization, dependent upon contractual arrangement.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
Erickson Advantage Plans (HMO-POS) • Erickson Advantage Freedom • Erickson Advantage Liberty • Erickson Advantage Liberty no RX • Erickson Advantage Signature **Special Needs Plans** • Erickson Advantage Champion (Chronic) • Erickson Advantage Guardian (Institutional)	Members who reside in an Erickson Retirement Community.	Members are assigned a PCP from the Erickson Health Medical Group network of providers. The PCP coordinates their care. These HMO-POS benefit plans provide out-of-network coverage for some covered benefits.*	No, a referral is not needed.	Prior authorization is required on a select set of services for Erickson Medicare Advantage plans: 1. DME with expense greater than $1,000 2. All out-of-network services when member requests coverage at in-network rates 3. Elective inpatient hospitalizations 4. Outpatient physical, speech and occupational therapy to members residing in long-term care facilities 5. Admission to non-Erickson home health care 6. Admission to a non-Erickson skilled nursing facility

* The plan will cover services from in-network and out-of-network providers, as long as the services are covered benefits and medically necessary. However, a member's cost-share may be higher for covered out-of-network services.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
• **Erickson Advantage Plans (HMO-POS)** (continued)				**7.** Routine transportation **8.** Experimental and investigational services **9.** Potential cosmetic services **10.** Transplants

*The plan will cover services from in-network and out-of-network providers, as long as the services are covered benefits and medically necessary. However, a member's cost-share may be higher for covered out-of-network services.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
HMO plans • UnitedHealthcare Group Medicare Advantage (HMO) **HMO-POS plans** • Peoples Health Group Medicare (HMO-POS) • Peoples Health Group Medicare (HMO-POS) Office of Group Benefits	Members must meet all Medicare eligibility requirements as well as the employer's requirements.	Members choose a PCP from the Medicare network of providers who can help coordinate their care. HMO benefit plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis. HMO-POS benefit plans provide out-of-network coverage for some covered benefits.*	A referral may or may not be required to see a specialist based on the benefit plan.** For further information, go to **Medicare Advantage referral plans**, or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. Have the ID card and your TIN available. PCPs should coordinate care with the appropriate Medicare network specialists.	Yes, see guidelines in **Chapter 7: Medical management**.

* The plan will cover services from in-network and out-of-network providers, as long as the services are covered benefits and medically necessary. However, a member's cost-share may be higher for covered out-of-network services.

** Most services rendered to members in referral plans require referrals and/or authorizations from the PCP or physician hospital organization, dependent upon contractual arrangement.

Product name	Medicare member's eligibility	How do members access physicians and health care professionals?	Does a primary care physician have to make a referral to a specialist?	Is the treating physician and/or facility required to give prior authorization or advance notification when providing certain services?
UnitedHealthcare Group Medicare Advantage (PPO)	Members must meet all Medicare eligibility requirements as well as the employer's requirements.	Members are encouraged but not required to see a PCP from the Medicare network of providers to help coordinate their care.	No, a referral is not needed.	Yes, see guidelines in **Chapter 7: Medical management**.

Medicare Advantage products

Individual HMO, HMO-POS and PPO plans

These plans provide all the benefits covered under Original Medicare and more. Our plans do not have limits for pre-existing conditions, and they do not require physical exams. The member may have multiple choices of health plans depending on where they live.

While exact benefits may vary, these plans may give:

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

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

Dual special needs plan

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

Chronic special needs plan

This SNP is for members who have 1 or more severe or disabling chronic conditions. We help members manage their condition as well as their overall health and well-being.

Institutional special needs plans

These SNPs are for members who reside in a contracted skilled nursing facility (institutional SNP) or who live in a community setting and require an institutional level of care (institutional-equivalent SNP).

UnitedHealthcare Group Medicare Advantage

We offer these plans to employer groups for their retired Medicare-eligible employees. They have benefits similar to the individual plans. The ID card has the employer group name and number on it. Currently, we do not offer group special needs plans.

PCP selection

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

Changing PCP

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

Medical policies for Medicare Advantage members

Hierarchy of references/resources

We develop our MA Medical Policies with the help of:

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

Medical policies

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

Medical policy updates

We publish monthly editions of the Medicare Advantage Medical Policy Update Bulletin. This online resource provides notice to our network providers of changes to MA Medical Policies. The bulletin is posted on the first calendar day of every month on **UHCprovider.com/policies** > For Medicare Advantage Plans > **Medicare Policies for Medicare Advantage Plans**.

A supplemental link to the policy updates announced in the Medicare Advantage Medical Policy Update Bulletin is also available at **UHCprovider.com/news**.

Special needs plans managed by Optum

UnitedHealthcare Dual Special Needs Plans (D-SNPs) and Chronic Condition Special Needs Plans (C-SNPs) are 2 types of Medicare Advantage Special Needs Plans. The protocols defined below establish the guidelines and process for clinical integration, cooperation, and collaboration of, and with respect to, the care of members of UnitedHealthcare D-SNPs and C-SNPs managed by Optum.

These protocols are applicable to PCPs in the UnitedHealthcare network for D-SNPs and/or C-SNPs, who are treating D-SNP or C-SNP members managed by our affiliate Optum.

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

Optum management of UnitedHealthcare D-SNP and C-SNP members includes the UnitedHealthcare At Home (UAH) Program, which is an integrated care delivery program that coordinates the delivery and provision of clinical care of members in their place of residence. When members participate in this program, their health care providers must follow a communications structure that helps ensure better coordination of their medical care.

To promote the best possible outcomes, the program supports:

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

The UnitedHealthcare At Home Program's Interdisciplinary Care Team includes an Optum-trained advanced practice clinician (ARNP/PA), the member's PCP and other health care providers as appropriate, in addition to the member and the member's family. Together, they provide care customized to the member's needs and goals of care. As part of this program, Optum clinicians:

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

The UAH Program supplements care provided by our members' PCPs. It is not intended to replace the care provided by our members' PCPs. If these protocols differ from, or conflict with, other protocols in connection with any matter pertaining to members of UnitedHealthcare D-SNP or C-SNP plans managed by Optum, these protocols govern unless statutes and regulations dictate otherwise.

Protocols for UnitedHealthcare D-SNPs members managed by Optum

PCPs for UnitedHealthcare D-SNP members managed by Optum, you agree to:

- Collaborate and cooperate with the UAH program, including UAH advanced-practice clinicians and other staff assigned to UnitedHealthcare D-SNP members managed by Optum
  - Work with applicable members of the Interdisciplinary Care Team (designated by UAH) and other treating clinicians to provide, and arrange for, the provision of covered services to UnitedHealthcare D-SNP members managed by Optum
  - Identify preferred process(es) for bidirectional communication with the UAH Interdisciplinary Care Team, including member care needs/concerns, facilitation of scheduling, social determinate issues, responding to acute clinical and/or mental health needs, home health certifications, etc., via the appropriate communication channel (phone or secure email)
  - Initiate proactive communication to UAH, as appropriate, regarding patient needs identified in previous bullet
- Attend quality meetings as requested by UAH; this includes monthly/quarterly/ad hoc meetings focused on comprehensiveness of patient care and ongoing coordination of such. Review information provided by UAH, including Provider Performance Reviews and tracking of clinical outcomes
  - Develop and execute action plans, targeting continuous quality improvement
- Review and adhere to Evidence-Based Guidelines to develop care plans, close gaps in care and respond to deficiencies identified in care monitoring
- Assist with care transitions, including (but not limited to) medication reconciliation, follow up visits, home health needs and prescription management
- Assess and refer patients with unmet Social Determinants of Health (SDOH) needs and notify UAH when unmet needs are identified
- Make every effort to accept new patients who do not have an attributed PCP relationship, as patient capacity permits
- Coordinate with the UAH team to identify and engage patients who are difficult to reach and/or unable to engage
- Share up-to-date patient contact information with the UAH team

Protocols for UnitedHealthcare C-SNP members managed by Optum

PCPs for UnitedHealthcare C-SNP members managed by Optum, you agree to:

- Comply with all of the requirements of Protocols for UnitedHealthcare D-SNP members managed by Optum (previous section)
- Complete a Chronic Condition Attestation, annually, for each applicable member
  - Assess each suspected or previously coded chronic condition (listed on attestation) by indicating "yes" or "no" to confirm or reject each specific diagnosis

- List all additional chronic conditions diagnosed
- Document all chronic conditions to the highest level of specificity, linking manifestations when applicable, per ICD-10 guidelines
- Submit supporting documentation (progress notes, visit summary, etc.) specifically addressing each chronic condition assessed

Medicare Supplement benefit plans

AARP Medicare Select benefit plans

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

What is Medicare Select?

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

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

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

Network hospitals agree to waive the Part A Inpatient Hospital Deductible ($1,632 in 2024). While a network hospital waives the Part A deductible, the hospital still receives the remaining reimbursement from Medicare. UnitedHealthcare reimburses all other Medicare-eligible expenses not paid by Medicare other than the Part A deductible amounts waived under the terms of the hospital Agreement. Hospitals can arrange for automatic deposits or reimbursements.

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

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

No prior authorization for medical services is required.

Medicare Select plans C, F, G and N

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

- Part A inpatient hospital deductible
- Part A inpatient hospital coinsurance for days 61–90 in a Medicare benefit period
- Part A inpatient hospital coinsurance for days where lifetime reserve days are used
- Part A eligible expenses for a lifetime maximum of 365 days after all Medicare Part A benefits are exhausted
- Part B coinsurance
- Part B deductible (Select Plans C and F only)
- Daily coinsurance for days 21–100 for Skilled Nursing Facility stays
- Part A and B blood deductible for the first 3 pints of unreplaced blood

- Foreign travel emergencies
- Hospice and respite care copayments and coinsurance
- Part B excess charges for Medicare approved services (Select Plans F and G only)

Claims submission information

Electronic (preferred) – contact your Clearinghouse and provide our electronic payer ID (36273). This number is specific to Medicare Select Plans and other AARP Supplemental and Personal Health Plans.

Mail – send a standard billing form along with a Part A or B Remittance Advice to:

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

To promote timely processing on all claim submissions, follow standardized Medicare billing practices. Be sure to include the member's 11-digit AARP membership ID number. If you have questions or need more information, please call UnitedHealthcare Customer Service at **1-800-523-5800.**

Free Medicare education for your staff and patients

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

Chapter 6: Referrals

Referrals vs. advance notification and/or prior authorization

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

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

Referral submission electronic options*

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

The member's assigned PCP must:

- Submit referrals electronically, prior to the service being rendered, using:
  - API: Visit the **API Marketplace** for more details on referral submissions and follow the Get Started prompts to schedule a meeting with an API consultant to learn more
  - EDI: Use the EDI 278 transaction. Go to **UHCprovider.com/edi278** for more information.
  - Online: **UHCprovider.com** > Sign In > Referrals
  - Delegated entity's website listed on the member's ID card
- Enter a start date within 5 calendar days of submission date
  - Referrals are effective immediately but may take up to 2 business days to be viewable in the portal system. They may be backdated up to 5 calendar days before the date of entry.
- Follow all requirements
  - If you provide services when a referral is not on file, see the product-specific details in the following section for the impact to your reimbursement and the member benefits, as they vary by product

If you need to refer a member to an out-of-network provider because there are no available network providers in the area, request prior approval by calling the Provider Services number on the member's ID card. You can also sign into the UnitedHealthcare Provider Portal by going to **UHCprovider.com** > Sign In > Referrals. For more information go to **UHCprovider.com/referrals**.

Maximum referral visits

The PCP determines the number of visits, up to the allowed maximum, needed for each referral in a 6-month period. They may submit another referral after the member uses the visits or they expire.

Commercial products referrals

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

- Navigate, Navigate Balanced, Navigate Plus
- Charter, Charter Balanced, Charter Plus
- Compass, Compass Balanced, Compass Plus
- Most Individual Exchange plans (for more information, refer to **Chapter 4: Individual Exchange plans**)
- NexusACO R, NexusACO RB, NexusACO RP
- UnitedHealthcare Freedom: Granite Advantage/Saver EPO

*Delegated may follow different referral submission requirements.

Not obtaining a referral for a required service means that:

Navigate, Charter, Compass, Freedom Granite Advantage/Saver EPO and NexusACO R	NexusACO RB, NexusACO RP, and Balanced and Plus versions of Navigate, Charter and Compass
The service is not covered, and the member is responsible for the charges.	There is a higher out-of-pocket cost for the member.

Commercial members of gated benefit plans have "PCP to send electronic referral" printed on the back of their ID card and "Referrals Required" on the front of the ID card.

Specialist referrals

The member's assigned PCP manages their care. The member's PCP needs to submit electronic referrals to us before the member sees another network provider (a network provider that is not within the same provider group and tax ID number as the member's PCP). Referrals are valid for any health care provider within the same provider group and tax ID number as the specialist listed. It is best practice to communicate clinical findings to the referring PCP. For tiered benefit plans, members have a lower out-of-pocket cost when referred to a tier 1 specialist.

Direct PCP referrals (ME only)

If a member needs covered health care services, you must accept a referral from a direct PCP; they are treated the same regardless of whether the referring physician is a PCP or direct primary care provider. UnitedHealthcare may require a direct PCP making a referral (who is not a member of the carrier's provider network) to provide information demonstrating the health care provider is a direct PCP through a written attestation or a copy of a direct primary care agreement with a member. To request a referral to an in-network health care provider, call the member phone number on the member health plan ID card.

Managing referrals

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

- Referrals are only valid for the authorized number of visits or through the indicated referral end date. Any unused visits are not valid after the end date.
- If a referral is no longer valid, but the member requires additional care, the member or specialist must contact the member's PCP to request a new referral. The PCP then decides whether to issue an additional referral.
- If a network specialist sees a need for a member to go to another specialist, the specialist must ask the member's PCP to issue an additional referral.

Online submissions of referrals

Referral submissions are separate from both notification and prior authorization requests. To submit a referral, go to **UHCprovider.com** > Sign In > Referrals.

Commercial benefit plan services not requiring a referral

Members in these plans do not need a referral for:

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

Refer to **Chapter 4** for individual exchange plans.

Referral submission requirements

- Submit electronic referrals to UnitedHealthcare before rendering services through API, EDI 278 or the UnitedHealthcare Provider Portal
- Referrals are effective immediately
- They are viewable online within 48 hours
- We do not accept referrals by phone, fax or paper, unless state law requires us to
- The PCP can backdate them up to 5 calendar days from the date of submission
- Web users must have access to the Referral Submission role on their user profile to submit and verify referrals
- Only the member's PCP, or other PCP practicing under the same provider group and TIN, can submit referrals for the member to see a network specialist. A specialist cannot enter a referral.

Maximum referral visits

The PCP may submit up to 6 visits on a referral. Unused visits expire after 6 months. For members with the following chronic conditions, the PCP may submit up to 99 visits for up to 6 months per referral:

- AIDS/HIV
- Anemia
- Cancer
- Cystic fibrosis
- Schizophrenia spectrum and other psychotic disorders

- Parkinson's disease
- Amyotrophic lateral sclerosis
- Multiple sclerosis
- Epileptic seizure
- Myasthenia gravis
- Glaucoma
- Retinal detachment
- Thrombotic microangiopathy
- Allergic rhinitis
- Renal failure (acute)
- Seizure
- Fracture care

Nonparticipating health care providers (all commercial plans)

In nonemergent circumstances, you are required to refer our members to an in-network care provider. You can confirm if a health care provider is in our network at **UHCprovider.com/findprovider**, or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

For an exception to this requirement, you must do one of the following:

1. Follow the prior approval process – to get prior approval to involve an out-of-network care provider, submit a request by calling the number on the back of the member's ID card. We review the request and network care providers available. If approved, we apply the network benefits to the services done by the out-of-network care provider. We communicate our decision to the requesting health care provider and the member.
2. Get the member's written consent to involve an out-of-network care provider and keep a copy of it with the member's health records. In the written consent, the member must acknowledge that you:
   - Summarized the reason you are referring them to an out-of-network care provider or facility, and why you are not referring them to an in-network care provider or facility
   - Disclosed the nature of any financial interest in, or relationship with, the health care provider or facility, to whom you are referring the member
   - Explained the member may have no coverage or be subject to out-of-network benefits and additional costs as a result of your referral
     - Some members may have additional costs for services they receive from out-of-network care providers. Some members don't have any out-of-network benefits, which means the out-of-network care provider will bill the member for the entire cost of the referred service.

For referrals to an out-of-network laboratory, go to **UHCprovider.com** > Sign In > Referrals.

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

- Disqualify you from any rewards or incentive program
- Decrease your fee schedule
- Hold you financially responsible for any costs collected from a member by a nonparticipating health care provider or facility and hold you financially responsible for any payments made by the member's plan to a nonparticipating health care provider or facility
- Terminate your agreement

Under any circumstances, and without exception, you may not refer a member to any health care provider or facility in violation of federal or state law. Violation may result in any of the above penalties.

Before submitting a request for network benefits for services from a nonparticipating health care provider:

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

To find a list of health care providers participating in the W500 network, go to **UHCprovider.com/findprovider** > Medical Care Directory > Employer and Individual Plans > Shopping Around > **W500 Emergent Wrap**.

Individual exchange referral required plans

Refer to **Chapter 4: Individual Exchange plans** for referral requirements for Exchanges in AL, AZ, FL, GA, IA, IL, IN, KS, LA, MI, MD, MO, MS, NC, NE, NJ, NM, OH, OK, SC, TN, TX, VA, WA, WI and WY.

Medicare Advantage referral plans

Some UnitedHealthcare MA benefit plans require referrals for specialty care. These plans emphasize the role of the member's PCP.

When referrals are required for a Medicare Advantage plan, plan referral requirements are included in member materials. Members are expected to check with their PCP before obtaining specialty care. UnitedHealthcare does not track or manage referrals and it is important to note that UnitedHealthcare does not require providers to submit referrals to process claims for MA plans. However, PCPs may still need to issue specialist referrals through **UHCprovider.com** if specialist care providers request a referral.*

When a PCP submits a referral, they determine the appropriate number of visits and the expiration date for the referral and can submit additional referrals if a referral expires. Coverage, cost-share and benefits will be determined based on the member's benefit plan for services provided by a specialist.

In referral plans, members can access any PCP in the network without a referral, including but not limited to the member's assigned PCP. In-network primary care services cannot be denied because a referral was not obtained.

Check the member's ID card for referral language. You can also check eligibility and benefits or referrals in the UnitedHealthcare Provider Portal for referral plans. Use the Referrals tool on the UnitedHealthcare provider site to submit any referral requests. Sign in at **UHCprovider.com/referrals**.

To see a sample ID card, refer to the **Health plan identification (ID) cards** section of **Chapter 2: Provider responsibilities and standards**.

Medicare Advantage services not requiring a referral*

For a list of services that **do not** require referral from the member's PCP, refer to the member's EOC. For information on prior authorization requirements, refer to **UHCprovider.com/priorauth**.

* Delegated providers of UnitedHealthcare Medicare Advantage referral plans have their own referral policies and may administer the referral process in a different manner than outlined above. For Preferred Care Network and Preferred Care Partners of Florida plans, refer to the Preferred Care Network and Preferred Care Partners supplements.

Chapter 7: Medical management

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

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

Advance notification/prior authorization protocol

For additional details on prior authorization requirements and processes unique to the Surest plan, see the Surest supplement to this guide.

Benefit plans not subject to this protocol

Some benefit plans may have separate notification or prior authorization requirements. Refer to the **Benefit plans subject to this guide table** in **Chapter 1: Introduction** and to the supplements of this guide for additional information for the plans listed.

- UMR
- **UnitedHealthcare Options PPO:** Depending on the member's particular benefit plan, UnitedHealthcare Options PPO health care providers may not be required to follow this protocol for Options PPO benefit plans unless members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization
- UnitedHealthcare Indemnity
- UnitedHealthcare Student Resources
- **UnitedHealthOne – Golden Rule Insurance Company** (GRIC group number 705214) only
- **M.D.IPA**, Optimum Choice or **OneNet PPO**
- Benefit plans subject to the **Neighborhood Health Partnership (NHP) supplement**
- Benefit plans subject to the **Oxford commercial supplement**, except for UnitedHealthcare Oxford Navigate Individual benefit plans (group number 908410)
- Benefit plans subject to the **River Valley entities supplement**
- Benefit plans subject to the **UnitedHealthcare West supplement**
- MA plans that have delegated arrangements with medical groups/IPAs – in these arrangements, the delegate's protocols must be followed. Submit prior authorizations as directed on the member's ID card.
- Benefit plans subject to an additional guide or supplement (refer to the **Benefit plans subject to this guide table**)
- Other benefit plans such as Medicaid, CHIP and Uninsured that are neither commercial nor MA

The advance notification requirements outlined in this protocol do not apply to services subject to the following protocols:

- **Outpatient cardiology prior authorization protocol**
- **Outpatient radiology prior authorization protocol**
- **Laboratory services protocol**

Each is addressed in separate sections later in this guide.

Advance notification vs. prior authorization

Advance notification is the first step in determining coverage. We also use it for case and condition management program referrals. The information we receive about planned medical services helps support the preservice clinical

coverage review and care coordination. Advance notification helps assist members from preservice planning to discharge planning.

Advance notification is required for services listed on the Advance Notification/Prior Authorization List located at **UHCprovider.com/priorauth** > **Advance Notification and Clinical Submission Requirements**. We require prior authorization for all MA benefit plans and some commercial benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the Advance Notification/Prior Authorization List, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We notify you of our coverage decision within the time required by law. Required notification for a service does not mean it is covered. Benefit coverage for health services is determined by the member's specific benefit plan document and applicable laws that may require coverage for a specific service.

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

Advance notification/prior authorization requirements

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

- Providing advance notification or requesting prior authorization for services on the Advance Notification/Prior Authorization List, including for nonemergent air transport services
- Directing members to use health care providers within their network. Members may be required to obtain prior authorization for out-of-network services.
- Confirming coverage approval is on file (for services requiring advance notification/prior authorization) prior to the date of service

Facilities are responsible for:

- Obtaining prior authorization for nonemergent, fixed-wing transportation services and using in-network, fixed-wing air ambulance providers
- Obtaining prior authorization for inpatient admission to skilled nursing facility, acute inpatient rehabilitation and/or long-term acute care
- Confirming coverage approval is on file (for services requiring advance notification/prior authorization) prior to the date of service
- Providing admission and discharge notification for inpatient services, even if coverage approval is on file

Prior Authorization and Notification tool

Simplify your administrative workflow with the Prior Authorization and Notification tool. Go to **UHCprovider.com** > Sign In > Prior Authorizations.

- Check requirements by member or procedure
- Submit requests
- Check status
- Upload medical notes
- Radiology, cardiology and oncology transactions
- Specialty pharmacy transactions
- Admission notification, discharge notification
- Update cases

Save time
No need to call, fax or mail information, so you can spend time on other things.

Reduce costs
Online solutions are the most efficient and cost-effective way to manage these transactions.

Get information
Check if prior authorization or notification is required by member or procedure code.

Find and check status
Many search options are available to check the status of your submissions, regardless of the submission method you used.

Superior documentation
Obtain a Decision ID for inquiries and a reference number for submissions. Save PDF confirmation files or print records.

Intuitive and accurate
Required information is highlighted, and fields automatically adjust as data is entered. Error messages alert corrections needed before submitting.

If you perform multiple procedures for a member in 1 day, and at least 1 service requires prior authorization, you must obtain prior authorization for any of the services to be paid.

If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If services have not been rendered and the specified date of service or date range has passed, you must contact us to update the date of service or date range. When you contact us, we will advise if we will require a new submission.

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

See the **Coverage and utilization management decisions** section for additional details.

Resources:
Access and New User Registration
- **UHCprovider.com/access** and new user registration

Resource page:
- Go to **UHCprovider.com/priorauth** for more resources. You'll find self-paced modules, live-webinar training registration information and more.

UnitedHealthcare Web Support:
Connect with us 24/7 from the **UnitedHealthcare Provider Portal**.
For chat options and contact information, visit **UHCprovider.com/contactus**.

Information required for advance notification/prior authorization requests

Your request must have the following information:

- Member name and member health plan ID number
- Ordering health care provider name and TIN or NPI
- Rendering health care provider name and TIN or NPI
- ICD-10-CM diagnosis code
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and, if relevant, the volume of service
- Place of service
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (end-stage renal disease [ESRD] only)

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

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

Advance notification/prior authorization list

The case entry for providing notification and submitting a prior authorization request is the same. Services that require prior authorization require a clinical coverage review based on medical necessity.

View the most current and complete advance notification requirements, including procedure codes and associated services, at **UHCprovider.com/priorauth** > **Advance notification**.

Advance notification/prior authorization lists are subject to change. We will inform you of changes on **UHCprovider.com/news**. Sign up to receive email updates at **UHCprovider.com/subscribe**.

When to submit advance notification or prior authorization requests

Notification should be submitted at least 15 calendar days in advance, if possible, but must be submitted at least 5 business days before the planned service date (unless otherwise specified). Following a facility discharge, advance notification for home health services and DME is required within 2 business days after the start of service.

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

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

We prioritize case reviews based on:

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

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

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

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

Durable medical equipment

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

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability or injury
- Ordered or prescribed by a health care provider
- Reusable, not consumable or disposable except as needed for the effective use of covered DME
- Appropriate for home use
- Determined to be medically necessary

Refer to the following policies pertaining to DME for more information:

- Commercial and Individual Exchange Medical Policy: **Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements**
- Medicare Advantage Medical Policy: **Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid**

Facilities: standard notification requirements*

Confirming coverage approvals**

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

If the facility performs the service without confirming a coverage approval is on file, and we decide the service is not a covered benefit, we may deny the facility claim.

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

Admission notification requirements

Benefit plans not subject to this protocol

Some benefit plans may have separate notification or prior authorization requirements. Refer to the **Benefit plans subject to this guide table** in **Chapter 1: Introduction** and to the supplements of this guide for additional information for the plans listed.

- **UnitedHealthcare Options PPO:** Depending on the member particular benefit plan, UnitedHealthcare Options PPO health care providers may not be required to follow this protocol for Options PPO benefit plans unless members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization
- UnitedHealthcare Indemnity
- **M.D.IPA**, Optimum Choice or **OneNet PPO**
- Benefit plans subject to the **Neighborhood Health Partnership (NHP) supplement**
- Benefit plans subject to the **Oxford commercial supplement**, except for UnitedHealthcare Oxford Navigate Individual benefit plans (group number 908410)
- Benefit plans subject to the **River Valley entities supplement**
- Benefit plans subject to the **UnitedHealthcare West supplement**
- MA plans that have delegated arrangements with medical groups/IPAs – in these arrangements, the delegate's protocols must be followed. Submit prior authorizations as directed on the member's ID card.
- Erickson Advantage
- Benefit plans subject to an additional guide or supplement (refer to the **Benefit plans subject to this guide table**)
- Other benefit plans such as Medicaid, CHIP and Uninsured that are neither commercial nor MA

Facilities are responsible for admission notification for the following inpatient admissions. We need admission notification, even if the physician provided advance notification and preservice coverage approval is on file:

- Planned/elective admissions for acute care
- All out-of-country admissions to include hospital admissions in a U.S. Territory i.e., U.S. VI, Guam, PR, Northern Marianas and American Samoa

*For state-specific variations, refer to **UHCprovider.com/priorauth** > **Advance notification.**

**For purposes of this section, 'facility' includes physicians, health care professionals and ancillary health care providers.

- Acute inpatient rehabilitation
- Long-term 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 is required within 24 hours of the mother's discharge

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

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

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

- Notify us within 24 hours, or the next business day if on a weekend/holiday, from the time coverage information is known
- When notifying us, you must communicate the extenuating circumstances. Payment is not reduced due to notification delay in an emergency.

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

You must include these details in your admission notification:

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

All SNF admissions for UnitedHealthcare Nursing Home plan members must be authorized by an Optum nurse practitioner or physician's assistant. Claims may be denied if authorizations are not coordinated through Optum. All SNF admissions for UnitedHealthcare Assisted Living plan members must be authorized by Home & Community Care Transitions. Claims may be denied if authorizations are not coordinated through Home & Community Care Transitions. Submit prior authorization for SNF, acute inpatient rehabilitation and long-term acute care through the UnitedHealthcare Provider Portal, Access Provider Portal or by calling Home & Community Care Transitions at **1-855-851-1127**. SNF admissions directly from the member's home setting may be authorized and coordinated by an Optum nurse practitioner or physician's assistant.

Discharge notification requirements

Hospitals must notify us of discharge from acute facility stays within 24 hours after weekday discharge (or by 5 p.m. local time on the next business day if the 24-hour limit would require notification on a weekend or holiday). For weekend and holiday discharges, we must receive the notification by 5 p.m. local time on the next business day.

Emergency services

Decisions regarding whether services met the definition of an emergency may be made by our medical director (or designee) or another process. This determination is subject to appeal. You can find a definition of emergency in the Glossary. In California, for those governed by Department of Managed Health Care (DMHC), no one is allowed to determine what is an emergency for the basis of denying the claim. Emergency services can only be denied if the services were never performed. DMHC does not follow the national prudent layperson standard; they follow the Knox-Keene standard, which is subjective.

Reimbursement reductions for lack of timely admission notification

Facilities must provide timely admission notification (even if the physician provided advance notification and preservice coverage approval is on file) or claims payments are denied in full or in part:

Notification time frame	Reimbursement reduction
Admission notification received after it was due, but not more than 72 hours after admission	100% of the average daily contract rate* for the days preceding notification
Admission notification received after it was due, and more than 72 hours after admission	100% of the contract rate (entire stay)
No admission notification received	100% of the contract rate (entire stay)

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

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

Maryland state-specific notification requirements for facilities

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

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

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

Inpatient review: clinical information

We determine the medical necessity of inpatient admissions through either concurrent or retrospective review. We require you to comply with the following:

- Requests for information, documents or discussions related to our reviews and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- Requests from our interdisciplinary care coordination team and/or medical director. This includes our requests that you help us engage our members directly face-to-face or by phone.
  - If you receive the request before 1 p.m. local time: Supply all requested information within 4 hours
  - If you receive our request after 1 p.m. local time: Provide the information within the same business day, but no later than 12 p.m. local time the next business day

Facility denial process

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

A facility denial letter is sent to the member and copied to the admitting physician, the PCP (if applicable) and the facility, as required.

How to submit advance notification/prior authorization, admission notification, discharge notification and observation stay notification

You must submit prior authorization requests electronically; we will not accept them by phone or fax, except where required by law.* After receiving confirmation, do not resubmit your request. Submit prior authorization for SNF, acute inpatient rehabilitation and long-term acute care through the UnitedHealthcare Provider Portal (preferred). For markets where Home & Community Care Transitions manages post-acute care, notification and prior authorization follows the Home & Community Care Transitions process.

	EDI 278 transactions	UnitedHealthcare Provider Portal
Method	Electronic **UHCprovider.com/edi278** Advance Notification and Prior Authorization (278) and **UHCprovider.com/edi278n** Admission Notification, Discharge Notification, Observation Stay Notification (278N).	Electronic **UHCprovider.com** > Sign In > Prior Authorizations
Description	The EDI 278 transaction is an authorization request to review services related to an episode of care. The EDI 278N transaction is to notify us of facility admissions.	Submit, update or check the status of an advance notification, prior authorization or admission notification, discharge notification or observation stay notification request.
Business hours (all times Eastern)	Monday–Friday: 7–2 a.m. Saturday: 7 a.m.–6 p.m. Sunday: 7 a.m.–6 p.m. Holidays: Same as above	Generally available 24 hours per day, 7 days a week. Maintenance is scheduled outside of the following hours: Monday–Friday: 6:30–12 a.m. Saturday: 7 a.m.–6 p.m. Sunday: 7 a.m.–5 p.m. Holidays: Same as above

Some plans have a state requirement for fax capability for prior authorization requests and will continue to use their existing fax number for their members. However, you can still use the Prior Authorization and Notification tool in the UnitedHealthcare Provider Portal to submit requests for those plans.

*Where telephonic submission of notifications or prior authorizations is permitted, dial the number on the member's ID card, Monday–Friday: 7 a.m.–8 p.m. ET; Saturday, Sunday and holidays: 9 a.m.–6 p.m. ET., or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. For Erickson Advantage, call Erickson Campus customer service number on the member's ID card.

Updating advance notification or prior authorization requests

This section applies to commercial members only. It does not apply to notification/prior authorization requests for genetic and molecular testing, BRCA, oncology, radiology, cardiology and injectable medications.

Before services are rendered, you may make certain updates to your notification/prior authorization request, depending on the status of the request and whether the service date has passed.

You may contact us at **UHCprovider.com** > Sign In > Prior Authorizations or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. Or call the number provided on the member's ID card, and we will let you know whether we updated your notification/prior authorization request.

If, during the service, you perform an additional or different procedure than what was originally approved, you are not required to modify the existing notification/prior authorization request or request a new notification/prior authorization record for code combinations on the **Prior Authorization Crosswalk Table** available at **UHCprovider.com**.

For code combinations not listed on the Prior Authorization Crosswalk table, you must contact us within 5 business days of rendering the service to advise of the changed or added procedure. If you do not contact us within 5 business days to advise of the changed or added procedure for code combinations not listed on the Prior Authorization Crosswalk table, and if the added or changed service is reduced or denied for lack of preservice notification, you can request a clinical review by submitting records indicating why the original procedure code was changed or a new procedure code was added.

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

Coverage and utilization management decisions

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

- Member's benefits
- State and federal requirements
- The contract between us and the plan sponsor
- Medicare guidelines including national coverage determination (NCD) and local coverage determination (LCD) guidelines
- Medicare Benefit Policy Manual (Medicare Advantage members)
- UnitedHealthcare medical policies, medical benefit drug policies and MA medical policies

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

We use tools such as UnitedHealthcare medical policies and third-party resources (such as InterQual® criteria and other guidelines), to assist us in administering health benefits and determining coverage.

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

Medical policies for Medicare Advantage

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

The complete libraries of our MA medical policies are on **UHCprovider.com/policies** > For Medicare Advantage Plans > **Medicare Policies for Medicare Advantage Plans**.

Coverage decisions

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

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

Clinical coverage review

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

- Return calls from our care management team and/or medical director
- Submit the most correct and specific code available for the services
- Comply with our request for additional information or documents and discussions, including requests for medical records and imaging studies/reports
  - If you receive our request before 1 p.m. local time, provide the information within 4 hours
  - If you receive our request after 1 p.m. local time, provide the information no later than 12 p.m. local time the next business day

Medical and drug policies for commercial members

A complete library of our medical policies is available on **UHCprovider.com/policies** > For Commercial Plans > **Medical & Drug Policies for UnitedHealthcare Commercial Plans**.

We develop medical policies and medical benefit drug policies to support the administration of medical benefits. You may request a copy of our medical policies by contacting our care management team. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. They are only for informational purposes — not medical advice. You are responsible for deciding what care to give our members. Members should talk to their health care providers before making medical decisions. Drug policies for commercial members covered under the pharmacy benefit are on **UHCprovider.com/pharmacy**.

Benefit coverage is determined by the following:

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

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

We develop our policies as needed. We regularly review and update them. They are subject to change. We believe the information in these policies is accurate and current as of the publication date. We also use tools developed by third parties, such as InterQual criteria, to help us manage health benefits. If you have questions or concerns about a specific service for a member, refer to the appropriate benefits, claims or prior authorization/notification process.

Medical policy updates

We publish monthly editions of the Medical Policy Update Bulletins. These online resources provide notice to our network providers of changes to our medical policies. The bulletins are posted on the first calendar day of every month on **UHCprovider.com/policies**. A supplemental link to the policy updates announced in the Medical Policy Update Bulletins is also available at **UHCprovider.com/news**. Also refer to **Chapter 18: Provider communication**.

Clinical trials, experimental or investigational services

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

Commercial

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

Medicare Advantage

Experimental and investigational procedures, items and medications are not a covered MA benefit. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Certain clinical trials are a benefit of MA plans. You should bill Medicare directly. Members can get additional information on clinical trials by calling 1-800-MEDICARE.

Approval or denial of clinical trials

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

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

Evaluations prior to entry into a clinical trial

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

You can find more information on clinical trials and experimental procedures in the medical policy titled **Clinical Trials**.

Medical management denials/adverse determinations

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

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

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

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

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

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

Denials, delays or modifications

Requests that do not meet the criteria for immediate authorization are reviewed by the medical director or the Utilization Management Program Committee (UMPC), designated health care provider or presented to the collective UMPC or subcommittee.

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

- Health care providers will not review their own referral requests
- Our qualified staff members review referral requests being considered for denial
- Any referral request where the medical necessity or the proposed treatment plan is not clear can be clarified by discussion with the health care provider thereafter. Complex cases go to the UMPC/medical director for further discussion and decision.
- Individual(s) who meet the qualifications of holding financial ownership interest in the organization may not influence the clinical decision-making regarding payment or denial of a service
- Prior authorization determinations may include the following decision:
  - Approved as requested – no changes
  - Approved as modified – referral approved, but the requested health care provider or treatment plan is modified. Denial letter must be sent if requested health care provider is changed or specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy)
  - Extension – delay of decision regarding a specific service (e.g., need additional documentation, information, or require consultation by an expert reviewer)

    CMS allows delays of decision (extensions) for MA members when the extension is justified and in the member's interest:

    - Due to the need for medical evidence from a noncontracted health care provider that may change the decision to deny an item or service
    - Due to extraordinary, exigent or other nonroutine circumstances and is in the member's interest
  - Delay in delivery – access to an approved service postponed for a specified period or until a specified date will occur. This is not the same as a modification. A written notification in the denial letter format is required.

- Denied – non-authorization of a request for health care services. Reasons for denials of requests for services include, but are not limited to, the following:
  - Not a covered benefit – the requested service(s) is a direct exclusion of benefits under the member's benefit plan — you must note a specific benefit exclusion
  - Not medically necessary or benefit coverage limitation – specify criteria or guidelines used in making the determination as it relates to the member's health condition
  - Member not eligible at the time of service
  - Benefit exhausted – include specific information as to what benefit was exhausted and when
  - Not a network provider – a network provider/service is available
  - Experimental, investigational or unproven procedure/treatment
  - Self-referred/no prior authorization (for nonemergent post-service)
  - Services can be provided by the PCP

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

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

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

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

Preservice appeals

A preservice appeal is a request to change a denial of coverage for a planned health care service. The member's rights in the member's benefit plan govern this process. To submit a normal preservice appeal request, follow the information in the preservice denial letter. A peer-to-peer review is highly recommended before you file a preservice appeal.

Expedited or urgent appeals

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

To request an urgent preservice appeal on behalf of the member, follow the information in the preservice denial letter. We consider requests urgent when:

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

Medical records request submission time frame

If we request medical records to process an appeal, you must provide the information within the following time frames. This includes providing a copy of the denial notice.

- **Expedited appeal** – within 2 hours* of receipt of request
- **Standard appeal** – within 24 hours* of receipt of request

*Time frames may change based on applicable law or your Agreement.

Medicare Advantage Part C reopenings

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

Reopening reason categories:

- **Clerical error** – includes human and mechanical errors on the part of the MA plan such as mathematical or computational mistakes, inaccurate data entry or coding errors, computer errors or denial of claims as duplicates
- **Fraud or similar fault** – post-service decision when reliable evidence shows the decision was procured by fraud or similar fault when the claim is auto-adjudicated in the system
- **Good cause** – includes new and material evidence and obvious errors made at the time of the determination based on all evidence presented in the appeal file
  - New and material evidence — evidence that was not available or known at the time of the decision and may result in a different conclusion. In order to be considered new and material evidence, it must meet the following:
    - Was not readily available or known to the person initiating the request at the time of the decision
    - Does not include evidence that was or reasonably could have been, available to the decision-maker at the time of the decision
    - May result in a different conclusion from the original decision

Reopening requests may be initiated by the member, a member representative or any other party to the determination. Requests:

- May be made verbally or in writing
- Should include the specific reason for requesting the reopening

  AND
- Must be filed within the time frames permitted for reopening

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

A case under appeal cannot be reopened until all appeal rights for that case are exhausted or a subsequent request by the appellant to withdraw the appeal has been granted. This includes preservice appeal requests that have been forwarded to the IRE, as CMS considers this an issue still under appeal.

After reopening, a revised decision is considered binding unless it is appealed or otherwise reopened.

Impact on peer-to-peer requests

We offer a peer-to-peer discussion with the medical director that made the preservice determination. Once a preservice adverse determination has been made, Medicare does not allow the decision to be changed as a result of the peer-to-peer discussion. You must submit any additional information from the post-decision discussion if you want to submit a Medicare appeal.

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

Outpatient cardiology prior authorization protocol

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

Commercial benefit plans not subject to these requirements

UnitedHealthcare Options PPO: Depending on the member's particular benefit plan, UnitedHealthcare Options PPO health care providers may not be required to follow this protocol for Options PPO benefit plans unless members enrolled in these benefit plans are responsible for requesting prior authorization.
UnitedHealthOne – Golden Rule Insurance Company (GRIC) group number 705214 only
M.D.IPA, Optimum Choice, (See the Mid-Atlantic Regional Supplement) or **OneNet PPO**
Oxford (USA, New Jersey Small Group, certain NJ public Sector groups, CT public Sector, Brooks Brothers [BB1627] and Weil, Gotshal and Manages [WG00101], any member at VAMC facility)
UMR and UnitedHealthcare Shared Services (UHSS)
UnitedHealthcare Indemnity/Managed Indemnity
Benefit plans sponsored or issued by certain self-funded employer groups

Delegated Medicare Advantage plans

Medicare Advantage (MA) plans may have delegated arrangements with a medical group/IPA. In these arrangements, the delegate's protocols must be followed. Call the number listed on the member's ID card to verify the protocols. Delegates may use their own systems and forms. They must meet the same regulatory and accreditation requirements as UnitedHealthcare.

Excluded Medicare Advantage plans

The UnitedHealthcare Prior Authorization Protocol does not apply to the following excluded UnitedHealthcare benefit plans. However, these UnitedHealthcare benefit plans may have separate prior authorization requirements.

UHC MedicareDirect (PFFS)
Erickson Advantage Plans

Prior authorization process for cardiac procedures

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

- Diagnostic catheterizations
- Electrophysiology implant procedures
- Echocardiograms
- Stress echocardiograms

Prior authorization is required for certain cardiology procedures. See the final paragraph of this section for information on locating the **most current listing of CPT codes** that require prior authorization.

A cardiology procedure for which prior authorization is required is referred to as a cardiac procedure.

Prior authorization is required under this protocol for outpatient and office-based services only.

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

- Emergency room visits
- Observation unit
- Urgent care
- Inpatient stays

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

For the most current listing of CPT codes for which prior authorization is required based on this protocol, refer to **UHCprovider.com/cardiology** > Specific Cardiology Programs. Note: For MA benefit plans, prior authorization is not required for echocardiograms.

Ordering health care provider

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

You must request prior authorization, by contacting us:

- **Online: UHCprovider.com** > Sign In > Prior Authorizations (for Level2, UnitedHealthcare, UnitedHealthcare Flexwork, UnitedHealthcare West, UnitedHealthcare Oxford Navigate Individual, UnitedHealthcare Level Funded, UnitedHealthcare Oxford Level Funded, Neighborhood Health Partnership, UnitedHealthcare of the River Valley Commercial and Medicare Advantage benefit plans subject to this protocol)
- **Phone: 1-866-889-8054** Monday–Friday, 7 a.m.–7 p.m. local time

Nonparticipating health care providers can complete the prior authorization process if applicable, either through the UnitedHealthcare Provider Portal (once registered) at **UHCprovider.com**, or by calling **1-866-889-8054**.

We may request the following information to complete our review:

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

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

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

If it is determined the service is not medically necessary, we issue a clinical denial. If we issue a clinical denial for lack of medical necessity, the member and health care provider receive a denial notice outlining the appeal process. Receipt of an authorization number does not guarantee or authorize payment unless state regulations (including regulations pertaining to a health care provider's inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System [PECOS] list, or Medicare Preclusion List) and MA guidelines require it. Payment for covered services depends upon:

- Coverage with an individual member's benefit plan
- If you are eligible for payment
- Claims processing requirements
- Your participation with UnitedHealthcare

The prior authorization number is valid for 45 calendar days. It is specific to the cardiac procedure requested, to be performed 1 time, for 1 date of service within the 45-day period. When we enter a prior authorization number, we use the date issued as the starting date for the 45-day period. The procedure must be performed within the 45 days. If you do not do the procedure within 45 calendar days, you must request a new authorization number.

Urgent requests during regular business hours

The ordering health care provider may make an urgent request for a prior authorization number if they determine the service is medically urgent. Make urgent requests online at **UHCprovider.com** > Sign In > Prior Authorizations or by calling **1-866-889-8054**. The ordering health care provider must state the case is clinically urgent and explain the clinical urgency. We respond to urgent requests within 3 hours of our receipt of all required information.

Retrospective review process for urgent requests outside of regular business hours

If the ordering health care provider determines a cardiac procedure is medically required on an urgent basis, and the ordering health care provider cannot request a prior authorization number because it is outside of our normal business hours, they must make a retrospective authorization request using the following guidelines:

- Within 2 business days of the date of service for:
  - Echocardiograms
  - Stress echocardiograms
- Within 15 calendar days of the date of service for:
  - Diagnostic catheterizations
  - Electrophysiology implants

Request the retrospective review by calling **1-866-889-8054** based on the following process:

- Documentation must explain why the procedure had to be done on an urgent basis and why an authorization number could not have been requested during our normal business hours.
- If the member's benefit plan requires medical necessity for services to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. If we determine the service was medically necessary, we will issue an authorization number. If we determine the service was not medically necessary, we will issue a denial and we will not issue an authorization number. The member and health care provider will receive a denial notice outlining the appeal process.

Rendering health care provider

Prior to performing a cardiac procedure, the rendering health care provider must confirm an authorization number is on file. If the member's benefit plan requires medical necessity to cover health services, the rendering health care provider must validate the ordering health care provider completed the prior authorization process and was issued a coverage determination.

If the rendering health care provider finds a coverage determination has not been issued, and the ordering health care provider does not participate in our network and is unwilling to complete the prior authorization process, the rendering health care provider is required to complete the prior authorization process. The rendering health care

provider must verify we have issued a coverage decision based on this protocol, prior to performing the service. Contact us at the online address or phone number listed in the previous **Ordering health care provider** section if you need to request prior authorization or confirm whether a coverage determination has been issued.

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

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

Crosswalk table

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

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

Outpatient radiology prior authorization protocol

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

Commercial benefit plans not subject to these requirements

UnitedHealthcare Options PPO: Depending on the member particular benefit plan, UnitedHealthcare Options PPO health care providers may not be required to follow this protocol for Options PPO benefit plans unless members enrolled in these benefit plans are responsible for requesting prior authorization.
UnitedHealthOne – Golden Rule Insurance Company (GRIC) group number 705214 only
M.D.IPA, Optimum Choice, (See the Mid-Atlantic Regional Supplement), or **OneNet PPO**
Oxford Health Plans
UMR and **UnitedHealthcare Shared Services (UHSS)**
UnitedHealthcare Indemnity/Managed Indemnity
Benefit plans sponsored or issued by certain self-funded employer groups

Delegated Medicare Advantage plans

Medicare Advantage (MA) plans may have delegated arrangements with a medical group/IPA. In these arrangements, the delegate's protocols must be followed. Call the number listed on the member's ID card to verify the protocols. Delegates may use their own systems and forms. They must meet the same regulatory and accreditation requirements as UnitedHealthcare.

Excluded Medicare Advantage plans

The UnitedHealthcare Prior Authorization Protocol does not apply to the following excluded UnitedHealthcare benefit plans. However, these UnitedHealthcare benefit plans may have separate prior authorization requirements.

UHC MedicareDirect (PFFS)
Erickson Advantage Plans

Prior authorization process for advanced outpatient imaging procedures

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

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Prior authorization is required for certain advanced imaging procedures. See the final paragraph of this section for information on locating the **most current listing of CPT codes** that require prior authorization.

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

Prior authorization is required for outpatient and office-based services only.

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

- Emergency room
- Observation unit
- Urgent care
- Inpatient stay

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

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

Ordering health care provider

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

You must request prior authorization by contacting us:

- **Online: UHCprovider.com** > Sign In > Prior Authorizations (UnitedHealthcare, UnitedHealthcare Flexwork, Level2, UnitedHealthcare West, UnitedHealthcare Oxford Navigate Individual, UnitedHealthcare Level Funded, UnitedHealthcare Oxford Level Funded, Neighborhood Health Partnership, UnitedHealthcare of the River Valley Commercial and MA benefit plans subject to this protocol)
- **Phone: 1-866-889-8054** Monday–Friday, 7 a.m.–7 p.m. local time.

Nonparticipating health care providers can complete the prior authorization process if applicable, either through the UnitedHealthcare Provider Portal (once registered) at **UHCprovider.com** or by calling **1-866-889-8054**.

We may request the following information to complete our review:

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

MA benefit plans and certain commercial benefit plans require covered health services to be medically necessary.

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

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

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

- Coverage with an individual member's benefit plan
- If you are eligible for payment
- Claims processing requirements
- Your participation with UnitedHealthcare

The authorization number is valid for 45 calendar days. It is specific to the advanced outpatient imaging procedure requested, to be performed 1 time, for 1 date of service within the 45-day period. When we enter an authorization number for a procedure, we use the date we issued the number as the starting date for the 45-day period you must perform the procedure. If you do not do the procedure within 45 calendar days, you must request a new authorization number.

Urgent requests during regular business hours

The ordering health care provider may make an urgent request for a prior authorization number if they determine the service is medically urgent. Make urgent requests online at **UHCprovider.com** > Sign In > Prior Authorizations or by phone, by calling **1-866-889-8054**. The ordering health care provider must state the case is clinically urgent and explain the clinical urgency. We respond to urgent requests within 3 hours of our receipt of all required information.

Retrospective review process for urgent requests outside of regular business hours

If the ordering health care provider determines an advanced outpatient imaging procedure is medically required on an urgent basis and they cannot request a prior authorization number because it is outside of our normal business hours, they must make a retrospective prior authorization request within 2 business days after the date of service.

Request the retrospective review by calling **1-866-889-8054**, based on the following process:

- Documentation must explain why the procedure had to be done on an urgent basis, and why an authorization number could not have been requested during our normal business hours
- If the member's benefit plan requires medical necessity for services to be covered, we conduct a clinical coverage review to determine medical necessity. If we determine the service was medically necessary, we will issue an authorization number. If we determine the service was not medically necessary, we issue a denial and do not issue an authorization number. The member and health care provider receive a denial notice outlining the appeal process.

Rendering health care provider

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

If the member's benefit plan requires medical necessity for covered services and:

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

Provision of an additional or modified advanced outpatient imaging procedure

If, during the delivery of an advanced outpatient imaging procedure, the rendering health care provider determines an additional advanced outpatient imaging procedure should be delivered above and beyond the approved service(s) assigned a prior authorization number, then the health care professional who determined the need for the additional or modified outpatient imaging procedure must request a new prior authorization number before scheduling the procedure, based on this protocol.

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

- **Contiguous body part** – if the procedure is for a contiguous body part, the ordering or rendering health care provider must modify the original authorization number request online or by calling within 2 business days after rendering the procedure
- **Non-contiguous body part** – if the procedure is not for a contiguous body part, the ordering health care provider must submit a new authorization number request and must have a coverage determination before the procedure takes place

Crosswalk table

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

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

Medications for Opioid Use Disorder

Medications for Opioid Use Disorder (MOUD) combines behavioral therapy and medications to treat opioid use disorders (OUD). The Food and Drug Administration (FDA) approved medications for OUD, including Buprenorphine, Methadone and Naltrexone.

To prescribe Buprenorphine, you must have a current registration with the United States Drug Enforcement Agency and be authorized to prescribe buprenorphine in the state.

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

To find a medical MAT provider in a state:

1. Go to **UHCprovider.com/findprovider**
2. Click on Medical Care Directory
3. Choose a type of plan
4. Select applicable plan
5. Refine the search by typing Medication Assisted Treatment in the search bar

For more information, visit samhsa.gov.

If you have questions about MOUD, connect with us 24/7 from the **UnitedHealthcare Provider Portal**.
For chat options and contact information, visit **UHCprovider.com/contactus**.

Trauma services

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

We may retrospectively review trauma service claims and medical records to verify that they met the trauma criteria. We may also confirm the trauma facility has an active trauma license.

We consider these criteria when authorizing trauma services:

- Trauma team activated
- Trauma surgeon is the primary treating health care provider
- Member's clinical status meets the county's current EMS protocols for designating a trauma member
- Trauma services, once rendered, apply to the first 48 hours post-facility admission, unless there is documented evidence of medical necessity indicating that trauma level services are continuing delivery

- Trauma service status should no longer apply when, based on medical necessity, the member is stable and/or medically appropriate for transfer out of the critical care area
- Clinical management of a member(s) by the trauma team is not the sole criterion used to determine and authorize continued trauma services care

Air ambulance licensure

UnitedHealthcare may request licensure for in-network and out-of-network air ambulance and all servicing medical personnel. To help ensure timely and proper air ambulance claim review and processing, submit this information with the claim.

You must obtain prior authorization for air ambulance service. See the **Advance notification/prior authorization protocol** section for more information.

Chapter 8: Specialty pharmacy and Medicare Advantage pharmacy

Commercial pharmacy

For information related to commercial pharmacy benefits:

Online: UHCprovider.com/pharmacy

- View and search the prescription drug list (PDL) and a current list of participating specialty pharmacy providers that apply to the use of certain pharmaceutical products or prescription drug products
- Learn about pharmaceutical management procedures for prior authorization requirements, supply limits and step therapy protocols

For additional information regarding pharmacy notification, prior authorization or questions on utilization management procedures:

Phone: 1-800-711-4555

Specialty pharmacy requirements for medical benefit specialty medications (commercial plans — not applicable to UnitedHealthcare West)

The Optum specialty medication guidance program

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

How the process works

Click on the Specialty Pharmacy Transactions tool in the Prior Authorization and Notification Tool from within the UnitedHealthcare Provider Portal. The system will document clinical requirements during the intake process and prompt you to provide responses to the clinical criteria questions. Attach medical records, if requested. For additional questions, call **1-888-397-8129**.

Coverage of self-infused/injectable medications under the pharmacy benefit

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

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

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

Prohibition of provision of noncontracted services

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

Requirement of specialty pharmacy and home infusion providers to be a network provider

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

Requirement to use a participating specialty pharmacy health care provider for certain medications

This requirement applies to specialty medications listed both in the Medication Sourcing - All Outpatient Providers table and the specialty medications listed in the Medication Sourcing - Outpatient Hospital Only table on **UHCprovider.com** > Resources > Drug lists and pharmacy > Specialty Pharmacy - Medical Benefit Management (Provider Administered Drugs) > Medication Sourcing - Requirements to use a participating specialty health care provider for certain medications > **Drugs that require Sourcing**. The tables on the drug list identify those drugs for which sourcing requirements apply to all outpatient health care providers and those for which the requirements only apply to outpatient hospital providers.

The medications subject to our sourcing requirement are subject to change. The requirement does not apply when Medicare or another health benefit plan is the primary payer and we are the secondary payer.

We have contracted health care providers for the distribution of these specialty medications. Our participating specialty pharmacy health care providers provide fulfillment and distribution services to meet the needs of our members and our health care providers. Our participating specialty pharmacy health care providers provide reviews consistent with our drug policies for these drugs. They work directly with the clinical coverage review unit to determine whether treatment is covered. Our participating specialty pharmacy health care providers report clinical data and related information and are audited on an ongoing basis to support our clinical and quality improvement activities. You must acquire these specialty medications from a participating specialty pharmacy health care provider, except as otherwise authorized by us.

Overview of submission, administration and billing processes

To fill a prescription through a contracted specialty pharmacy health care provider, submit an enrollment form (**UHCprovider.com** > Resources > Drug lists and pharmacy > **Specialty Pharmacy Program - Commercial** > Pharmacy Enrollment Forms) and a prescription request directly to the specialty pharmacy. The specialty pharmacy will advise the member of any medication cost-share responsibility and arrange for collection of any amount due before dispensing the medication to the service location.

The specialty pharmacy will dispense these medications to you in compliance with the applicable UnitedHealthcare drug policy and the member's benefit plan and eligibility and bill UnitedHealthcare for the medication. You may bill for administration of the medication. You cannot bill us or the member for the medication itself.

For a list of the medications and participating specialty pharmacy provider(s), refer to the **Drugs that require Sourcing list**.

For more information about the sourcing requirement and participating specialty pharmacies, go to **UHCprovider.com** > Resources > Drug lists and pharmacy > Specialty Pharmacy Program > **Specialty Pharmacy - Medical Benefit Management (Provider Administered Drugs)** > Medication Sourcing - Requirements to use a participating specialty pharmacy health care provider for certain medications.

Administrative actions for acquisition of certain specialty medications from nonparticipating pharmacies

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

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

In the event that we deny, in whole or in part, any claim from a nonparticipating specialty pharmacy health care provider, wholesaler or direct purchase from manufacturer submitted by you or any other health care professional, you may not balance bill the UnitedHealthcare member consistent with the terms of your Participation Agreement.

Contact your **UnitedHealthcare Network Management representative** if you have any questions.

ePrescribe (commercial and Medicare Advantage)

UnitedHealthcare recommends that network care providers turn on two-pay prescribing features with their EMR vendor so that pharmacies may request refills and authorization from care providers. This supports a more seamless member experience and less abrasion for care providers.

Medicare Advantage pharmacy

Pharmacy network

A member may fill prescriptions from any MA network pharmacy or online at **myuhc.com**.

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

Medicare Advantage prescription drug formulary

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

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

Medicare Advantage formulary tier structure

The MA Prescription Drug Formulary is a list of drugs covered as a pharmacy plan benefit for MA members. For non-group plans, we categorize medications into 5 tiers:

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

Note: Tiers 3 and 4 may include higher-cost generic drugs as well.

For employer-sponsored group plans, several formularies with various 3-tier, 4-tier, or 5-tier designs are available. Medications can be included as follows in an example 4-tiered formulary:

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

Note: Tiers 2 and 3 may include higher-cost generic drugs as well. Please refer to the patient's Formulary Drug List for details.

For MA Prescription Drug Formulary information for non-employer sponsored group plans, see **aarpmedicareplans.com**, **uhc.com/medicare** or **UHCprovider.com/pharmacy**. If a drug is not on our Formulary, you might be able to switch the member to a different drug that we do cover or request a formulary exception. While we are evaluating the exception request, we may provide the member with a temporary supply of the drug.

Medicare Advantage Part D prescription drug benefit

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

- **Prescription drug deductible** – some benefit plans have a deductible the member must meet before getting access to the prescription drug benefit. In some plans, this deductible will only apply to specific drug tiers (i.e., Tier 3, Tier 4 and Tier 5 only).
- **Initial coverage limit** – in this stage, the member will pay their plan copays or coinsurance. The plan pays the rest. Once the member, and others on their behalf, have paid a combined total of $2,000, which includes the amount they paid toward their deductible, if any, they move to the catastrophic coverage stage.
- **Catastrophic coverage level** – once in this stage, members won't pay anything for their Medicare covered Part D drugs for the rest of the plan year

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

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

Refer to the exceptions process included in the following section for the coverage criteria for a non-formulary or noncovered drug.

Medicare Advantage Part D members

Prior authorization requests

We follow the coverage determination timelines established by CMS. We must complete standard coverage determinations within 72 hours of the receipt of the request or prescriber's supporting statement for exceptions. Optum Rx® must complete expedited coverage determinations within 24 hours of receipt of a request, or prescriber's supporting statement for exceptions.

If we do not have enough information to make a determination, we may ask for more information from the prescriber or their designee. We may also ask the member and send them notification of the resulting case decision.

Different types of requests include:

- Prior authorization (PA)
- Medicare Part B vs Medicare Part D coverage determination
- Non-formulary (NF) exception
- Step therapy (ST) exception
- Quantity limit (QL) exception
- Opioid safety edits
- Safety edit exception
- Tier cost-sharing exception (TCSE)

TCSE rules vary by specific benefit plans and available alternatives. Criteria for copayment reduction TCSE are:

- One of the following:
  - The requested drug is FDA-approved for the condition being treated, or
  - Diagnosis is supported as a use in American Hospital Formulary Service (AHFS) or Micromedex Drugdex, and
- History of failure, contraindication or intolerance to all applicable formulary alternatives in the lower qualifying tiers

Coverage limitations

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

We provide an exception process for cases where the formulary may not accommodate the member's unique medical needs. To make an exception to any applicable restrictions or limits, or to request a prior authorization, submit a coverage determination request:

Online: professionals.optumrx.com/prior-authorization

Phone: 1-800-711-4555

More information about prior authorization requirements is available at **professionals.optumrx.com** > Resources > **Formulary and updates** or by calling the Optum Rx Prior Authorization department at the above number.

Part B covered drugs

Drugs covered under Part B are typically obtained and administered at the health care provider's office (i.e., certain cancer drugs administered by a physician in their office as buy and bill). Some drugs covered under Part B are dispensed to the patient by outpatient pharmacies (e.g., injections, specialty medications, certain oral cancer drugs, insulin when administered by a pump, immunosuppressants for Medicare-covered transplants, diabetic testing and monitoring supplies). For more information on Part B drug coverage, see **Medications/Drugs (Outpatient/Part B) Medicare Advantage Medical Policy**.

Part B medication prior authorizations

Optum manages prior authorization requests for Part B medications for Medicare plan members.

How the process works

For noncancer related medications, after logging in, click on the Prior Authorizations link. From the Create a new prior authorization submission section, select Specialty Pharmacy from the drop-down menu. The system will document clinical requirements during the intake process and prompt you to provide responses to the clinical criteria questions. Attach medical records, if requested. For additional questions, call **1-888-397-8129**.

For cancer-related medications, after logging in, click on the Prior Authorizations link. From the Create a new prior authorization submission section, select Specialty Pharmacy from the drop-down menu. The system will document clinical requirements during the intake process and prompt you to provide responses to the clinical criteria questions. Attach medical records, if requested. For additional questions, call **1-888-397-8129**.

Medicare Advantage diabetes monitoring supplies

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

For plans participating in the Preferred Diabetic Supply program, the following brands of blood glucose monitors and test strips are covered:

- Blood glucose monitors: OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide
- Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView

Other brands are not covered. An exception review is required for noncovered glucose monitors and test strips.

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

Continuous glucose monitors that are coverable by Medicare are available through Optum Rx and through our DME providers. Select Dexcom systems and supplies along with Freestyle Libre systems and supplies are available at participating pharmacies.

Drugs covered under Part B or Part D

Some drugs may be covered under either Part B or Part D depending on the circumstances. We determine whether a drug is covered under Part B or Part D using several factors, including diagnosis, route of administration and method of administration. UnitedHealthcare may coordinate Part D vaccine submitted charges with the member's prescription benefit plan. For a list of medications covered under Part B and Part D in each category, refer to cms.gov > Medicare > Coverage > **Prescription drug coverage** > Downloads and select the appropriate document. You may also call Optum Rx at **1-800-711-4555**.

Long-term care facility (includes mental health facilities) pharmacies

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

Home infusion

Our plan covers home infusion therapy drugs for home infusion services provided by a home infusion therapy network pharmacy. However, Medicare Part D does not cover the supplies and equipment needed for the administration of such drugs. The supplies and equipment may be covered by Part B. For information on home infusion therapy, call our Pharmacy department at **1-877-306-4036**.

Vaccines

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

Part D covers most preventive vaccines. Part B covers COVID-19, flu, pneumococcal, hepatitis B (for intermediate- or high-risk individuals), and some other vaccines (e.g., rabies) for intermediate- or high-risk individuals when directly related to the treatment of an injury or direct exposure to a disease or condition.

The rules for coverage of vaccinations are complex and depend on several factors. If you are unsure of the member's benefit coverage for vaccines, contact the member's drug plan to discuss the cost-share and allowable Part D vaccine charges as part of the drug plan's out-of-network access and/or to ask about other vaccine access options.

- Many network pharmacies can both dispense and administer vaccines at the pharmacy
- The member may obtain the vaccine from an in-network pharmacy and take it into their physician visit for administration. The physician may bill UnitedHealthcare for the vaccine administration fee; $20 is the maximum reimbursable amount for an administration fee.
- The physician or member may request that the pharmacy ship the vaccine directly to the physician's office for administration. The physician may bill UnitedHealthcare for the vaccine administration fee; $20 is the maximum reimbursable amount for an administration fee.

If the member has been informed about coverage and elects to receive the Part D vaccine and administration from the physician, do not collect any applicable cost-sharing from the member upfront if the Part D vaccine claim will be submitted to UnitedHealthcare along with other medical services provided during the visit.

For approved claims where a payment is due, Optum Rx issues a paper check and remittance advice soon after. As a contracted UnitedHealthcare entity, providers must refrain from collecting anything more than the applicable cost-sharing from the member (i.e., balance billing) for any UnitedHealthcare approved claim, which includes Part D vaccine out-of-network claims.

If you have questions about claims' status, payments or need additional information, connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. Passing costs onto the member without first contacting the plan to discuss the member's liability and balance billing is strictly prohibited by UnitedHealthcare and may result in corrective action.

You may access the TransactRx application to submit claims electronically and receive real-time claim adjudication, which allows you to communicate cost-shares to the member at point of service. It eliminates the need to manually bill pharmacy claims and prevents the need for the member to seek reimbursement. Refer to the **TransactRx** section for details or enroll for TransactRx at transactrx.com/enrollment for real-time Part D vaccine claim adjudication.

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

Part D vaccines administered in a physician's office, clinic or hospital

Check the member's eligibility and benefits prior to providing care to verify whether the member's plan covers the vaccine and communicate any out-of-pocket costs to the member prior to dispensing and administering a vaccine in a medical outpatient setting. Check your network status to ensure the out-of-pocket costs communicated to the member reflects the correct contracted or noncontracted rate. Medical benefit plans and pharmacy benefit plans have separate networks.

Specialty or injectable medications

We may require prior authorization for specialty or injectable medications administered in your office or self-administered medications obtained from a specialty pharmacy supplier. Refer to the **Drug utilization review program** section for more information.

Request these authorizations 1–2 weeks in advance of the service date to allow for coverage review, determination and shipping, if the request is approved.

Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. CMS deems some medications as self-administered (SAD). To prevent the member from having unnecessary out-of-pocket costs, they may need to obtain the SAD drug from a network pharmacy. Providers who fail to follow UnitedHealthcare buy and bill protocols for specialty or injectable medications or SAD drugs cannot bill the member or pharmacy benefit for reimbursement.

Call Optum Rx at **1-800-711-4555** for details on the rules governing injectable medications or to submit a prior authorization request for injectable medications obtained by the pharmacy.

Optum manages prior authorization requests for Part B medications for MA plan members. Refer to the Part B Medication prior authorizations section for more information on how to request a preservice prior authorization request.

TransactRx

TransactRx is an online application that allows providers to bill the member's Part D prescription benefit plan for all Part D covered vaccines (such as Shingrix and TDAP) and the vaccine administration fee.

With TransactRx, you can submit claims electronically and receive real-time claim adjudication. This allows you to determine and collect any cost-sharing at the point of service and eliminates the need to submit a claim to the member's medical plan or prescription drug plan.

Once enrolled in Transact Rx, you will be able to:

- Verify member's eligibility and benefits
- Submit Part D vaccine claims electronically
- Advise members of their cost-share and collect this amount at point of service (reducing the potential for balance billing)
- Manage multiple provider billing addresses
- Receive electronic payments
- Receive payments and remits directly from TransactRx twice a month. You have the flexibility to use patient IDs or chart numbers when submitting a claim, making it easier to reconcile to the remit and payment received.

If interested, please contact TransactRx at 1-866-522-3386 or enroll at transactrx.com/enrollment.

Drug utilization review program

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

As part of the program, we review member drug utilization each time members fill a prescription and by regularly reviewing our records. We look for medication errors such as:

- Duplicative drugs because the member is taking another drug to treat the same medical condition
- Drugs that may be inappropriate because of the member's age
- Possible harmful interactions between drugs
- Drug allergies
- Drug dosage errors
- Drug overutilization and underutilization
- Misuse

If we identify any potential issues, we share our findings with you. You may receive calls, faxes or letters from our pharmacy department following up on findings. If you have questions, contact the pharmacy department at **1-855-356-3212**.

Drug management program

Our drug management program (DMP) helps ensure members safely use their prescription opioid medications and other medications that are frequently abused. If members use opioid medications obtained from several doctors or pharmacies and/or have a recent opioid-related overdose, we may talk to you to make sure opioid medications are appropriate and medically necessary. Working with you, if we decide the use of prescription opioid medications and/or benzodiazepines is unsafe, we may limit how the member can get those medications. Limitations can range from drug dosage restrictions to prescriber and pharmacy lock-ins.

The DMP does not apply to members who have certain medical conditions such as cancer, sickle cell disease and/or members receiving hospice, palliative care, end of life care, those being treated for cancer-related pain or who reside in a long-term care facility. If a member disagrees with our decision or member circumstances change, you or the member have the right to appeal.

If you have questions about the program, contact Optum Care Management at **1-855-218-3456**.

Electronic prescribing of controlled substances

To help address the misuse and abuse of opioids and other controlled substances, Optum Rx home delivery pharmacy requires electronic prescribing for controlled substances. Several resources are available at **professionals.optumrx.com/epcs** to help you get started.

This only affects Optum Rx home delivery services. If electronic prescribing is not an option, members still have access to the retail pharmacy network.

Exceptions process

We offer a formulary exception process to allow for cases where the formulary or its restrictions may not accommodate a member's unique medical needs. To request an exception, submit a prior authorization request online or by phone. You must include a supporting statement explaining why you are requesting an exception.

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

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

You can request a prior authorization or exception by:

- **Online: professionals.optumrx.com/prior-authorization**
  This online service enables health care providers to submit a real-time prior authorization or exception request 24 hours a day, 7 days a week. After logging on at **optumrx.com** with a unique NPI number and password, a physician or health care provider can submit patient details securely online and enter a diagnosis and medical justification for the requested medication. In many cases, you can receive authorization instantly.
- **Phone: 1-800-711-4555**
  We delegate prior authorization services to Optum Rx. Optum Rx staff adhere to CMS requirements, NPTC practice guidelines and other professionally recognized standards.

Generic substitution

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

Therapeutic interchange

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

Medication therapy management

The medication therapy management (MTM) program is a free service we offer to members. We conduct reviews on members who:

- Have multiple chronic conditions
- Are taking multiple Part D drugs
- Incur annual out-of-pocket costs of at least $1,623 for all covered Part D drugs
- Are locked into a specific pharmacy or health care provider in the drug management program

We use the MTM program to help ensure our members are using appropriate drugs to treat their medical conditions and to identify possible medication errors and to reduce the risk of adverse events. We educate members about drugs currently on the market, making recommendations for lower-cost or generic drugs where applicable. In addition, we inform members in the MTM program about the safe disposal of unused medications, including controlled substances.

We may relay this information to you as well with the option to change drug therapies, as appropriate. You may receive calls or faxes from our pharmacy department following up on any options discussed with the member.

Transition policy

Our transition policy provides coverage for up to a 1-month supply for certain members who have an immediate need for a Part D drug not on our formulary, subject to restriction or no longer covered. To ensure continuity of care, you should switch the member to a different drug or request a formulary exception. We may provide the member with a temporary transition supply while you pursue an exception. To be eligible for transition coverage, the drug must be a Part D drug purchased at a network pharmacy.

The following table summarizes the rules for receiving a transition supply of a Part D drug. Members should read their plan's evidence of coverage (EOC) for additional details.

Transition eligible situations	Temporary transition supply amount
New members: During the first 90 days of membership in the plan **Continuing members:** During the first 90 days of the calendar year if the drug encountered a negative formulary change	At least a 1-month supply, as described in member's EOC
For members who have been in the plan for more than 90 days **and** reside in a LTC facility **and** need a supply right away	At least a 31-day supply, as described in the member's EOC
Members who have unplanned transitions such as hospital discharges (including psychiatric hospitals) or level of care changes (i.e., changing long-term care facilities, exiting and entering a long-term care facility, ending Part A coverage within a skilled nursing facility, ending hospice coverage and reverting to Medicare coverage) at any time during the plan year	At least a 1-month supply, as described in member's EOC

To request a formulary exception, you may use the online tool at **professionals.optumrx.com** or call our pharmacy department at **1-800-711-4555**.

Chapter 9: Specific protocols

Nonemergent ambulance ground transportation

Nonemergent ambulance transportation is appropriate with documentation that the member's condition is such that other means of transportation could endanger the member's health, and ambulance transportation is medically required.

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

Interoperability protocol

To help encourage the exchange of real-time health information, you are required to communicate with us electronically through the use of near real-time data exchange services, based on Health Level Seven (HL7) standards inside your Electronic Health Record (EHR) workflow. This includes:

- Eligibility inquiries: HL7 Fast Healthcare Interoperability Resources (FHIR)
- Patient care opportunities
- Admission, discharge and transfer (ADT) notifications: HL7 ADT
- High-performing provider referral with cost estimation
- Identification of preferred labs and/or diagnostic radiology locations
- Prior authorization for medical and pharmacy services

As a result of this protocol, we are expanding our medical records standards and requirements. If asked, you'll work with us to develop a clinical data exchange and integration plan within 60 days of outreach to provide us with remote access to your EHR for UnitedHealthcare members. This clinical data exchange and integration plan will support near real-time data exchanges with UnitedHealthcare in an automated fashion. To support this initiative, we'll work with you to establish EHR access to decrease administrative burden for programs that aren't currently supported by interoperability standards. These capabilities are in addition to the medical records requirements in your Participation Agreement. If we can't access the medical records in your EHR system, or the information contained in your EHR system is unclear or insufficient, you'll need to submit paper copies of medical records for UnitedHealthcare members upon request.

For more information, go to **UHCprovider.com/protocols**.

Laboratory services protocol

Clinical information submission

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

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

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

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

We use the clinical data:

- To perform treatment
- For payment
- To follow state and federal law
- For health care operations, as defined in HIPAA

Health care operations may include:

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

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

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

Self-referral and anti-kickback

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

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

- Investments in an entity where the referring health care provider generates business
- Profits from collection, processing and/or transporting of specimens
- Cost reductions such as:
  - Free Wi-Fi
  - Free urine cups

If you do not follow this rule, we may:

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

Structured exchange of clinical data

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

Health care providers are required to submit an expanded set of clinical data following a physician visit, as well as a discharge summary within 7 days of an inpatient discharge. Failure to comply with this clinical data exchange may result in penalties to your practice.

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

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

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

Nursing home and assisted living plans

UnitedHealthcare nursing home plans and assisted living plans are Medicare Advantage Institutional Special Needs Plans. These protocols are only applicable to PCPs, nurse practitioners (NP) and physician assistants (PA) who participate in the network for the nursing home plan and/or the assisted living plan care team, which may include both an on-site advance practice clinician (ARNP/PA) and a registered nurse (RN) who cooperate with and are bound by these additional protocols.

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

Nursing Home Plan PCP protocols

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

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

Nursing Home Plan and Assisted Living Plan protocols for other provider types

The Nursing Home Plan NP, PA and/or assisted living plan care team member (i.e., RN or ARNP/PA), must follow these additional protocols:

1. Attend training and orientation meetings as scheduled by the plan
2. Deliver health care to our members at their place of residence in collaboration with a PCP

3. Communicate with the member's responsible parties, family and/or legal guardian on a regular basis. Participate in conferences with responsible parties to discuss the member's condition, care needs, overall plan of care and goals of care.
4. Collaborate with other members of the primary care team and other health care providers to provide and arrange for the provision of covered services for our members. This includes:
   - Making joint visits with others on the primary care team to our members
   - Participating in conferences with primary care team members and/or other treating professionals following a scheduled member reassessment, significant change in plan of care and/or condition
5. Collaborate and communicate with the director of clinical operations to coordinate all inpatient, outpatient and facility care for our members. Forward copies of the required documentation to our office. Work with the director to develop a network of health care providers who are aware of the special needs of the frail elderly.
6. Conduct a complete initial assessment for all our nursing home plan members within 30 calendar days of enrollment (90 days for Assisted Living Plan members), that includes:
   - History and physical examination, including mini-mental status and functional assessment
   - Review previous medical records
   - Prepare problem list
   - Review medications and treatments
   - Review lab and X-ray results
   - Review current therapies (e.g., physical therapy, occupational therapy, speech therapy)
   - Update treatment plan
   - Review advance directive documentation including Do Not Resuscitate: Do Not Intervene (DNR/DNI) and use of other life-sustaining techniques
   - Contact the family/responsible party within 30 calendar days of enrollment to:
     - Schedule a meeting at the facility, if possible
     - Obtain further history
     - Agree on type and frequency of future contacts
     - Discuss advance directives
   - Perform clinical and quality initiative documentation as directed
7. Provide care management services to coordinate all the covered services outlined in our member's benefit plan Examples include:
   - All medically necessary and appropriate facility services
   - Outpatient procedures and consultations
   - Inpatient care management
   - Podiatry, audiology, vision care and mental health care provided in the facility:
     - When a member is admitted, notify the PCP and UnitedHealthcare or payer immediately if it is for an emergency or observation
     - If contact information is not available, call the local office or coordinate communication through the nursing facility clinical staff
8. Give us at least 45 calendar days' notice when discontinuing services at any facility where our members live

Social determinants of health protocol

We strongly encourage you to document social determinants of health (SDOH) using ICD-10 diagnostic code(s) (or successor diagnostic codes) in the member's medical record. Unless prohibited by federal or state law, this protocol applies to all UnitedHealthcare members.

As a result of this protocol, we strongly encourage you to routinely screen, document and submit the corresponding ICD-10 code(s). Although the list of ICD-10 codes is not comprehensive of all social determinants, it is a step we can take together in improving the lives of our members. We encourage you to remain current on the use of these SDOH ICD-10 codes, as they may be updated.

For more information, go to **UHCprovider.com** > Resources > Health plans, policies, protocols and guides > Under Additional Resources, choose Protocols > **Social Determinants of Health ICD-10 Coding Protocol**.

Telehealth services protocol

UnitedHealthcare will consider payment for telehealth services performed while the member was at home or another originating site under certain commercial and MA benefit plans.

To be eligible for payment, you must meet the following telehealth service requirements:

- Comply with the American Medical Association (AMA) and Federation of State Medical Board guidelines, which require all telemedicine visits to use live interactive audio and video as well as visual transmission of a physician-patient encounter. For UnitedHealthcare individual and fully insured group market plans, some state-specific variations may apply.
- Use a secure technology platform that meets federal and state requirements for security and confidentiality of electronic member information
- Comply with all applicable federal and state laws concerning the security and confidentiality of member information, including HIPAA and its governing regulations
- Maintain member records related to telehealth services in a secure medium that meets federal and state requirements for encryption and security of electronic member information. Additionally, records should include the application/service used to conduct the telehealth visit.
- Offer telehealth services in a clean, private space and not in vehicles or public spaces
- Code the telehealth services in accordance with applicable reimbursement policies

Artificial intelligence/generative AI

Providers are required to disclose the use of generative artificial intelligence to include but not limited to the model, deployment and tool used as well as the method in which AI is used in the provider's course of business.

Chapter 10: Our claims process

For information on submitting claims using Electronic Data Interchange (EDI), go to **UHCprovider.com/edi837**.

You can learn more about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims on **UHCprovider.com/claims**. These include training tools and resources such as frequently asked questions (FAQs), quick references, step-by-step instructions and tutorials.

Prompt claims processing

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

1. Review the member's eligibility as described in **Verifying eligibility, benefits and your network participation status**
2. Follow the instructions outlined in **How to submit advance notification/prior authorization, admission notification, discharge notification and observation stay notification**
3. Prepare complete and accurate claims as described in **Claims and encounter data submissions**
4. Ensure you are submitting claims to the correct payer ID using our **Claims Payer List**
5. Submit claims electronically for fast delivery and confirmation of receipt. Electronic submissions are preferred for sending claims to UnitedHealthcare.
   - Our contracts generally require you to conduct business with us electronically and contain specific requirements for electronic claim submission. Review your Agreement and follow the requirements. While some claims may require supporting information for initial review, we have reduced the need for attachments. We will request additional information when needed.
   - For information about submitting claims online using the UnitedHealthcare Provider Portal, visit **UHCprovider.com/portal**, and view the drop-down labeled Estimate and manage claims and payments
   - For information about submitting claims using Electronic Data Interchange, visit **UHCprovider.com/edi**. You'll find links to our Claims Payer list, Training Guides, EDI contacts, connectivity options and more.
   - Submit additional information to support a health care claim or encounter transaction using **EDI 275 Unsolicited Claim Attachments**
   - Check the status of a claim using EDI 276/277 Claim Status Inquiry and Response transactions
   - Contact your vendor or clearinghouse if these transactions are not available or activated in your system

Note: When we give you eligibility and benefit information, we are not guaranteeing payment or coverage in any specific amount. Actual reimbursement depends on many factors, such as compliance with administrative protocols, date(s) of services rendered, and benefit plan terms and conditions. For MA benefit plans, reimbursement also depends on CMS guidance and claims processing requirements. Under most benefit plans, and in accordance with Medicare guidelines, except where prohibited by applicable law, services that providers deliver to themselves or an immediate family member are not covered services. In this context, immediate family member means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

HIPAA claim edits and Smart Edits

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

Smart Edits are an EDI capability that auto-detects claims with potential errors. Smart Edits may also be applied to help reduce claim denials and improve the claim processing time. You have 5 calendar days to correct claims flagged or identified by Return and Documentation Smart Edits before they are automatically processed. Rejection Smart Edits require you to take action in for your claims to make it into our claim processing system.

For more information on HIPAA claim edits, go to **UHCprovider.com/claimedits**. For more information on Smart Edits, go to **UHCprovider.com/smartedits**.

Optum Pay

Optum Pay offers electronic funds transfer (ACH)/direct deposit and electronic remittance advice services. Optum Pay is the preferred method of receiving ACH/direct deposit payments from us. Printable and downloadable provider remittance advice (PRA) documents related to those ACH/direct deposit payments are also accessible in the Optum Pay portal.

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

If you use a billing service company, Optum Pay created a new portal just for third-party billing service companies. The billing service first needs to **enroll for access to Optum Pay**.

After your billing service enrolls, it can set up users on its Optum Pay account and then associate its Optum Pay account with your practice. This enables the service to access the claim payment information needed to post and close claims.

You may choose to receive electronic payments by direct deposit/ACH into your organization's bank account. The ACH initial setup or a change in banking information will take approximately 10 business days for processing and bank account validation. If ACH/direct deposit is not chosen, a virtual card payment (VCP) will be issued. This method does not require bank account information, as you would process your payments using your credit card point of sale terminal. Your current credit card processing fees apply. You can confirm those rates with your merchant processor directly.

In certain unique situations or where required by applicable law, you may be entitled to request payment by paper check. For a list of health care providers who may qualify for an exemption, and how to request one, go to **UHCprovider.com/claims** > Digital payment options > Frequently asked questions > ACH/direct deposit/EFT > **Electronic Payment Solutions frequently asked questions**.

Optum Pay posting and balancing with direct deposit

There are a few options for you to access your remittance and PRA documents electronically:

1. With the basic level of Optum Pay, you can access the last 13 months of your PRAs in PDF format on Optum Pay
2. You can also access the past 24 months of most UnitedHealthcare commercial, Medicare and Medicaid PRAs from the Document Library at no cost
3. PRAs from UnitedHealthcare-affiliated networks are generally available at no cost on their portals, such as Oxford Health Plans and UMR
4. If you are using the premium level of Optum Pay, you can access the last 36 months of your PRAs on Optum Pay

To sign up, visit **UHCprovider.com/payment**.

Virtual card payments

Process VCPs using the same method your organization uses to process credit card payments. Your current credit card processing fees apply. You can confirm those rates with the merchant processor directly. If your practice does not want to receive VCPs, you can register for ACH/direct deposit as described previously. The VCP process does not require that you share your banking information.

Posting and balancing with VCP

1. A single-use VCP will be issued and provided with each payment you receive
2. Process your payment the same way you process a card-not-present transaction from a member. Enter:
   - The exact amount of the payment
   - The 16-digit account number found on your virtual card statement
   - The expiration date
   - The card validation code
   - The payer's ZIP code if prompted by your point-of-sale terminal

All the information you'll need to process your VCP is on the virtual card statement.

Credit card processing fees may apply to virtual cards. Contact your merchant processor or financial institution for information on specific costs.

Unspent funds for VCPs are subject to state unclaimed property laws. OptumHealth Financial Services, a UnitedHealthcare-affiliated company, provides payment services to the health care industry and offers various claim payment options.

UnitedHealthcare-affiliated companies may receive transaction fees or other compensation related to some payment options.

Enroll and learn more about Optum Pay

To enroll with Optum Pay to receive direct deposit payments, visit **myservices.optumhealthpaymentservices.com**. To complete the enrollment, upload an image of a voided check and an image of your organization's Internal Revenue Service (IRS) Form W-9, Request for TIN and certification.

If you have questions about Optum Pay or direct deposit, call us at **1-877-620-6194** to speak with an Optum Pay representative.

Simplify your administrative workflow with

Claims in the UnitedHealthcare Provider Portal

Get the most up-to-date claims status and payment information, and submit your claim reconsideration and appeal requests. Go to **UHCprovider.com** Sign In > Claims & Payments.

- Check requirements by member or procedure
- Submit requests
- Check status
- Upload medical notes
- Radiology, cardiology and oncology transactions
- Specialty pharmacy transactions
- Admission notification, discharge notification and observation stay notification
- Update cases
- Submit claims and attachments

View claims information for multiple UnitedHealthcare plans

Access letters, remittance advice documents and reimbursement policies

Submit additional information requested on pended claims

Flag claims for future viewing

Submit claim reconsideration and appeal requests

Receive instant printable confirmation for your submissions

Learn more

For more information about submitting claims through the UnitedHealthcare Provider Portal – including quick reference guides and videos – visit **UHCprovider.com/portal** and view the drop-down labeled Estimate and manage claims and payments.

Claims and encounter data submissions

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

It is important to accurately code the claim because a member's level of coverage under their benefit plan may vary for different services. For more information and instructions, visit **UHCprovider.com/training** > **Digital solutions** > UnitedHealthcare Provider Portal Tools.

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

Complete claims by including the information listed under the **Requirements for complete claims and encounter data submission** section. We prefer to receive claims electronically.

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

Requirements for complete claims and encounter data submission

We may pend or deny your claim if you do not include the following information:

- Member's name, address, gender, date of birth or relationship to subscriber (policy owner)
- Subscriber's name (enter exactly as it appears on the member's ID card), ID number, employer group name and employer group number
- Rendering health care provider's name, signature or representative's signature, address where service was rendered, Remit to address, phone number, NPI, taxonomy and federal TIN
- Referring health care provider's name and NPI, as well as TIN (if applicable). All laboratory, DME, imaging and home health claims and/or encounters must include the referring health care provider's name and NPI number in addition to the other elements of a complete claim and/or encounter described in this guide.
- Complete service information, including date of service(s), place of service(s), number of services (days/units) rendered, current procedural terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes, with modifiers where appropriate, and current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity. You must communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item.
- Charge per service and total charges
- Itemized bill – there may be times when we request an itemized bill to help adjudicate the claim. In an effort to avoid unnecessary delays, submit itemized bills upon request.
- Detailed information about other insurance coverage
- Information regarding job-related, auto or accident information, if available
- Retail purchase cost (or a total retail rental cost) greater than $1,000 for DME
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure (F2, GR, ML, UN, ME) and NDC units dispensed (must be greater than 0) for all claims submitted with drug codes. Enter the NDC information for the drug(s) administered in the 24D field of the CMS-1500 Form, field 43 of the UB-04 form, or the LIN03 and CTP04-05 segments of the HIPAA 837 Professional or institutional electronic form.
- Method of administration (self or assisted) for hemophilia claims — note the method of administration and submit with the claim form with applicable J-CODES and hemophilia factor, to enable accurate reimbursement. Method of administration is either noted as self or assisted.

- Detailed description of the procedure or service for claims submitted with:
  - Unlisted medical/surgical CPT
  - Other revenue codes
  - Experimental services
  - Reconstructive services

Additional information needed for a complete UB-04/CMS-1450 Form

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

- Date and hour of admission
- Date and hour of discharge
- Member status-at-discharge code
- Type of bill code (3 digits)
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current 4-digit revenue code(s)
- Attending physician ID number
- For inpatient and outpatient services/procedures, complete service information, including line item date of service(s), number of services (days/units) rendered, the specific CPT and HCPCS procedure codes, with modifiers where appropriate, appropriate revenue codes (e.g., laboratory, radiology, diagnostic or therapeutic) and current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity. You must communicate the primary diagnosis for the service performed, especially if more than 1 diagnosis is related to a line item.
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)
- Any special billing instructions that are in your Agreement
- On an inpatient hospital bill type of 11x, the actual time the member was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount ($10 or $100) on all other surgical revenue code lines to assure appropriate adjudication
- The condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within 3 calendar days of an inpatient admission and are not related to the admission
- For high cost implants over $25k, the serial number in box 80 of the claim

Timely filing

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

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

Risk adjustment data – Medicare Advantage, commercial and exchange per TOC

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

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

- Medical records must support all conditions coded on the claims or encounters you submit using clear, complete and specific language
- Code all conditions that co-exist at the time of the member visit and require or affect member care, treatment or management
- Never use a diagnosis code for a probable or questionable diagnosis. Code only to the highest degree of certainty for the encounter/visit. Include information such as symptoms, signs, abnormal test results and/or other reasons for the visit.
- Specify whether conditions are chronic or acute in the medical record and in coding. Only choose diagnosis code(s) that fully describe the member's condition and pertinent history at the time of the visit. Do not code conditions that no longer exist.
- Carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a 3-digit code if a 5-digit code more accurately describes the member's condition.
- Check the diagnosis code against the member's gender
- Sign chart entries with credentials
- All claims and/or encounters submitted to us for risk adjustment consideration are subject to federal and/or UnitedHealthcare audit. Audits may come from CMS, HHS or us, where we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Give us any requested medical records quickly. Provide all available medical documentation for the services rendered to the member.
- Notify us immediately about any diagnostic data you have submitted to us that you later determine may be erroneous

CMS HCC risk adjustment

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

NPI

HIPAA, federal Medicare regulations and many state Medicaid agencies require health care providers to obtain and use a standardized NPI. You are required to use an NPI as identification on electronic transactions as outlined in the instructions for HIPAA electronic transaction X12N Implementation Guides.

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

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

We accept NPIs submitted through:

- **UnitedHealthcare Provider Portal:** In My Practice Profile, under Practice Management, select the Provider Demographics or Group Demographics tab to make health care provider updates
- **Credentialing/Contracting:** NPI and National Uniform Claim Committee = taxonomy indicators are collected as part of credentialing, recredentialing, new provider contracting and recontracting efforts

Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

How to submit NPI, TIN and taxonomy on a claim or encounter

Information is provided for the location of NPI, TIN and taxonomy on claims on **UHCprovider.com/mypracticeprofile**.

Medicare Advantage claim processing requirements

Section 1833 of the Social Security Act prohibits payments to a care provider if there is not sufficient information to determine the amounts due to such provider. We apply various claims processing edits based on:

- National and local coverage determinations
- The Medicare Claims Processing Guide
- National Correct Coding Initiative (NCCI)
- Other applicable guidance from CMS, including the Official ICD-10-CM Guidelines for Coding and Reporting

These edits provide us with information to determine:

- The correct amount to pay
- If you are authorized to perform the service
- If you are eligible to receive payment
- If the service is covered, correctly coded and correctly billed to be eligible for reimbursement
- If the service is provided to an eligible beneficiary
- If the service was provided in accordance with CMS guidance

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

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

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

Hospice – Medicare Advantage

Effective Jan. 1, 2024, UnitedHealthcare is not participating in the CMS Value-Based Insurance Design (VBID) hospice pilot. Refer to **UHCprovider.com/mahospice** to review protocol applicable to members that elected hospice on or before Dec. 31, 2023, that were enrolled in a 2023 VBID Hospice Plan. Any member that elected hospice on or after Jan. 1, 2024, while enrolled in any UnitedHealthcare MA plan will adhere to the following protocol.

When an MA member elects hospice, bill claims to the Medicare administrative contractor for:

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

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

Medicare Crossover

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

- For more information on Medicare Crossover, refer to **UHCprovider.com/ediclaimtips** > Secondary/COB or Tertiary Claims and Medicare Crossover
- More information on Medicare Crossover can be found at **UHCprovider.com/edi837**

Claim submission tips

Do not use a claim form to resubmit claims that were denied or pended for additional information. Use the claims tool in the UnitedHealthcare Provider Portal.

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

- Before submitting your EDI claims to us, refer to the member's ID card for the payer ID
- If no payer ID is listed, or you do not have access to the member's ID card, go to **UHCprovider.com/edi** > **Claims Payer List** for the correct payer ID number

On E/M Codes be sure to include social determinates of health documentation and ICD-10-CM.

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

The HIPAA ANSI X12 5010 837 format is the only acceptable format for submitting claims and encounter data.

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

For additional help, please utilize the Smart Edit Tool, which is a claims optimization tool that helps identify claim billing errors and provides the opportunity to review and repair certain potentially problematic claims. **Smart Edits** are reported in a timely manner so timely adjustments can be made to help avoid claim denials.

Estimating treatment costs

Several tools on our website can help you determine member and health benefit plan responsibility. For more information and instructions, visit **UHCprovider.com/training** > **Digital solutions** > UnitedHealthcare Provider Portal Tools.

HRA and HSA benefit plans claims submission tips

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

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

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

Balances for HSA members are not available through the UnitedHealthcare Provider Portal or EDI.

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

Submit claims electronically as an 837 EDI transaction or through the Claims Submission tool in the UnitedHealthcare Provider Portal, or to the address on the back of the member's ID card.

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

Consumer account cards and qualified medical expenses

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

Examples of non-qualifying expenses include:

- Cosmetic surgery/procedures (i.e., procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), such as:
  - Face lifts
  - Liposuction
  - Hair transplants
  - Hair removal (electrolysis)
  - Breast augmentation or reduction
    - Surgery or procedures necessary to improve a defect from a congenital abnormality, and reconstructive surgery following a mastectomy for cancer, may qualify
- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Weight-loss programs – disease-specific nutritional counseling may be covered
- Illegal operations or procedures

An expense may be a qualified medical expense even if not covered under a member's benefit plan. For updated information regarding qualified medical expenses, go to irs.gov or call the IRS at 1-800-TAX-FORM (1-800-829-3676).

Pass-through billing

You may only bill for services that you or your staff perform. You may not bill on behalf of another provider who actually performed the services.

Pass-through billing is not permitted and may not be billed to our members. UnitedHealthcare reserves the right to recover the full amount paid.

Clinical Laboratory Improvement Amendments requirements

We only reimburse for laboratory services that you are certified to perform through the federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services and respective procedure codes if you don't have the applicable CLIA certification.

In-office laboratory tests and CLIA waived tests

Health care provider offices granted a CLIA Certificate of Waiver may conduct a limited number of tests in-house.

As defined by CLIA, waived tests are simple tests with a low risk of an incorrect result. Sites that perform only waived testing must have a CLIA Certificate of Waiver and follow the manufacturer's instructions; other CLIA requirements do not apply to these sites. To determine if the test being performed has been approved for Certificate of Waiver status, make sure the test is on the CLIA Waived Test List.

All other laboratory tests require a referral to a participating or capitated laboratory. You can find a list of approved codes on cms.gov > Medicare > Quality > Clinical Laboratory Improvement Amendments (CLIA). Participating laboratories are listed on **UHCprovider.com/findprovider** > **Preferred Lab Network**.

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

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

Special reporting requirements for certain claim types

Anesthesia services

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

Laboratory claims

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

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

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

Genetic and molecular tests

To access the online Palmetto DEX® registry to register for a DEX Z-code®, go to dexzcodes.com. For molecular pathology claims where a Palmetto DEX Z-code® is required for reimbursement under a reimbursement policy, submit the DEX Z-code® identifier preceding the decimal in field 2400 SV-101-7 for professional lab services submitted on the electronic claim or in the shaded area of the service line in box 19 on a paper claim form. Facility lab services should submit the DEX Z-code® identifier in line SV-202-7 for electronic claims or block 80 for paper claims. The AMA Claim Designation Code or Abbreviated Gene Name may also be added after the assigned DEX Z-code®. When requesting notification or prior authorization, include the codes and services that will be performed and only the authorized procedure code(s) that should be billed. For more information on the UnitedHealthcare Genetic and molecular testing prior authorization/advance notification program, go to **UHCprovider.com/priorauth** > **Genetic and Molecular Testing**.

Physical medicine and rehabilitation services

Physical medicine and rehabilitation services are eligible for reimbursement if provided by a physician or therapy health care provider duly licensed to perform those services.

Assistant surgeons or surgical assistants claim submission requirements

The practice of using non-participating health care providers significantly increases the costs of services for our members. We require our participating health care providers to use reasonable efforts to find network providers, including network surgical assistants or assistant surgeons, for our members. The use of a non-participating assistant surgeon practice, in which our participating health care provider has an ownership interest or other financial arrangement, is prohibited unless the participating health care provider discloses that interest or arrangement to us in advance.

Erythropoietin (for commercial members)

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

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

Report the MEA segment as follows:

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

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

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

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

Overpayments

If we inform you of an overpaid claim, and you do not disagree, refund can be made via electronic payment (EFT) at **personapay.com/optumrecovery/login**, or send us the refund check or recoupment request within 30 calendar days (or as required by law or your Agreement) from the date of notification. We may apply the overpayment against future claim payments unless your Agreement states otherwise or as required by law. If you find we overpaid for a claim, use the **Overpayment refund/notification form**. Call **1-800-727-6735** with questions related to overpayments.

Send refunds to:

Electronic payment

personapay.com/optumrecovery/login
View list of outstanding overpayments eligible for EFT processing.

Regular mail

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

Overnight mail

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

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

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

Disagreement

If you disagree with the claim adjustment, or request for an overpayment refund or recoupment, you may submit a notice of disagreement within 30 calendar days (or as required by law or your Agreement) from the date of receipt of notification. You must clearly state the basis for your disagreement and include any relevant and supporting documentation. The notification letter includes instructions on how to submit a notice of disagreement.

Direct Connect

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

- Track and manage certain types of overpayments in a controlled process; some inventory restrictions apply
- Create a transparent view between health care provider and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution time frames
- Track inventories in resolution process through real-time reporting
- Provide control over financial resolution method
- Manage and review overpayment disagreements
- Attach images for quick reference

For more information, contact the Optum Direct Connect Team at **directconnectaccess@optum.com**.

Subrogation and COB

Our benefit plans are subject to subrogation and COB rules.

1. **Subrogation** – We have the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan. For subrogation/reimbursement matters, contact:

   Optum
   11000 Optum Circle MN102-0300
   Eden Prairie, MN 55344

   subroreferrals.optum.com

   Fax: 1-800-842-8810

2. **COB** – COB is administered according to the member's benefit plan and in accordance with law. We accept secondary claims electronically. To learn more, go to **UHCprovider.com/edi** > **EDI quick tips for claims** > Secondary/COB or Tertiary Claims and Medicare Crossover. You can also contact EDI Support at **UHCprovider.com/edi** > EDI support and contacts.
3. **Workers' Compensation** – In cases where an illness or injury is employment-related, workers' compensation is primary. If you receive notification that the workers' compensation carrier has denied a claim for services, submit the claim to us. It is also helpful to send us the workers' compensation denial statement with the claim.
4. **Medicare** – If the health care provider accepts Medicare assignment, all COB types coordinate up to Medicare's allowed amount. Medicare Secondary Payer rules dictate when Medicare pays secondary.

Other coverage is primary over Medicare in the following instances:

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

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 employer's group plan for the first 30 months after becoming eligible for Medicare. After the 30 months, Medicare is the primary payer. However, if the employer group benefit plan coverage was secondary to Medicare when the member developed ESRD, Medicare is the primary payer, and there is no 30-month period.

Continuation of Benefits – Consolidated Omnibus Budget Reconciliation Act

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

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

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

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

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

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

Claim correction and resubmission

Electronic process:

- Submit corrected claims electronically as an EDI 837 transaction with the appropriate frequency code. For more details, go to **UHCprovider.com/ediclaimtips** > Corrected Claims.
- Use the claims tool in the UnitedHealthcare Provider Portal to resubmit corrected claims that have been paid or denied
- If you received a letter asking for additional information, please follow instructions on the letter for options on electronic submission
- When correcting or submitting late charges on 837 institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim.
- When correcting or submitting late charges on a 1500 professional claim, use the following frequency code in Box 22 and use left justified to enter the code. Include the 12-digit original claim number under the Original Reference Number in this box.
  - Frequency code 7 Replacement of Prior Claim: Corrects a previously submitted claim
  - Frequency code 8 Void/Cancel of Prior Claim: Indicates this bill is an exact duplicate of an incorrect bill previously submitted. This code will void the original submitted claims.

Claim reconsideration and appeals process

Claim reconsideration does not apply in some states, such as MD, based on applicable state law. Refer to the **Health care provider dispute resolution (CA Commercial HMO, OR HMO claims, OR and WA commercial plans)** section for more information on similar prohibitions in those jurisdictions.

Note: For Medicare non-network providers claim appeals and dispute process, refer to **UHCprovider.com/plans** > Choose your state > Medicare > Select plan name > Tools and Resources > Medicare Advantage Non-Contracted Care Provider Dispute and Appeal Rights.

Except where prohibited by applicable law (as noted above), you must follow a 2-step process when you don't agree with a claim determination. First, you must submit a claim reconsideration request. If you don't agree with the outcome of the reconsideration, you may submit an appeal.

You must submit both your reconsideration and appeal to us within 12 months (or as required by law or your Agreement) from the date of the EOB or PRA. The 2-step process, as outlined in the following graphic, allows for a total of 12 months for timely submission for both steps (Step 1: Reconsideration and Step 2: Appeals). For more information visit **UHCprovider.com/claims**.

Step 1: Claim reconsideration

If you disagree with the outcome of a processed claim (payment or denial), you can ask us to take another look at the decision by submitting a claim reconsideration request. Follow one of the processes outlined below:

Submit your claim reconsideration request online. Go to **UHCprovider.com** > Sign In > Claims & Payments and include any necessary additional supporting materials not included in the original claim submissions.

For detailed instructions, visit **UHCprovider.com/training** > Digital solutions > UnitedHealthcare Provider Portal Tools.

OR

Submit your claim reconsideration request (with attachments) using API. Visit the **API Marketplace** for more details.

OR

Call the number on the back of the member's ID card to request an adjustment to a claim that does not require written documentation.

Step 2: Appeals

If you disagree with the outcome of the claim reconsideration in Step 1, you may follow one of the processes below to submit an appeal.

Submit your appeal electronically online at **UHCprovider.com** > Sign In > Claims & Payments. For detailed instructions, visit **UHCprovider.com/training** > Digital solutions > UnitedHealthcare Provider Portal Tools.

Attach all new supporting materials to the appeal, including member-specific treatment plans or clinical records. Please do not include any materials that you sent to us as part of the reconsideration request. We make our decision based on the materials available at the time of appeal review.

OR

Submit your appeal (with attachments) using API. Visit the **API Marketplace** for more details on submitting appeals and follow the Get Started prompts to schedule a meeting with an API consultant to learn more.

If you disagree with an audit finding from a vendor as outlined in Chapter 11, rather than follow the steps set forth above, please follow the instructions for reconsideration and/or appeal set forth in the vendor letter.

Proof of claim timely filing

To show the date of the claim submission, please include confirmation we received and accepted your claim within your filing limit or include a screen print from your accounting software to show the date of submission. Timely filing limits vary based on state requirements and contracts. Refer to your Agreement for your specific timely filing requirements.

20 or more claims (research request)

If you have a request to reconsider 20 or more paid or denied claims for the same administrative issue (and attachments are not required), you may submit these in bulk online. Go to **UHCprovider.com** > Sign In > Claims & Payments > Claims Research Project.

Attachments

If you are submitting medical documentation we requested for a pended claim, go to **UHCprovider.com** > Sign In > Claims & Payments.

To submit proof of timely filing for a claim denied for timely filing, go to **UHCprovider.com** > Sign In > Claims & Payments and provide one of the following documents:

- EDI report – and include confirmation that it was received and accepted within your filing limit

- A submission report from your accounting software to include a screen print to show the date the claim was submitted
- A billing software statement to show the claim was submitted timely to the clearinghouse (if rejected proof is not acceptable)
- A resubmission form or letter with a statement that you billed the wrong insurance, or the member gave you the wrong insurance information. If available, include any other evidence you may have such as the other insurance carrier's denial or rejection, EOB, letter indicating coverage terminated or member not eligible.

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

Reconsideration and appeal decisions

If, as a result of a reconsideration or appeal review, UnitedHealthcare determines that a claim is eligible for additional payment, an updated EOB or PRA will be produced and serve as notification of the outcome on the review. If the original claim status is upheld, you will be provided a letter outlining the details of the review.

Retroactive eligibility changes

Eligibility under a benefit plan may change retroactively if:

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

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

Medicare Advantage hospital discharge appeal rights protocol

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

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

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

Resolving potential reimbursement issues

If you believe there was an error with what we reimbursed you, you must complete the claim reconsideration and appeal process as set forth in this guide before you can initiate the dispute resolution process set forth in your Agreement.

If you intend to pursue your potential issue beyond the reconsideration and appeal process, you must send a Notice of Dispute. Unless your Agreement prescribes a different time frame, a Notice of Dispute must be sent no later than 60 days after the date of our decision on your appeal. A Notice of Dispute contesting adjudication of a claim must:

- Be sent in the manner and method required by your Agreement to the notice address identified in your Agreement or any subsequently updated address
- State that you are initiating the dispute resolution process. Include Notice of Dispute in the reference line
- If challenging payment of any claims, include the following claim information:
  - Group number
  - Subscriber number
  - Patient first name
  - Patient last name
  - Patient date of birth
  - Provider TIN
  - First date of service
  - Last date of service
  - Total billed charges
  - Units billed
  - UnitedHealthcare payment received
  - Patient responsibility received
  - Contractual reimbursement expected
  - Balance due (variance due)
  - Patient account number
  - Detailed issue description with the specific basis for the challenge to our claim denial or payment and why you contend the claim was incorrectly paid
  - CPT/HCPCS code or other applicable procedure code
  - Claim or call reference number
  - Reconsideration filed date
  - Reconsideration reference number
  - Appeal filed date
  - Appeal reference number
- Include any other information required by your agreement

You agree not to include any claim or issue in any Notice of Dispute submitted to UnitedHealthcare that does not comply with the requirements of this section. Failure to timely comply with this process and the requirements in your Agreement will result in the waiver of your right to initiate dispute resolution and waiver of your right to pursue such claim or issue in any forum.

Arbitration locations

Unless your Agreement states differently, these are locations where arbitration proceedings are held, based on the locations where you provide care:

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

Member appeals, grievances or complaints

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

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

1. Assist the member with filing an appeal or grievance upon request from the member. This form is located by logging onto **myuhc.com** > Claims and Accounts > Medical Appeals and Grievances.

Note: An appeal, grievance or complaint process may differ based on product. See the applicable benefit plan supplement to verify the process for those plan members. Encourage the member to contact UnitedHealthcare Customer Service for assistance in filing an appeal or grievance.

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

Individual Exchange plans	Member and Provider Appeals and Reconsiderations UnitedHealthcare P.O. Box 6111 Mail Stop CA-0197 Cypress, CA 90630 **Fax:** 1-888-404-0949 (standard requests) 1-888-808-9123 (expedited requests)	Pharmacy: Optum Rx c/o Appeals Coordinator P.O. Box 2975 Mission, KS 66201 Pharmacy fax: 1-877-239-4565
Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) plans	UnitedHealthcare P.O. Box 6106 Mail Stop CA 124-0157 Cypress, CA 90630	
Medicare and Retirement Prescription Drug plans (PDP)	UnitedHealthcare P.O. Box 6106 Mail Stop CA 124-0197 Cypress, CA 90630	
Commercial plans	UnitedHealthcare P.O. Box 30573 Salt Lake City, UT 84130-0573	
UnitedHealthcare Level Funded and UnitedHealthcare Oxford Level Funded	Appeals Review P.O. Box 31393 Salt Lake City, UT 84131	
UnitedHealthcare Student Resources	Claim reconsiderations UnitedHealthcare Student Resources Attn: Claims P.O. Box 8098025 Dallas, TX 75380	Clinical appeals UnitedHealthcare Student Resources Attn: Appeals P.O. Box 8098025 Dallas, TX 75380 You must submit all supporting materials with the appeal request, including member-specific treatment plans or clinical records. Please note that clinical appeals are only for services that received a medical necessity review and were determined to lack medical necessity.
	Email: customerservice@uhcsr.com **Fax:** 1-469-229-5510 send to the attention of a person that you have spoken to, if applicable	

UnitedHealthOne Individual Plans Supplement (Golden Rule Insurance Company, UnitedHealthcare Oxford Navigate Individual benefit plans offered by Oxford Health Insurance, Inc.)	Grievance Administrator P.O. Box 31371 Salt Lake City, UT 84131-0370 **Standard fax:** 1-801-478-5463 **Expedited fax:** 1-866-654-6323 **Phone: 1-800-657-8205**	
UMR and UnitedHealthcare Shared Services	**Appeals** (preservice) **UMR** **Fax:** 1-888-615-6584 **Mail:** UHC Appeals - UMR P.O. Box 400046 San Antonio, TX 78229 **UHSS** **Fax:** 1-888-615-6584 **Mail:** P.O. Box 400046 San Antonio, TX 78229	**Reconsiderations and appeals** (post-service) **UMR** **Phone:** Call the number listed on the back of the member's ID card. **Mail:** UMR - Claim Appeals P.O. Box 30546 Salt Lake City, UT 84130-0546 (or send to the address listed on the provider ERA) **UHSS** **Fax:** 1-866-427-7703 **Mail:** P.O. Box 30783 Salt Lake City, UT 84130-0783
Oxford Commercial plans	**Phone: 1-800-444-6222** **Fax:** 203-601-6893 **CT and NY** Correspondence Department P.O. Box 29134 Hot Springs, AR 71903 **NJ** Oxford Health Plans Correspondence Department 4 Research Dr. Shelton, CT 06484	

3. Respond to our requests for information within the designated time frame. You must supply records as requested within 2 hours for expedited appeals and 24 hours for standard appeals. This includes weekends and holidays.
4. For Medicare member appeal requests, CMS regulation states once an appeal is received, within 60 calendar days of the denial, it must be reviewed under the appeal process. A request to review a post-service determination will not be reopened for any reason (i.e., New and Material Evidence, Fraud or Similar Fault, Other) other than for a clerical error, unless the 60-calendar-day time frame to file a reconsideration has expired.
5. Cooperate with our external independent medical review organization and us. This includes:
   - Promptly forwarding all medical records and information relevant to the applicable health care service to the external review organization
   - Providing newly discovered relevant medical records or any information in the participating medical group's/IPA's possession to the external review organization

6. Provide us with proof that reversals of adverse determinations were done within the stated time frames. You must supply proof of effectuation within:
   - Expedited appeals – 2 hours of overturn notice
   - Standard appeals – 24 hours of overturn notice. This applies to all calendar days (no exceptions or delays allowed for weekends or holidays).

Submission of claims for services subject to medical claim review

We have the right to review claims to confirm a health care provider is following appropriate and nationally accepted coding practices. Health care providers must cooperate by providing access to requested claims information, all supporting documentation (such as medical records) and other related data and information that we may request, including itemized bills and manufacturer invoices. We may adjust payment to the health care provider at the revised allowable amount based on our review of this information. If such information is not submitted following our request, we may deny the claim or adjust payment to the health care provider at a revised allowable amount as we determine appropriate.

We may pend or deny a claim and request medical records to determine whether the service rendered is covered, including medically necessary and eligible for payment. In these cases, we send a letter explaining what we need.

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

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

Chapter 11: Compensation

Reimbursement policies

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

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

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

Charging members

Members are responsible for copayments, deductibles and coinsurance. You may collect copayments at the time of service. Once we process the claim, the final member financial responsibility is listed on the provider remittance advice (PRA) and the member's explanation of benefits (EOB).

Individual and family annual deductibles and out-of-pocket maximums (commercial)

Annual individual and family out-of-pocket maximums are equal to the combined total of deductible, copayment and coinsurance amounts the member pays as shown on their Schedule of Benefits. Cost-share is the amount the member is financially responsible for, such as copayments, coinsurance and deductibles according to their plan benefits. Cost-sharing for certain types of covered services may not apply toward the annual individual or family out-of-pocket maximums. Refer to the member's Schedule of Benefits to determine if a cost-share amount, for a particular covered service, applies to the member's annual individual and/or family out-of-pocket maximums.

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

When a family's out-of-pocket expenses have reached the annual family out-of-pocket maximum, the family members will not have any additional cost-share for services that apply to the annual family out-of-pocket maximum for the rest of that plan year.

Some services may not be covered until the member meets the annual individual deductible. Only amounts incurred for covered services that are subject to the annual individual deductible will count toward the annual individual deductible. Benefit plans may have an annual individual deductible only or both an annual individual and annual family deductible. No further deductible will be required for any individual family member when the individual deductible amount has been satisfied for the rest of the plan year. For plans with both annual individual and family deductibles, no further deductible will be required from any covered family member for the rest of the plan year when the annual family deductible has been met.

As previously indicated, only certain covered services apply to the annual individual and family deductibles. Covered services that do not apply to the annual individual and family deductibles may incur a member cost-share that is considered separate from, and not included in, the annual individual and family deductibles. The annual individual and family deductibles apply to the annual individual and family out-of-pocket maximums. The amounts applied are based upon the UnitedHealthcare contracted rates, copayments and coinsurance.

Annual out-of-pocket maximum (Medicare Advantage)

Annual out-of-pocket maximum is equal to the member's annual copayment maximum (if any), as shown on the member's Evidence of Coverage (EOC).

Cost-sharing for certain types of covered services may not apply toward the annual out-of-pocket maximum. Refer to the member's EOC to determine applicability to the benefit plan. When an individual member's out-of-pocket expenses has reached the individual annual out-of-pocket maximum, no further cost-share amounts will be due by the member for those services that apply to the annual out-of-pocket maximum. Plans with benefits that do not apply to the annual out-of-pocket maximum will still require cost-sharing for those excluded benefits after the annual out-of-pocket maximum reached.

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

Coinsurance calculation

For all MA products, coinsurance is calculated as follows:

1. For services reimbursed on a service-specific contracted rate, or on a fee-for-service basis, the coinsurance is based on the contracted rate or billed amount, whichever is less or as agreed upon in your Agreement with us
2. For services reimbursed under a downstream capitation Agreement between your organization and a health care provider of the service, and where payment is not issued for each specific service rendered, coinsurance is based on Medicare's allowance for the location at which the service is rendered

This coinsurance calculation is consistent with the definition of coinsurance as the amount a member pays as their share of the cost for services or prescription drugs. The methodology is used for all UnitedHealthcare MA plans nationwide. Ensure you have the correct system setup and use consistent coinsurance calculations to help reduce member appeals and complaints.

Additional fees for covered services

Do not charge additional fees for:

- Covered services beyond their copayments, coinsurance or deductible
- Retainers or administrative fees
- Services/claims that were denied because you failed to follow our protocols and/or reimbursement policies
- Reductions applied to services/claims resulting from our protocols and/or reimbursement policies

You may charge members for missed appointments. (CMS does not allow you to charge MA members for missed appointments unless the member was aware of that policy.)

Concierge/boutique medical practices

Concierge/boutique medical practices charge members a service fee in exchange for longer visits, a commitment from the practices for shorter wait times, or in many cases, access to the provider's cell phone number and email address to get in touch with their health care provider quickly.

We will allow our contracted network providers to charge concierge/boutique medicine fees with the following restrictions:

- You must give members the choice of paying the concierge membership fee; if the member chooses not to pay the fee, you may not refuse to see the member
- You must be transparent with the member about what they will receive as part of the concierge membership and fees
- If you cannot meet the criteria because you are requiring all members to pay the fees, you will need to consider changing your concierge program to comply with our requirements, or you will be terminated from our network

- We must have the opportunity to review and approve the services included with the concierge membership fee. The concierge services should not consist of any covered services that are already included in your Participation Agreement with us.

Charging members for noncovered services

You may collect payment from our commercial members for services not covered under their benefit plan if you first get the member's written consent. The member must sign and date the consent before the service is done. Keep a copy in the member's medical record. If you know or have reason to suspect the member's benefits do not cover the service, the consent must include:

- An estimate of the charges for that service
- A statement of reason for your belief the service may not be covered
- When we determine the planned services are not covered services, a statement that we have determined the service is not covered and that the member knows our determination and agrees to be responsible for those charges

Generic, blanket or blank written consent forms are not allowed.

- **Generic written notices** – routine written notices to members only state that a denial of payment is possible or that you do not know if payment will be denied. Generic written notices are not acceptable evidence of written notice and will not protect you from liability. The written notice must specify the item and/or service and a genuine reason that denial is expected. Written notice standards are not satisfied by a generic document that is little more than a signed statement by the member to the effect that, should payment be denied, the member agrees to pay for the item and/or service.
- **Blanket written notices** – giving written notices for all claims or items or services (i.e., blanket written notices) is not an acceptable practice. Notice must be given to a member about the likelihood of payment for that individual's claim.
- **Signed blank written notices** – you are prohibited from obtaining member signatures on blank written notices and then completing the details later. For a written notice to be effective, it must be completed before giving it to the member.

You should know or have reason to suspect that a service or item may not be covered if we have:

- Provided notice through an article on **UHCprovider.com**, including clinical protocols and/or medical policies
- Determined that the planned service or item is not covered and have communicated that determination

In addition to the consent requirements, if you know or have reason to suspect that a commercial member's benefits do not cover the service, a GA modifier must be submitted on the claim if you want to bill our member for the non-covered service. You will use the GA modifier to document when the enhanced content requirements of the consent were met. Do not bill the member for noncovered services in cases where you do not follow this protocol.

For MA members, in addition to obtaining the member's written consent before the service is done, you must:

- Request a preservice determination from us prior to rendering services, if you know or have reason to believe that a service or item you are providing or referring may not be covered
- Make sure the member has received the Integrated Denial Notice (IDN) prior to rendering or referring for noncovered services or items to collect payment. If we determine the service or item is not covered, we issue an IDN to the member and you. The IDN gives the member their cost for the noncovered service or item and appeal rights. Per CMS requirements, for you to hold an MA member financially liable for the noncovered service or item, the member must first have an IDN, unless the Evidence of Coverage, or other related materials, clearly excludes the item or service.
- To submit an advance notification request using the UnitedHealthcare Provider Portal, go to **UHCprovider.com** > Sign In > Prior Authorizations. A preservice organization determination is not required to collect payment from an MA member where the EOC or other related materials issued to an MA member is clear that a service or item is not covered. The Prior Authorization and Notification tool does not issue denials. It tells you if a procedure code requires review or not.

- Review the Medicare Coverage Center. CMS has published information to help you determine if the service or the item is covered. If you do not follow this protocol, you cannot bill our member.

See the information below for including modifiers on your claims:

- GA modifier: If you followed this protocol and requested a preservice organization determination, and an IDN was issued before the noncovered service was rendered, you must include the GA modifier on your claim for the noncovered service. Including the GA modifier on your claim helps ensure your claim for the noncovered service is appropriately adjudicated as member liability.
- GZ modifier: If you know or have reason to believe that a service or item you are providing or referring will be denied as not reasonable and necessary and you did not provide an advance notice of noncoverage to member, you must include the GZ modifier on your claim. Including the GZ modifier on your claim helps ensure your claim for the noncovered service is appropriately adjudicated as provider liability.
- GY modifier: If you know the service or item you are providing or referring is statutorily excluded from Medicare coverage and the service is explicitly excluded in the members EOC, you must include GY modifier on claim. Including the GY modifier on your claim helps ensure your claim for noncovered service is appropriately adjudicated as member liability.

If you don't follow the terms of this protocol (such as requesting a preservice organization determination for a MA member or rendering the service to a MA member before we issue the preservice organization determination), you may receive an administrative claim denial. You cannot bill the member for administratively denied claims.

Balance billing

You cannot bill members for covered services beyond their normal cost-sharing amounts (copayment, deductible or coinsurance).

You cannot:

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

You must either:

- Accept payment made by or on behalf of us as payment in full
- Bill the appropriate state source for such cost-sharing amount

Billing for dual-eligibles

Dual-eligible members qualify for both Medicare and Medicaid. If you are a participating health care provider in our MA network, you cannot refuse to see these members. For dual-eligibles for whom the state is responsible for covering Medicare cost-sharing, our contract requires that you accept payments made by or on behalf of our MA plans for covered Part A and B services as payment in full. You can bill the appropriate state Medicaid source for the balance.

Cost-sharing for Qualified Medicare beneficiary

Qualified Medicare beneficiaries (QMBs) are not responsible for Medicare cost-sharing under CMS regulations. Medicare cost-sharing includes the deductibles, coinsurance and copays associated with covered Part A and B services included under MA plans. You cannot bill, charge, collect a deposit from or seek compensation from any MA member who is eligible for both Medicare and Medicaid. You can accept payment from us as payment in full or bill Medicaid for the remaining amount.

Member financial responsibility

Members are responsible for paying their copayments, deductibles and coinsurance. You can collect copayments at the time of service.

To determine the exact member responsibility, submit claims first and refer to the EOB or PRA before billing our members.

If you prefer to collect payment at time of service, you must make a good faith effort to estimate the member's responsibility and collect no more than that amount at the time of services. You must help ensure the member has not exceeded their annual out-of-pocket maximum. Several tools on our website can help you determine member and health benefit plan responsibility.

To learn more and view detailed instructions, visit **UHCprovider.com/training** > **Digital solutions** > UnitedHealthcare Provider Portal Tools.

If the member pays you more than the amount indicated on the EOB/PRA, you must refund the member.

Preventive care

The Department of Health and Human Services requires most benefit plans to include certain preventive care services to be covered without any out-of-pocket costs if a participating health care provider provides the service.

We update our medical policy titled **Preventive Care Services** to help you identify and correctly code preventive services.

We update the medical policy when we receive new guidance about preventative services and revised codes. The United States Preventive Services Task Force is one of the primary references driving changes to the medical policy. We must cover items that have an A or B rating without cost-share by non-grandfathered benefit plans. This applies to both fully insured and self-funded benefit plans. While grandfathered benefit plans are not required to implement these changes, some grandfathered benefit plans have chosen to cover preventive care services at no cost-share.

This does not apply to members enrolled in government health benefit plans (Medicare/Medicaid), including our MA benefit plans. For more information, visit:

- Benefit verification – check the Eligibility and Benefits tool in the UnitedHealthcare Provider Portal
- Health care reform – **uhc.com/united-for-reform**

Extrapolation

We may review paid claims to help ensure payment integrity. If reviewing all medical records for a procedure would burden you, we may select a statistically valid random sample (SVRS) or smaller subset of the SVRS. This gives an estimate of the proportion of claims we paid in error. The estimated proportion, or error rate, can be projected across all claims to determine overpayment. You may appeal the initial findings. You must supply all requested medical records. Failure to do so may result in a failure of the entire SVRS and all claims submitted within the review.

You must handle overpayment disagreements as outlined in this guide and in your Agreement.

Provider claim reviews may be conducted through a phone call, on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews. We ask that you provide us, or our designee, during normal business hours, access to examine, review, scan and copy any and all records necessary to determine compliance.

If you refuse to allow access to your facilities, we reserve the right to recover the full amount paid or due to you.

Audit services

Audit services develops and implements audits designed to identify billing and coding inaccuracies. (See **Chapter 17: Fraud, waste and abuse** (FWA) for examples of potentially fraudulent, wasteful or abusive billing.) Audit programs are developed in response to identified overpayment risk and include comprehensive review of critical

claim elements, such as medical records, itemized bills and manufacturer invoices. We conduct audits in conjunction with applicable federal or state regulations, national guidelines and contract terms.

UnitedHealthcare may use external vendors to conduct the audits. Audits may be conducted on-site or remotely.

Not all medical record reviews are considered an audit. For example, medical records may be reviewed for the purpose of the administering claims, assessing quality of care or performing our utilization management programs.

Access

Our auditors notify you of our intent to audit a claim by notifying your appropriate representative. As the health care provider, you are responsible for:

- Sending a copy of the medical record, itemized bill, bill breakdown and/or other requested documentation within the time frame specified in the intent to audit letter
- Obtaining the member authorization to release their medical information
  - In many cases, the member signs this authorization at the time of admission
- Waiving the fee associated with the audit or copying of records, unless otherwise specified in your Agreement

In addition, for on-site audits, you are responsible for:

- Cooperating in a timely manner to allow audit scheduling within 30 calendar days of the scheduling request
- Coordinating the audit location
- Providing the auditor access to the medical records, department charge sheets, itemized bills, other documentation and any applicable policy and procedure (if requested)
- Providing our audit vendors the same access as our employee auditors
  - Vendors authorized by us are bound to our obligations under the Agreement
- Not imposing time limitations on our right or ability to audit, unless otherwise stated in the Agreement or by state/federal law

Audit findings

- When the audit is complete, the auditor notifies you of any findings. If an overpayment has been identified, the auditor will request an overpayment refund.
- **Refund remittance** – you must remit the overpayment amount within 30 calendar days of receipt of the overpayment refund request, or as required by state or federal law
- **Audit findings** – if you disagree with the findings, you may submit notification of the disagreement within the time frame outlined in the overpayment refund request. The notification must clearly identify the items of disagreement and include any relevant documentation to support your position.
- **Disagreement resolution** – we respond to audit disagreements in writing, according to the terms of your contract and/or applicable state law. If you are not satisfied with our response, please follow the instructions in the vendor letter for reconsideration and appeal rights (See **Chapter 10: Our claims process - Claim reconsideration and appeals process** in this guide), or, if/when available, pursue other dispute resolution procedures outlined in your contract.
- **Offsets** – when we issue a refund request in connection with an audit, we recoup or offset the identified overpayment and/or disallowed charge amounts after 45 calendar days from the date of the refund request, except when:
  - You have already remitted the amount due
  - You have provided written notification of disagreement with the audit findings within the 45-calendar-day repayment period
  - Your Agreement or state law says otherwise

Audit failure denials

You are required to submit, or provide access to, medical records upon our request. Failure to do so in a timely manner may result in an audit failure denial, creating an overpayment. Overpayments created as a result of a failure to provide access to requested medical records will be subject to recoupment in accordance with the process listed in the **Overpayments section of Chapter 10** (Our claims process) of this manual.

Notice of Medicare Noncoverage

You must deliver required notice to members at least 2 calendar days before termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member's services are expected to be fewer than 2 calendar days in duration, the notice should be delivered at the time of admission or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds 2 calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or their authorized representative, if the member is incompetent. You must use the most current version of the standard CMS approved notice titled Notice of Medicare Noncoverage (NOMNC).

The standardized form and instructions regarding the NOMNC may be found on the CMS website at cms.gov > Medicare > Beneficiary Notices Initiative (BNI) > MA ED Notices or contact your Quality Improvement Organization (QIO) for information. There can be no modification of this text, and all required elements must be present, including instructions on how to contact the QIO and the member's MA benefit plan.

Any appeals of such service terminations are called fast-track appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of calendar day of the day you are notified by us or the QIO if the member has requested a fast track appeal. This includes weekends and holidays.

Chapter 12: Medical records standards and requirements

Access to records

Unless otherwise stated in your Agreement, you are required to:

- Send copies of our members' medical, financial, administrative or purchasing and leasing records
- Provide electronic medical records (EMR) access to UnitedHealthcare on a 24 hours a day, 7 days per week basis
- Give United access to member records for all dates of service
- Supply records to UnitedHealthcare within 14 days upon request (not related to urgent requests), free of charge
  - Supply records faster in certain circumstances; you have 24/48/72 hours to provide records via electronic file transfer for urgent requests
- Maintain and protect records for 10 years
- Assist us, or our designee, in completing chart reviews for MA members

Medical record standards

You may access medical record tools, templates and patient safety resources on **UHCprovider.com/patient**.

Member encounters

For every visit, document the:

- Member's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit
- Diagnosis and treatment plans
- Member education, counseling or coordination of care with other health care providers
- Date of return visit or other follow-up care, including phone calls
- Review by the PCP (initialed) on consultation, lab, imaging and special studies, as well as ancillary, outpatient and inpatient records
- Follow-up care plans

When coding the encounter, if appropriate, pick the evaluation and management level that reflects the member's condition at the time of the visit in accordance with proper coding conventions and scope of provider license.

Monitoring the quality of medical care through review of medical records

A well-documented medical record reflects the type of care delivered to patients. Accreditation and regulatory groups review medical records as part of their oversight activities. Maintain your medical records in a manner that is current, detailed and organized. This allows for effective and confidential patient care and quality reviews.

Correspondence from the Quality of Care Department is considered privileged and confidential. The involved health care provider cannot share or discuss correspondence with the patient, member or any member representative. You may not file the communication in the patient's medical record.

Medical records duplication

- **Medical record copies for specialist referrals** – the PCP office pays for the cost of duplicating and shipping the records due to a referral. You cannot charge members to receive records used during the member's course of treatment.
- **Member transfer to another PCP** – do not charge the member if they need records sent to another PCP

- **Member request for medical records** – the member, or member's representative, may request copies of records from your office. You can charge a fee of up to 25 cents per page plus any reasonable clerical costs incurred, unless state laws indicates otherwise.

Medical record guidelines

Medical records must have all information necessary to support claims for your services. You are expected to have written policies for the following:

- Medical records guidelines, including maintenance of a single, permanent medical record that is legible, current and detailed
- Process for handling missed appointments
- Nondiscrimination of health care delivery
- Staff training on confidentiality and safe record keeping
- Release of information
- Medical record retention
- Availability of medical records if housed in a different location
- Coordination of care between medical and behavioral health care providers
- Process for notifying UnitedHealthcare upon becoming aware of a patient safety issue or concern

General documentation guidelines

We expect you to follow guidelines for medical record information and documentation, including the following:

- Date all entries, and identify the author and their credentials. The documentation should show which individual performed a given service.
- Clearly label or document changes to a medical record entry by including the author, date of change and reason for the change. You must keep a copy of the original record and the changed record, including the author, date of change and reason for the change.
- Generate documentation at the time of service or shortly thereafter. Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.
- Gather demographic information, including name, gender, date of birth, member number, emergency contact name, relationship, phone numbers and insurance information
- Transcribe family and social history, including marital status and occupational status or history
- Prominently place information on whether the member has executed an advance directive. This is critical.
- List medical history, chronic conditions and significant illnesses, accidents and operations. Include the chief complaint, diagnosis and treatment plan at each visit.
- List medication allergies and adverse reactions. Also note if the member has no known allergies or adverse reactions. This is critical.
- Include name of current medications, dosages and over-the-counter drugs
- Reflect all services provided, ancillary services/tests ordered and all diagnostic/therapeutic services referred by the health care provider
- Document member history and health behaviors such as:
  - Tobacco habits, including advice to quit, alcohol use and substance use (age 11 and older)
  - Immunization record
  - Preventive screenings/services and risk screenings
  - Screenings for depression and evidence of coordination with behavioral health care providers
  - Blood pressure, height and weight and body mass index
  - Physical assessment for each visit
  - Growth charts for children and developmental assessments

- Physical activity and nutritional counseling
- Clinical decision and safety support tools in place to help ensure evidence-based care and follow-up care. Examples include:
  - Lab, X-ray, consultation reports, behavioral health reports, ancillary health care providers' reports, facility records and outpatient records show health care provider review by signature or initials
  - Report from eye care specialist related to medical eye examinations

Record accuracy goals

- 90% of medical records will contain documentation of critical measures
- 80% of medical records will contain documentation of all other elements when those elements are included in quality improvement medical record assessments
- 100% of medical records will contain documentation of allergies and adverse reactions

Chart assessments and failure to comply

We have the right to assess health care provider records to determine the accuracy of ICD-10-CM and CPT coding. We notify you of the results. We may charge a penalty if you fail to submit the information.

Risk adjustment and medical records

Medical records are important for both CMS reimbursement for our members and to accurately calculate an annual patient risk score that represents the specific patient's disease burden for the Department of Health and Human Services (DHHS). Every year, CMS and DHHS require information about the demographic and health of our members. Diagnoses do not carry forward to the following year and must be assessed and reported every year. Records must show all conditions evaluated during the visit. It is important to evaluate all medical conditions, both chronic and acute, at least annually. Report the appropriate diagnosis code for all documented conditions that coexist at the time of the visit that require or affect care.

For accurate reporting on ICD-10-CM diagnosis codes, the medical record documentation must describe the member's condition. This should include specific diagnosis, symptoms, problems or reasons for the visit. You are responsible for making sure ICD-10-CM coding adheres to ethical standards. Member charts are subject to review. We may review the charts to identify conditions not coded on claims.

CMS conducts audits to confirm that the Hierarchical Condition Categories triggered for payment based on ICD-10-CM coding and supported by chart documentation. CMS works through us to obtain these records for the MA program. The DHHS requests this data from us for the Commercial Risk Adjustment Program. Since our legal obligation is to provide this information to federal agencies, we appreciate and require your cooperation with this as well.

Chapter 13: Health and disease management

Clinical and preventive health guidelines

We use evidence-based clinical guidelines from nationally recognized sources during review of our quality and health management programs. Recommendations contained in clinical practice guidelines are not a guarantee of coverage. Covered benefits vary based on the member's benefit plan. When applicable, UnitedHealthcare medical policies are used to determine coverage under the member's benefit plan. A complete list of clinical guidelines is on **UHCprovider.com/policies** > Additional Resources > **Clinical Guidelines**.

Health management programs

We offer case and disease management programs to support your treatment plans. They also assist members in managing their conditions. By using medical, pharmacy and behavioral health claims data, we can identify members who are high-risk and a good fit for our programs. A referral from a health risk assessment, the NurseLine or a member/caregiver can also help identify these high-risk members. You can refer these members to the appropriate program by calling the number on the member's health plan ID card. Participation in these programs is voluntary. Upon referral, we assess members for the appropriate level of care for their individual needs. The programs vary based on the member's benefit plan.

Case management

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

- Disease management
- Complex condition management
- Behavioral health employee assistance
- Disability

Case management services are voluntary. The member can opt out at any time.

Transitional case management – the collaboration of evaluating and coordinating post-hospitalization needs for members who are at risk of rehospitalization or frequent users of high-cost services

General condition management – serves members:

- With chronic conditions
- In need of long-term care support
- Who have unmet access
- Who have care plan, psychosocial or knowledge needs

Commercial complex medical conditions programs

Transplant Resource Services – members eligible for this program have access to the Optum Center of Excellence (COE) transplant network

Congenital Heart Disease Program – members 18 and younger who have a clinical diagnosis of CHD can join. It offers them clinical management and support throughout the process of selecting a facility, being inpatient and experiencing post-discharge.

Cancer Resource Services – members eligible for this program have access to the COE cancer network

Cancer Support Program – provides comprehensive support for members with all types of cancer, adult and pediatric. Experienced cancer nurses serve as a single source for individuals diagnosed with cancer to obtain cancer information, support and guidance in navigating the health care system. The program guides patients through their course of care while identifying gaps in care and utilizing evidence-based guidelines to close those gaps.

Bariatric Resource Services – helps achieve positive results by using evidence-based guidelines and access to a COE/designated health care provider network of quality bariatric centers to help improve clinical and economic outcomes. It also offers clinical case management by a dedicated nursing staff.

Women's Health Services – we offer integrated, connected care strategies to positively influence pregnancy outcomes for both mother and the baby

- Our fertility, maternity and neonatal care management programs support members with appropriate guidance, education and counseling. Members with unique health needs and high-risk pregnancies receive personalized case management support to minimize pregnancy complications.

Kidney Resource Services – our specialized chronic kidney disease (CKD) stages 4–5 and end-stage renal disease (ESRD) care management programs focus on patients who have experienced a severe decrease in kidney function, are transitioning into renal replacement therapy or are already on dialysis. We engage and support our members to slow the progression of the disease (CKD), to identify gaps in care and address them with the member and their caregivers, utilizing evidence-based guidelines to close those gaps, and provide longitudinal care for the many co-morbid conditions that these members experience.

Decision support programs

NurseLine – this program uses a call model and Integrated Clinical User Experience (ICUE) to help facilitate better health outcomes. Each call becomes an opportunity to address a symptom and to connect members with the right care, right health care provider, right medication and right lifestyle.

Emergency Room Decision Support – this is a program that helps identify, educate and assist members whose emergency room visits are preventable, avoidable or treatable in a lower-care, nonemergency setting

Commercial health services, wellness and behavioral health programs

We offer many types of programs for members. They focus on delivering skilled resources to support members as they seek their personal best health. To access these programs, have the member call the phone number listed on the back of their ID card. Programs and health services may vary based on the member's coverage.

Tobacco cessation – we offer a comprehensive tobacco-cessation solution that uses an evidence-based combination of physical, psychological and behavioral strategies to help members overcome their tobacco addiction, including use of electronic nicotine delivery systems or e-cigarettes

Wellness coaching – this is an online or phone-based program. It helps members identify and prioritize unhealthy behaviors and set personalized goals that focus on positive, healthy behavior change.

Real Appeal – Real Appeal is a health service that takes an evidence-based approach to support weight loss. This service helps people make small changes necessary for larger, long-term health results. It is based on weight-loss research studies commissioned by the National Institutes of Health.

Biometrics – health screening solutions allow employers to offer wellness screenings to on-site, remote and mobile employees, as well as spouses and adult dependents. Broad access is achieved by offering both on-site and offsite screening options. These delivery options include offering Know Your Numbers on-site screening events, at-home screening materials, lab screening visits or health provider results forms.

Wellness incentive programs – these programs reward employees with financial incentives when they complete wellness activities and/or achieve targeted health outcomes

UnitedHealthcare Motion – a digital wellness program designed to promote physical activity with compatible activity trackers enabling members to earn incentives for meeting certain daily walking goals

Behavioral health programs – we offer specialized mental health and substance use disorder benefits delivered by our affiliate company United Behavioral Health, operating under the brand Optum. This may be available to members depending on their health benefit plan. To access these programs, have the member call the phone number listed on the back of their ID card.

Employee Assistance Programs (EAP) – the EAP provides confidential support and short-term counseling for individuals who may be struggling with everyday challenges or for more serious personal concerns such as:

- Depression
- Stress and anxiety
- Relationship difficulties
- Financial and legal advice
- Parenting and family problems
- Child and elder care support
- Dealing with domestic violence
- Substance use disorder and recovery

Commercial consumer transparency tools

An online cost estimator tool is available in some markets at **myuhc.com**. The tool is designed to assist members in making informed health care choices based on cost and quality. It displays health care provider-specific cost estimates together with UnitedHealth Premium physician designations. Information can be found on **myuhc.com**. Once logged in, select Find Care & Costs.

If you would like to review your cost data, contact your UnitedHealthcare Network Management representative or hospital or provider advocate at **UHCprovider.com/contactus**.

Medicare Advantage

Note: Medicare Advantage (MA) may include Dual Special Needs Plans (D-SNP).

Clinical programs: Condition management and care management

Our MA plans provide a full spectrum of care management programs as part of our standard plan offerings. Clinical programs include inpatient care management, care and condition management, specialty care management (e.g., transplant and ESRD management), behavioral health care management, Advanced Illness, HouseCalls, (not all members are eligible for this program), and Solutions for Caregivers (available on select MA plans). Participation by the member is encouraged but voluntary.

Condition management programs

These programs help members with chronic conditions — such as diabetes, heart failure and ESRD — to be their healthiest. We offer education and resources to support optimal health of members actively treated for chronic conditions. Members receive case management and can attend workshops to help manage their condition.

Care management programs

- **Inpatient Care Management** – nurses review the clinical information that outlines the clinical treatment plan for the member. They evaluate appropriateness for admission based on evidence-based medicine and discharge planning needs, including identifying members for post-discharge follow-up and referral to outpatient programs.
- **Behavioral Health** – led by experienced psychiatrists and licensed behavioral health clinicians, our program integrates with our medical team to identify, engage and manage a member's mental health/substance use disorder concerns

- **Community Transitions Program** – designed to reduce complications by smoothing the transition from hospital to home, program staff coordinate transitions in care or changes in member health status to avoid potential adverse outcomes and unnecessary readmissions
- **High-Risk Care Management** – nurses support members who have complex care needs by helping them access care, coordinate services and learn to better manage their chronic conditions
- **Advanced Illness** – provides comprehensive care for members facing life-limiting illness generally defined as the last 12 months of life
- **Transplant resources** – our transplant management program drives positive clinical outcomes by addressing the complex needs of members who are facing transplants
- **Post-Acute Transition Program** – uses an individualized, whole-person approach to remove barriers to discharge from post-acute care, such as SNF so the member can safely return to the least restrictive setting possible

Special Needs Plans Model of Care

The Model of Care (MOC) is the framework for care management processes and systems that enable coordinated care for Special Needs Plans (SNP) members. The MOC includes descriptions of the following:

- SNP population (including health conditions)
- Care coordination
- Provider network
- Quality measurement
- Performance improvement

The MOC helps ensure the unique needs of the population are identified and addressed through care management practices. We evaluate MOC goals on an annual basis to determine effectiveness.

To learn more, contact us at **snp_moc_providertraining@uhc.com**.

CMS requires annual SNP MOC training for all health care providers who treat SNP members. The training is reviewed and updated annually to reflect current practices related to care coordination. This includes communication of the Individualized Care Plan (ICP) for each member. The Annual SNP MOC Provider Training is available at **UHCprovider.com/training**. Updates about the annual training can be found at **UHCprovider.com/news**. To receive news updates by email, sign up at **UHCprovider.com/subscribe**.

Commercial and Medicare Advantage behavioral health information

The U.S. Preventive Services Task Force recommends that PCPs screen patients for depression, substance use disorder and alcohol misuse. If left untreated, these disorders can adversely affect quality of life and clinical outcomes.

Screening for these disorders is critical to treatment since it can contribute to the patient's readiness to change.

You can help by screening all patients, including adolescents. To assist, we recommend the following screenings:

Depression	Patient Health Questionnaire (PHQ-9)†	CPT 99420
Alcohol misuse	Alcohol Use Disorders Identification Test (AUDIT) or CAGE	CPT 99420

†PHQ-9 was developed by Drs. Robert L Spitzer, Janet B. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

When doing a screening for depression in adults, include the 99420 CPT Code and the ICD-10-CM Z13.89 code.

Find these screening tools and other resources online at **UHCprovider.com** > Resources > Resource library > Patient care resources for health care professionals > **Behavioral health resources**.

For more information on depression, alcohol use disorders, opioid use disorders and other behavioral conditions, access the Optum website **Providerexpress.com** > Clinical Resources > **Behavioral Health Toolkit for Medical Providers**. You may also email your request to **bhinfo@uhc.com**.

To refer a member to an Optum network provider for assessment and/or treatment, call the number on the back of the member's ID card. A link to the Optum Clinician Directory is on **Providerexpress.com** > **Our Network** > Directories.

The UnitedHealthcare Preventive Medicine and Screening Reimbursement Policy notes that counseling services are included in preventive medicine services. This policy is available on **UHCprovider.com/policies** > For Commercial (or Medicare Advantage) Plans. Also, you can refer to the medical policy titled **Preventive Care Services**.

Optum has developed online health resources that offer up-to-date information and tools to support treatment of major depressive disorder, alcohol and drug use, and ADHD. Resources are available at **liveandworkwell.com**, including:

Depression, alcohol and substance use disorder, and attention deficit hyperactivity disorder resources and information

Optum has developed online preventive health resources that offer up-to-date information and tools to support treatment of major depressive disorder, alcohol and drug use disorder and ADHD. Resources are available at **liveandworkwell.com**, including:

- Screening tools to help patients decide whether to seek care
- Articles about behavioral health conditions and how they are treated
- A list of organizations you and your patients can contact if you want more information about a condition and its treatment
- Contact information for self-help groups if your patients want to talk with others who can provide support and encouragement
- Information on how to contact us if you have questions or concerns

Substance use disorder helpline

- Optum offers a 24/7 helpline for health care providers and patients to:
- Identify local medication for opioid use disorder and alcohol use disorder treatment care providers and other behavioral health care providers
- Provide targeted referrals for evidence-based care
- Educate members/families about substance use disorder
- Find community support services
- Assign a care advocate to provide ongoing support for up to 6 months, when appropriate

Health care providers and patients can call **1-855-780-5955.** More information is available at **liveandworkwell.com** > Substance use > Get support.

Collaboration between primary physicians and behavioral health clinicians

When a member receives services from more than one health care provider, collaborate and coordinate effectively to help ensure care is comprehensive, safe and effective. Lack of communication may negatively affect quality patient care. For example, members with medical illnesses may also have mental health or substance use disorders concerns. Continuity and coordination of care is important for members with severe and persistent mental health and/or substance use disorders concerns. This is especially true when the member is prescribed medication and has:

- Coexisting medical/psychiatric symptoms
- Been hospitalized for a medical or psychiatric condition

Talk to your patients about the benefits of sharing essential clinical information.

Psychiatric, substance use and mental health consults for medical patients

Contact Optum Behavioral Health if you:

- Want to arrange a psychiatric consultation for a member in a medical bed
- Are unclear whether a mental health or a substance use consultation is warranted
- Need assistance with a behavioral health service authorization

Reach Optum Behavioral Health by calling the phone number on the back of the member's ID card.

Chapter 14: Quality Management program

The Quality Management (QM) program helps ensure access to health care and services with a review using established quality improvement principles.

We use our QM program to:

- Identify the type of care and services given
- Use clinical guidelines and service standards to monitor clinical performance
- Review the quality and appropriateness of services given to our members
- Review the medical qualifications of participating health care professionals
- Continue to improve member health care and services
- Improve patient safety and confidentiality of member medical information
- Resolve identified quality issues

Our board of directors oversees the QM program. The vice president of quality and chief medical officer are in charge of day-to-day QM operations.

QM committee structure

Committee structure for Medicare and commercial product lines may include the following:

- The National Quality Oversight Committee (NQOC) directs the QM program for UnitedHealthcare at the national level and interfaces with other national and regional committees, as applicable. The board of directors has delegated responsibility for the oversight of health plan QM activities to NQOC and Regional Quality Oversight Committee (RQOC).
- The Medical Advisory Committee (MAC) oversees, reviews and provides recommendations on QM activities. These include:
  - Clinical indicators monitoring
  - Analysis of potential/actual barriers to improve clinical performance
  - Medical policies
  - Pharmacy updates
  - Service standards

This committee suggests quality improvement activities based on a review of potential/actual barriers to improving clinical performance found in their regions. They create and implement regional components of the QM work plan.

- The RQOC oversees these quality improvement activities.
- When there are significant concerns about quality of care, the Regional Peer Review Committee (RPRC) is a forum for physicians to investigate, talk about and take action on these cases. The RPRC can make decisions on behalf of the National Peer Review and Credentialing Policy Committee (NPRCPC).
  - The NPRCPC is a forum for physicians to talk about and take disciplinary action on member cases involving quality of care concerns that were unresolved through Improvement Action Plans administered by the RPRC.
- The National Practitioner Sanctions Committee is a forum for physicians to discuss and act on sanction reports related to compliance with provider participation agreements, our credentialing plan and/or patient safety concerns. Sanctions by government agencies and authorities related to licensed independent practitioners are monitored by government agencies and authorities. These include sanctions by:
  - Centers for Medicare & Medicaid Services (CMS)
  - Medicaid agencies
  - State licensing boards
  - The Office of the Inspector General within the federal Department of Health and Human Services
  - The Office of Personnel Management

Program scope

The QM program:

- Identifies high-volume and/or high-risk areas of care and service affecting our members
- Develops clinical practice guidelines for preventive screening, acute and chronic care, and appropriate drug usage. These are based on available national guidelines.
- Identifies clinical areas for quality improvement activities using claims and other data analyses. These include frequency and cost breakdown by member's age, sex and line of business. It also includes groupings like episode treatment groups, major medical procedure categories and diagnosis-related groups.
- Reviews preventive care delivered using health care audit results
- Surveys members, health care providers and employers to track satisfaction and reason for voluntary health care provider disenrollment
- Measures results against physician service standards like wait times for appointments, in-office care, practice size and availability. We use information from members, Consumer Assessment of Healthcare Providers and Systems (CAHPS) member survey information and GeoAccess analysis.
- Checks to help ensure providers perform QM-related activities as our contracts require
- Audits records to see if medical record standards and preventive care guidelines were met. This is not the only reason we audit medical records. Other audits may have different purposes and processes.
- Helps to ensure medical record documentation provides the plan for member care. This includes continuity and coordination of care with other physicians, facilities and health care professionals.
- The RPRC and NPRCPC investigates and resolves member complaints about medical care and services. The investigation may include contact with the member, physician and/or other health care professionals. It may also review medical records and your responses to potential concerns.

UnitedHealth Premium program (commercial plans)

The **UnitedHealth Premium® program** designates physicians based on safe, timely, effective and efficient quality care criteria. This designation may be used by members to help make more informed choices for their medical care and by physicians to make referrals. Physicians may also use evaluation details to support their efforts to provide quality care to their patients.

In markets where tiered benefit plans are available, employers may offer employees a tiered benefit plan with a lower member cost-share for using select Premium Care Physicians.

The UnitedHealth Premium program evaluates physicians annually using updated methodologies and data. Premium Care Physicians are those who:

- Meet safe, timely, effective and efficient quality care criteria; or
- Meet safe, timely and effective quality care criteria but do not have enough data to evaluate efficient care quality criteria

Premium Care Physicians are featured in our medical care directories with the following icon and description. All other physicians have no designation display.

Premium Care Physician
This physician meets the UnitedHealth Premium quality care criteria, which include safe, timely, effective and efficient care.

For more information regarding the UnitedHealth Premium program, including measures, measurement methodology and how we use the results, go to **unitedhealthpremium.uhc.com**. To contact us, go to **unitedhealthpremium.uhc.com** > Help and Support > **Contact Premium**.

Star ratings for Medicare Advantage and prescription drug plans

CMS Star Ratings provide external validation of our MA and Part D benefit plan performance and quality progress. For information on CMS Star Ratings, go to **UHCprovider.com/starratings**.

Members' experience of care

A certified National Committee for Quality Assurance (NCQA) vendor conducts our annual survey of member experience of care using the CAHPS survey. Members rate their experience and satisfaction in multiple areas:

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

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

Imaging accreditation protocol

The imaging accreditation protocol promotes compliance with nationally recognized quality and safety standards. Accreditation is required for the following advanced imaging studies:

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

If you fail to obtain accreditation, your reimbursement may be affected. We may do an administrative claim reimbursement reduction for global and technical service claims.

Additional information on this protocol and the required accreditation agencies is on **UHCprovider.com/join** > Dental, vision, behavioral health and other > **Imaging accreditation**.

Chapter 15: Credentialing and recredentialing

Credentialing/profile reporting requirements

Credentialing program

We credential physicians, health care providers and facilities who want to join our network and be listed in our provider directory. We recredential at least every 36 months. Our credentialing program helps us maintain and improve the quality of care and services delivered to our members. Our credentialing standards are fully compliant with the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and applicable state requirements. We have a thorough, written credentialing program, outlined in our Credentialing Plan on **UHCprovider.com/join**. We review and revise our credentialing program at least every 2 years, or as NCQA, state or federal requirements change.

When we contract with a delegate to carry out credentialing activities, they must meet our standards as outlined in:

- This Administrative Guide
- The Credentialing Plan
- The Delegation Agreement

We use the Council for Affordable Quality Healthcare (CAQH) process for credentialing application submissions, unless state law requires differently. Health care providers applying to join our network, and those scheduled for recredentialing, must use CAQH Provider Data Portal. Instructions are provided on **UHCprovider.com/join**. Minnesota and western Wisconsin health care providers may submit applications to the Minnesota Credentialing Collaborative, also known as ApplySmart. Log into credentialsmart.net/mcc to select UnitedHealthcare as a preference, complete your application and submit to us. Health care providers in other states and jurisdictions may be required or allowed to submit credentialing applications via other methods.

As a participating health care provider, you are responsible for verifying your clinical staff have required licenses and other credentials.

Nondiscrimination

Credentialing and recredentialing decisions are not based on a health care provider's or professional's:

- Race or ethnic/national identity
- Gender
- Age
- Sexual orientation
- Specialties that serve high-risk populations or conditions that require costly treatment

We may, however, choose to include health care providers in our network because they meet certain demographic, specialty or cultural needs of our members.

Network providers and business needs

When we decide to approve or deny an application/reapplication, we consider:

- Our current network of health care providers
- Our business needs
- The health care provider's credentials and qualifications

Discretion by UnitedHealthcare

Our credentialing criteria, standards and requirements do not limit our discretion in any way or create rights on the part of health care providers who seek to provide health care services to our members. We retain the right to approve, suspend and terminate individual health care providers and sites in situations where we have delegated credentialing decision-making authority.

Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require delegated entities to maintain the confidentiality of credentialing information. Credentialing staff or representatives will not disclose confidential health care provider credentialing information to any persons or entity except with the express written permission of the health care provider or as otherwise permitted or required by law.

Health care provider rights related to the credentialing process

Health care providers applying for participation in our network have the right to:

- Review the information submitted for your application. This excludes personal or professional references or peer review protected materials.
- Correct erroneous information. We let applicants know in writing, by fax or email, if we find any information that varies substantially from the information they provided. Applicants must submit corrections, in writing, directed by the credentialing entity within 30 days of the notification of the discrepancy.
- Be given the status of your credentialing or recredentialing application, upon request, by visiting **UHCprovider.com** > Sign In and clicking the chat icon in the lower right corner. For chat options and contact information, visit **UHCprovider.com/contactus**.

Additional information on our credentialing program can be found by clicking the following links:

- **UnitedHealthcare Credentialing Plan**
- **UnitedHealthcare Credentialing Plan State and Federal Addendum**
- **Join our Network & Credentialing**
- **Credentialing FAQs**

Credentialing committee decision-making process (non-delegated)

Determination and notice of approval or denial

After it completes the review and evaluation of all of the credentialing information, the National Credentialing Committee approves or denies the credentialing application.

For initial credentialing, all health care providers are notified of initial credentialing decisions within 30 calendar days of the National Credentialing Committee's decision or as required by state law, though we are generally able to notify health care providers within 14 days of the National Credentialing Committee's decision. For recredentialing, we notify health care providers within 30 calendar days of the decision or as required by law if the National Credentialing Committee determines they are no longer eligible to participate in our network. We send written notice of recredentialing approvals to health care providers as required by state law. If a participating facility provider fails credentialing or recredentialing for any LOB, United will unilaterally amend the Agreement to remove that LOB.

Right to see members

Approval of the credentialing application does not mean a provider is actively participating in the UnitedHealthcare network. Health care providers may not begin seeing our members until we have signed a contract with the provider and the provider is in our systems, or they receive the effective date of their active status. We send written notice that the contract is active.

Monitoring of network providers and health care professionals

We monitor sanction activity from state licensing boards, CMS, Office of Inspector General (OIG) and other regulatory bodies. If we find a health care provider has a sanction that results in loss of license or governmental authorization, loss of approval from participation under the UnitedHealthcare credentialing plan and/or unsuccessful completion of the UnitedHealthcare recredentialing process we terminate the provider from our network.

Health care provider office site quality review

We have office site standards that you must follow, including:

- Physical accessibility, such as handicapped accessible
- Physical appearance and cleanliness of the site
- Adequacy of waiting and examining room space
- Availability of appointments
- Adequacy of treatment record keeping (e.g., secure/confidential filing system)

Chapter 16: Member rights and responsibilities

Our members have certain rights and responsibilities to help uphold the quality of care and services they receive from you. We list the rights and responsibilities in the member materials for commercial and MA benefit plans.

- Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
- An online version of member rights is on **uhc.com** > About us > **Member rights & responsibilities**. These apply to all members.
- Member rights and responsibilities specifically for MA members can be found on:
  - **uhc.com/medicare**
  - **aarpmedicareplans.com**
  - **uhcretiree.com**
- Find provider news and updates at **UHCprovider.com/news**. Subscribe to receive updates by email at **UHCprovider.com/subscribe.**
- Members have a right to a second opinion. Members should be referred to their benefit plan for specific steps to obtain the second opinion.

Member appeals and grievance complaints

We maintain a system of logging, tracking and analyzing appeals and grievance issues received from members and health care providers consistent with state and federal regulatory requirements. We use the information to measure and improve member and health care provider satisfaction. This system helps us fulfill the requirements and expectations of our members and our network providers. In addition, it supports compliance with the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), The Joint Commission, and other accrediting and/or regulatory requirements.

Members have the right to appeal the determination of any denied services or claims by filing an appeal. Time frames for filing an appeal vary depending on applicable state or federal requirements.

We track and trend health care provider complaints and use the information during recredentialing. We conduct an annual analysis of the complaint data to look for opportunities for improvement. Health care provider and member complaints are important to the recredentialing process because they help us attract and retain health care providers, employer groups and members.

Members' request for confidentiality

The state and federal government allows an individual, other than the subscriber, to request confidential treatment as it relates to the following:

- Referrals
- Authorizations
- Denials
- Claims payments

We require our members to submit written requests for confidential status to you. The request must include their current address, private phone number, and date and time you received it. Having a written request prevents disagreements regarding the accuracy of their personal contact information. Members are responsible for resubmitting new confidentiality forms if their information changes.

Privacy regulations

HIPAA privacy regulations provide federal protection for the privacy of health care information. These regulations control the internal and external uses of health information. They also create certain individual patient rights. Information related to our privacy practices can be found on **uhc.com** > **Privacy**.

Advance directives

The federal Patient Self-Determination Act gives patients the legal right to make choices about their medical care prior to a severe illness or injury through an advance directive. Under the federal act, health care providers and facilities must:

- Not discriminate against an individual based on whether the individual has executed an advance directive
- Document in a prominent part of the individual's current medical record whether the individual has executed an advance directive
- Educate its staff about its policies and procedures for advance directives
- Provide for community education regarding advance directives
- Give patients written information on state laws about advance treatment directives, patients' rights to accept or refuse treatment, and their own policies regarding advance directives

We also inform members about state laws on advance directives through our member's benefit material. We encourage these discussions with our members.

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

Chapter 17: Fraud, waste and abuse

The purpose of our Fraud, Waste and Abuse (FWA) program is to protect the ethical and fiscal integrity of our health care benefit plans and programs. Our program has 2 main features:

- UnitedHealthcare Payment Integrity, Optum entities and others perform our payment integrity functions to help:
  - Ensure reimbursement accuracy
  - Keep up to date on new and emerging FWA schemes
  - Discover methodologies and technologies to combat FWA
- Special Investigations Units perform prospective and retrospective investigations of suspected FWA committed against our benefit plans and programs

This program is part of our Compliance Program led by our chief compliance officer. Our Compliance Department works closely with internal business partners in developing, implementing and maintaining the program.

For definitions of fraud, waste or abuse, refer to the **Glossary** at the back of this guide.

If you identify compliance issues and/or potential FWA, report it to us immediately so we can investigate and respond appropriately. Refer to the **Online resources and how to contact us** section in **Chapter 1: Introduction** for contact information. UnitedHealthcare prohibits any form of retaliation against you if you make a report in good faith.

Medicare compliance expectations and training

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) organizations and Part D plan sponsors, including UnitedHealthcare, to annually communicate specific compliance and FWA requirements to their first tier, downstream and related entities (FDRs). FDRs include contracted physicians, health care professionals, facilities and ancillary providers as well as delegates, contractors and related parties. As a delegate that performs administrative or health care services, CMS and other federal or state regulators require that you and your employees meet certain FWA and general compliance requirements.

FDRs are expected to have an effective compliance program, which includes training and education to address FWA and compliance knowledge. Our expectation remains that FDRs and their employees are sufficiently trained to identify, prevent and report incidents of noncompliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or managers and subdelegates who are involved in or responsible for the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

We have general compliance training and FWA resources available at **unitedhealthgroup.com**. The required education, training and screening requirements include the following:

Standards of conduct awareness

What you need to do

Provide a copy of your own code of conduct, or the UnitedHealth Group Code of Conduct at **unitedhealthgroup.com** > Corporate Governance > Ethics & Compliance > **Code of Conduct** to your employees. Provide the materials annually and within 90 days of hire for new employees.

Maintain records of distribution standards (i.e., in an email, website portal or contract) for 10 years. We may request documentation to verify compliance.

Fraud, waste, and abuse and general compliance training

What you need to do

Provide FWA and general compliance training to employees and contractors of the FDR working on MA and Part D programs. Administer FWA and general compliance training annually and within 90 days of hire for new employees.

Exclusion checks

Prior to hiring or contracting with employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and subdelegates who are involved in or are responsible for the administration or delivery of UnitedHealthcare MA and Part D and Medicaid benefits or services.

What you need to do

- Make sure potential employees are not excluded from participating in federal health care programs. For more information or access to the publicly accessible excluded party online databases, use the following links:
  - Department of Health and Human Services – Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov
  - General Services Administration (GSA) System for Award Management at sam.gov
- Review the exclusion lists every month and disclose to UnitedHealthcare any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs
- Maintain a record of exclusion checks for 10 years. We or CMS may request documentation of the exclusion checks to verify they were completed.

Preclusion list policy

The CMS has a Preclusion List effective for claims with dates of service on or after April 1, 2019. The Preclusion List applies to MA plans as well as Part D plans.

The Preclusion List is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active re-enrollment bar and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program

Health care providers receive a letter from CMS notifying them of their placement on the Preclusion List. They have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with UnitedHealthcare. CMS updates the Preclusion List monthly and notifies MA and Part D plans of the claim-rejection date, the date upon which we reject or deny a health care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded health care provider's claims will no longer be paid, pharmacy claims will be rejected and the health care provider will be terminated from the UnitedHealthcare network. Additionally, the precluded health care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim-rejection date.

As contracted health care providers of UnitedHealthcare, you must ensure that payments for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or entities.

For more information on the Preclusion List, visit cms.gov.

Examples of potentially fraudulent, wasteful or abusive billing

Back filling – billing for part of the global fee before the claim is received for the actual global code

Billing for non-FDA approved services – charging for lab tests, prescriptions and implants that lack FDA approval. This includes unapproved prescription drugs and lab tests, which can pose significant risks due to lack of FDA review for safety, effectiveness or quality.

Billing for services not rendered – billing for services or supplies that were not provided to the member

Billing for unauthorized services or equipment – billing for ancillary, therapeutic or other services without a required physician's order

Billing for Non-FDA Approved Services - charging for lab tests, prescriptions and implants that lack FDA approval. This includes unapproved prescription drugs and lab tests, which can pose significant risks due to lack of FDA review for safety, effectiveness or quality.

Billing while ineligible – billing for services after health care provider's license has been revoked/restricted or after a health care provider has been debarred from a government benefits program for fraud or abuse

Documentation deficiencies – missing, incomplete or illegible documentation may cause claim denials or delays because the information needed to validate the service performed is not available

Double billing – billing more than once for the same service

Falsified documents – submitting falsified or altered claims or supporting claims with falsified or altered medical records or supporting documentation, and amending or correcting medical records or claims significantly after the date of service

Improper modifier usage - misusing modifiers to add unnecessary details, bypass coding edits or impact reimbursement. This includes missing modifiers, which can cause claim delays or denials.

Incorrect code – if documentation does not support the CPT/HCPCS reported, there may be a more appropriate code to report based on code criteria

Looping – submitting claims for various family members when only one member is receiving services

Misrepresentation – misrepresenting the diagnoses and/or services provided to obtain higher payment or payment for noncovered services

Patient brokering – using brokers who offer money to subscribers for the use of their ID cards

Phantom billing – billing by a phantom or non-existent health care provider for services not rendered

Unbundling – billing each component of a service when one comprehensive code is available

Up-coding – billing at a higher level of service than was actually provided

Waiver of copay – choosing not to collect copayments or deductibles

Prevention and detection

We help prevent and detect potential FWA through many sources. These include the following:

- UnitedHealthcare payment integrity functions
- Optum companies within UnitedHealth Group
- Health care providers
- Health plan members
- Federal and state regulators and task forces
- News media
- Professional anti-fraud and compliance associations
- CMS websites

We also monitor and audit prevention and detection by:

Prospective detection

- Prepayment data analytics
- Data mining queries

- Abnormal billing patterns
- Other activities to determine if we need additional prospective activities

Retrospective detection

- Post-payment data analytics
- Payment error analytics
- Industry trend analysis
- Health care provider audits

Corrective action plans

As a part of our payment integrity responsibility, we evaluate the appropriateness of paid claims. We may initiate a formal corrective action plan if a provider does not comply with our billing guidelines or performance standards. We will monitor the plan to confirm that it is in place and address any billing/performance problems.

Beneficiary inducement law

The Beneficiary Inducement Law is a federal health care program created in 1996 as part of the Health Insurance Portability Accountability Act (HIPAA). The law makes it illegal to offer money or services that are likely to influence a member to select a particular health care provider, practitioner or supplier. Examples include:

- Offering gifts or payments to induce members to come in for a consultation or treatment
- Waiving copayments and deductibles

Health care providers who violate this law may be fined up to $10,000 for each item or service for which payment may be made, and $5,000 for each individual violation. Fines may be assessed for up to 3 times the amount claimed. Violators may also be excluded from participating in Medicare and Medicaid programs.

Allowable gratuities – items or services offered to members for free must be worth less than $15 and total less than $75 per year per beneficiary. Never give cash or gift cards to members.

Reporting potential FWA to UnitedHealthcare

When you report a situation you believe is FWA, you are doing your part to protect patients, save money for the health care system and prevent personal loss for others. **Taking action and making a report is an important first step.** After your report is made, UnitedHealthcare works to detect, correct and prevent FWA in the health care system.

You can report to UnitedHealthcare online on **uhc.com/fraud** or by calling **1-844-359-7736**.

Chapter 18: Provider communication

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. Consistent with your Agreement and applicable law, UnitedHealthcare may provide electronic notice of policy, protocol and payment policy changes, news and other important updates through our online news source – **Network News**.

Email communication

Required email contact information

Health care professionals and facilities in the UnitedHealthcare network are required to do business with us electronically. We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. **Sign up for a One Healthcare ID**, which also gives you access to the UnitedHealthcare Provider Portal
   - Already have an ID? To review or update your email, simply sign in to the portal and click your user name in the upper menu and then click Account Information to manage your email.
2. **Subscribe** to Network News to receive regular email updates
   - Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.

Network News email

Subscribe to receive a regular summary of the latest news relevant to your state, specialty and role.

Network News emails include:

- Monthly notification of policy and protocol updates, including medical and reimbursement policy changes
- Announcements of new programs and changes in administrative procedures
- Enhancements and additions to our suite of digital tools
- Events, trainings, education and more

Direct messaging

Direct messaging is a secure and HIPAA-compliant mode of electronic communication that exchanges information through Electronic Health Record (EHR) systems. If your EHR system supports direct messaging, UnitedHealthcare may use direct messaging to send you required notifications and other important information (e.g., changes to prior authorization requirements or to other policies and processes). Unless your Agreement or applicable law requires otherwise, UnitedHealthcare may use direct messaging as the sole means of communicating such notifications and information to you.

Online resources

There are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare.

The benefits of going digital

Our digital tools offer a more direct path to the information you need. This means:

- **24/7 access** – Our website, portal and chat windows never close
- **Complete common and complex tasks quicker** – Self-serve first for everyday tasks. This includes:

  - Completing and tracking credentialing requests in real time with Onboard Pro
  - Viewing claim status
  - Verifying benefits and eligibility
  - Submitting prior authorizations
  - Viewing ID cards
  - Verifying your demographic data accuracy
- **Reliable routing, faster decisions and better documentation** – Online requests and submissions are routed to the right people, right away — all with a digital trail. This includes:
  - Prior authorizations
  - Reconsiderations and appeals
- **Streamlined submissions** – We're always adding new digital capabilities and portal enhancements to simplify your workflow and help process your claims faster. Added features include:
  - Online attachment capabilities
  - More detailed remark codes
  - Automation to reduce rekeying
  - Smart features that make verifying your identity easier than phone

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, quality programs and more.

Questions? Sign in with your One Healthcare ID to access our online chat.

We encourage you to bookmark the following frequently referenced pages for quick access:

Policies and protocols

This library includes UnitedHealthcare Commercial, Individual Exchange, Medicare Advantage and Community Plan policies and protocols. Go to **UHCprovider.com/policies**.

Health plans by state

This is the fastest way to review all of the health plans UnitedHealthcare offers in each state. Go to **UHCprovider.com/plans** > Choose a location > View plans to review specific plans offered in that market.

UnitedHealthcare Provider Portal

This secure portal allows you to access patient information such as eligibility and benefit information and digital ID cards. You can also perform administrative tasks such as maintaining demographics, submitting prior authorization requests, checking claim status, submitting appeal requests and finding copies of PRAs and letters in Document Library. Go to **UHCprovider.com** > Sign In.

To access the portal, you will need to create or sign in using a One Healthcare ID.
To use the portal:

- If you already have a One Healthcare ID, go to **UHCprovider.com** > Sign In to access the portal
- If you need to set up an account on the portal, follow **these steps** to register

You can learn more about the portal in **Chapter 1** of this guide or by visiting **UHCprovider.com/portal.** You can also access self-paced user guides for many of the tools and tasks available in the portal by visiting **UHCprovider.com/training** > **Digital solutions**.

Network News website

Bookmark the Network News page at **UHCprovider.com/news**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans. You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.

Subscribe today

Capitation and/or delegation supplement

This supplement is for risk-based participating physicians, health care providers, facilities and ancillary providers who are part of a capitation or delegated risk arrangement or operate in a market that includes capitation. It applies to all benefit plans, as stipulated in the terms of the risk-based or capitated contract, for members who have been assigned to or have chosen a health care provider who receives a capitation payment from us for that member.

In cases where it contradicts with the main guide, this supplement takes precedence. For protocols, policies and procedures not referenced in this supplement, refer to the main guide.

For health care professionals associated with a UnitedHealthcare delegate, refer to the delegate's policies and protocols.

What is capitation?

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period of time. We pay you whether or not that person obtains care. An Independent Practice Association (IPA) and a medical group are the 2 most common types of capitated health care providers. Sometimes a hospital system or ancillary health care provider is the capitated health care provider.

For this supplement, we use the term medical group/IPA interchangeably with capitated health care providers and Managed Care Risk Entity. Capitation payments may also be made when a medical group or IPA receives management services from UnitedHealthcare on a limited or selective basis.

Also, capitated health care providers may be subject to both UnitedHealthcare and the capitated provider's protocols, policies and procedures related to any or all delegated activities.

What is delegation?

Delegation is a process that gives another entity the authority to perform specific functions on our behalf. We may delegate:

- Medical management
- Credentialing
- Claims
- Complex case management
- Other clinical and administrative functions

When we delegate any of these responsibilities to you, you are a delegated health care provider, and for this supplement, referred to as a delegated entity or delegate. We are responsible to external regulatory agencies and other entities for the performance of the delegated activities.

At times, the delegated entity may enter into its own contractual arrangement with health care providers. Those arrangements must adhere to all applicable UnitedHealthcare regulations, per product. To become a delegate, the provider must be in compliance with our established standards and best practices. To remain a delegate, the provider must continue to comply with our standards and best practices. If the delegate is non-compliant with our standards and best practices, we may revoke any or all delegated activities.

How to contact us

For phone numbers and websites related to specific products, refer to **Online resources and how to contact us** in **Chapter 1: Introduction** or in the appropriate supplement.

For specific product information, refer to the appropriate supplement.

Verifying eligibility and effective dates

For information on ways to verify eligibility, refer to **Verifying eligibility, benefits and your network participation status** in **Chapter 2: Provider responsibilities and standards**. This helps ensure you:

- Submit the claim to the correct payer
- Collect copayments
- Determine if a referral, prior authorization or advance notification is required
- Reduce denials for noncoverage

We provide you with weekly and/or monthly member eligibility information using an electronic file. You must coordinate initiation of electronic eligibility files with your software vendor and us. Advantages of receiving electronic eligibility are:

- Lower cost and effort required to maintain eligibility manually
- Faster updates loaded into your system

Refer to **ASC X12 Technical Report Type 3/Companion Guides** or ask your health care provider advocate for more information.

Commercial eligibility, enrollment, transfers and disenrollment

Members must meet all eligibility requirements established by the employer group and us. We may request proof of eligibility requirements.

Enrollment

To enroll, an applicant must complete a UnitedHealthcare enrollment form or an employer enrollment form approved by us. Some larger member accounts may provide open enrollment through electronic means rather than enrollment forms.

Newly eligible members may present a copy of the enrollment form as proof of eligibility. Make a copy of the enrollment form. If unable to verify member eligibility online or through our voice response systems, follow up with member services the next business day. The health care provider is responsible for ensuring its contracted network of health care providers accepts the enrollment form as temporary proof of eligibility.

Enrollment periods

Each employer group typically has an annual open enrollment period when current employees elect their health insurance choices for the following benefit year. Jan. 1 is a commonly used benefit start date. However, many employers select different dates throughout the year. Benefit plan codes change throughout the year on your eligibility reports.

Effective date

Coverage begins at 12:01 a.m. on the effective date.

Selection of PCP or medical group/IPA

Members enrolled in some commercial benefit plans, such as HMO or Managed Care Organization (MCO) plans, must choose a PCP. This process is outlined in the **PCP selection** section in **Chapter 3: Commercial products**.

Newborn dependents coverage

Unless the subscriber's benefit plan or state law says otherwise regarding enrollment and coverage, coverage of the subscriber's newborn children begins at birth. Many plans require enrollment through the employer group to have coverage.

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

We do not cover medical or facility services for surrogate mothers who are not our members unless covered by state law or subscriber's benefit plan.

Newborn enrollment policy

Unless the subscriber's benefit plan dictates otherwise:

If the mother (subscriber, spouse or domestic partner) is our member, the newborn remains with the mother's medical group/IPA until another PCP or medical group/IPA is selected following the 15/30 rules.

Standard coordination of benefits rules apply when 2 coverages exist.

If both the parents' insurance plans provide coverage for the newborn, coordination of benefit rules apply. The medical group/IPA must make sure they handle care coordination appropriately.

If both parents of a dependent newborn are eligible under separate UnitedHealthcare benefit plans, we add the dependent newborn to both plans, as determined by the subscribers newborn enrollment, per the terms of the plan. Subscribers covered under the same employer may only permit enrollment in one plan.

Any subsequent PCP or medical group/IPA transfer of a dependent newborn will follow the 15/30 rules.

Adopted dependents coverage

Coverage begins on the first day of physical custody if the subscriber submits an enrollment application to the employer group within 30 calendar days of physical custody of the child, unless the subscriber's benefit plan dictates otherwise.

Surrogate (newborn coverage)

We may provide coverage for a surrogate when the surrogate is the subscriber or eligible dependent. Refer to the UnitedHealthcare benefit plan. However, the newborn dependent(s) may not have coverage at birth. Surrogate cases need individual review. We make decisions on a case-by-case basis. We may issue newborn coverage denials to the facility before the newborn's birth. Contact your Provider Relations representative if a surrogate case comes to your attention.

California – under California rescission rules, if UnitedHealthcare or the member's health care provider or medical group/IPA authorizes surrogate newborn care (beyond 30 days from birth), and the facility relies upon such authorization to render treatment, those claims must be paid.

We may seek recovery of our actual costs from a member receiving reimbursement for medical expenses for maternity services while acting as a surrogate.

Member transfers between contracted providers in their plan

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

Members may change their PCP within the same medical group/IPA. The change is effective the first day of the following month after the member calls requesting the change, unless the benefit plan says otherwise.

If a member requests a transfer out of the member's medical group/IPA entirely, and the change request is received prior to or on the 15th of the month, we will change the member's medical group/IPA effective the first day of the following month. If the request to transfer to another medical group/IPA is received after the 15th of the month, the change is effective the first day of the second month following receipt of the request.

If the member expresses dissatisfaction with the proposed effective date, we, in our discretion, may process the member's request as a Forward Primary Care Provider Change Request, (if our contract with requested network provider allows for a retroactive transfer). Based on the contract, you may have the right to refuse to accept the member until the first day of the second month following the request receipt. Some health care provider groups may only accept new members during an open enrollment period. If the member meets all eligibility requirements, the change becomes effective the first day of the following month, even though the change request was received after the 15th of the month. If the 15th of the month falls on a weekend or holiday, we will allow transfer requests received on the first business day after the 15th to become effective the first day of the following month.

Transfers from one participating medical group/IPA to another, or PCP transfers initiated outside a member's open enrollment period, will not be effective until the first day of the month following the member's discharge from care, if at the time of the request for transfer or on the effective date of transfer, the member is currently:

- Receiving inpatient care at an acute care facility
- Receiving inpatient care at a skilled nursing facility (SNF), at a skilled level
- Receiving other acute institutional care
- In the third trimester of her pregnancy (defined as when the member reaches the 27th week of pregnancy)
- Experiencing a high-risk pregnancy (not applicable to California members)

Retroactive member transfers

Members may retroactively change their medical group/IPA or PCP within the same month if the member calls to request a change within 30 calendar days:

- Of their effective date and has not received services with the originally assigned health care provider
- Due to a household move over 30 miles, and the member has not received services with the originally assigned health care provider

If the member received services during the current month from you, other than the month requested, a current month change is not permitted.

Termination of medical group/IPA, facility or health care provider

If the member's medical group/IPA, PCP or facility is terminated, we give prior written notice to members as applicable or when required by state or federal law. In such event, the member may qualify for continuation of care as outlined in the **Continuity of care** section of this supplement or the main guide under the **CAA requirements**. For individual physician terminations, the medical group/IPA is responsible for providing the notice to commercial members in the following circumstances:

- PCP terminations in medical groups/IPAs where medical group/IPA assigns members to the PCPs
- All specialist terminations

Each commercial member has at least 30 calendar days (exception: 60 calendar days in California) to select another medical group, IPA, PCP or facility.

When a member needs care, and their PCP terminated without proper notice, we transfer the member to another PCP. The new PCP will be in the same medical group/IPA with an effective date retroactive to the first of the current month.

Termination of hospital agreements contracted with global medical group/IPA

A global medical group/IPA is one that accepts both professional and institutional risk. The medical group/IPA is required to notify the UnitedHealthcare Network Management Department in writing within 5 business days of any closure, potential termination or definite termination notice received from or issued to a contracted hospital. If medical group/IPA obtains a contract extension, medical group/IPA must also notify the UnitedHealthcare Network Management Department in writing within 5 business days of the date the extension was received.

Upon receipt, the UnitedHealthcare Network Management Department may request additional information requiring a prompt response. The additional information may include, but is not limited to, confirmation of the closure/termination date, likelihood of termination, number of affected enrollees, alternate providers, and confirmation that alternate providers are within the regulatory agency's time and distance standards. Medical group/IPA is responsible for ensuring that UnitedHealthcare is updated on a regular basis regarding the status of the closure or termination.

For California commercial members, also known as enrollees, medical group/IPA is responsible for ensuring all affected enrollees are notified according to the Department of Managed Health Care timelines and guidelines. For a hospital closure or termination, medical group/IPA must notice all enrollees no later than 5 days post-termination or closure who had services in the past 12 months, have an open authorization up to 6 months post-termination, and have a scheduled procedure up to 6 months post-termination (the Enrollee Transfer Notice).

The Enrollee Transfer Notice must comply with California Code Regulations, Title 28, § 1300.67.1.3 and include:

1. The name of the closed/terminating hospital
2. A brief explanation outlining the reason redirection to alternate providers for future services is necessary due to the closure or termination of the contract between the group and terminating provider
3. The date of the closure/pending contract termination and redirection to alternate providers
4. A statement indicating the affected enrollee may contact the group's customer service department to request completion of care for an ongoing course of treatment from a terminated provider. This statement may include either:
   - A statement outlining the specific conditions set forth in California Health and Safety Code section 1373.96(c) (with each of the conditions specifically enumerated in bullet point format); or,
   - An explanation to the affected enrollee that their eligibility is conditioned upon certain factors as outlined in the group's written continuity of care policy and evidence of coverage or disclosure form
5. The telephone number, clearly printed, through which the affected enrollee may contact the group for a further explanation of the enrollee's rights to completion of care
6. The following statement in at least 8-point font:
   If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number of 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at hmohelp.ca.gov. The statement may be modified to include the health care service plan's name in place of the phrase your HMOs.
7. Compliance with all applicable language assistance statues and regulations, including Section 1367.04 and any regulations based upon Section 1367.04 (which, at a minimum, shall include a written notice of the availability of interpretation services in the health plan's identified threshold languages and in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the Department of Health Care Services (DHCS)).

UnitedHealthcare will provide medical group/IPA with a copy of the Enrollee Transfer Notice template upon request.

If medical group/IPA reaches agreement to renew or not to terminate the contract, medical group/IPA must send an additional enrollee notification (i.e., Good News Letter) to all affected enrollees who received an Enrollee Transfer Notice. This notification must be sent within 5 business days of the date of the agreement to renew or not to terminate the contract.

In the event medical group/IPA does not send the Enrollee Transfer Notice and UnitedHealthcare must send on medical group/IPA's behalf, medical group/IPA will be responsible for all costs associated with the mailing.

Member removal

The medical group/IPA agrees we may move a medically stable member to another medical group/IPA or health care provider due to a strained relationship between the medical group/IPA and member.

Commercial members

When commercial members refuse treatment or prevent you from delivering care, the medical group/IPA may consider the health care provider-member relationship as unworkable. In these cases, the medical group/IPA may believe they need to dismiss the member from their panel.

The medical group/IPA may request a member change to another medical group/IPA in these cases. We evaluate requests based on the interest of the member and accessibility of another medical group/IPA. If we approve the transfer request, we ask the member to choose another medical group/IPA within 30 calendar days. The primary medical group/IPA is responsible for directing and managing all care until the change or transfer is effective.

If the member does not select another medical group/IPA, we will select another medical group/IPA for them.

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

Areas of concern for requesting removal of a commercial member from the medical group/IPA include:

- Repeated disruptive behavior or dangerous behavior exhibited in the course of seeking/receiving care
- Failure to pay required copayments (minimum dollar amount of $200 outstanding)
- Fraudulently applying for any UnitedHealthcare benefits

Once you send us a completed Incident Report for Removal of Members and related documentation, we respond to the member. We copy the PCP or medical group/IPA on all correspondence.

If you receive notification of a member's intent to sue, tell your health care provider advocate.

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

Criteria and procedure for removal of commercial members from the medical group/IPA

Level I	Level II	Level III
Criteria:		
Demanding a payment from medical group/IPA for non-authorized services Minor disruptive behavior* Failure to pay required copayments** 3 or more missed appointments within 6 consecutive months without 24-hour prior notice	Refusal to follow recommended treatment or procedures by health care provider resulting in deterioration of member's medical condition. Disruptive behavior, verbal threats of bodily harm toward medical group/IPA personnel and/or other members, provided the conduct is not a direct result of the member's medical condition or prescribed medication.†	Member fraudulently applies for any UnitedHealthcare benefits. Dangerous behaviors exhibited in the course of seeking or receiving care provided the conduct is not a direct result of the member's medical condition or prescribed medication. Need an eyewitness willing to formally document the incident in writing. For example: law enforcement involvement, police report.

Level I	Level II	Level III
First occurrence:		
Medical group/IPA must counsel and send the member a certified letter saying such behavior is unacceptable. Discussions need documentation. Send copies to UnitedHealthcare, which sends a warning letter outlining behavior and possible consequences.	Medical group/IPA must counsel and send the member a certified letter saying such behavior is unacceptable. Discussions need documentation. Send copies to UnitedHealthcare, which will send warning letter outlining behavior and possible consequences.	Medical group/IPA requests immediate removal of subscriber/member from medical group/IPA. Incident must be formally documented by medical group/IPA. Send written notification to member in a certified letter. Mail copies of documentation and member letter to UnitedHealthcare for review.
Second occurrence:		
Medical group/IPA must counsel and send second letter to member expressing concern regarding their unacceptable behavior. Send copies to UnitedHealthcare, which sends warning letter outlining continued behavior and possible consequences.	Send UnitedHealthcare a request to immediately remove subscriber/member from the medical group/IPA. UnitedHealthcare reviews the medical group/IPA documentation outlining continued unacceptable behavior.	
Third occurrence:		
Send us a request to immediately remove a subscriber/member from the medical group/IPA. We review the medical group/IPA documentation, which outlines continued unacceptable behavior.		

*Minor disruptive behavior: Unruly behavior, use of abusive and/or profane language directed toward medical group/IPA and/or other members.

**UnitedHealthcare West will not consider the removal of a member unless the unpaid copayment balance exceeds $200.

†Disruptive behavior: Physical or verbal threat of bodily harm toward medical group/IPA personnel and/or other members or property, and/or use of unacceptable behavior relative to drug and/or alcohol misuse.

Notification of platform transitions or migrations

A delegated entity agrees to provide at least 270 days advance written notice to the UnitedHealthcare Network Management contractor or health care provider advocate of its intent to:

1. Change administrative platforms for impacted delegated functions or upgrade current platform, including migrations or versions
2. Make material changes in existing administrative platforms impacting delegated functions

If you are unsure of what a material change is, contact your delegation oversight representative. Most changes will require pre-cutover evaluation by UnitedHealthcare delegation oversight team(s) and integrated testing with UnitedHealthcare. Failure to adhere to these notification requirements may result in financial penalties or loss of delegation responsibilities.

Medicare Advantage (MA) enrollment, eligibility, transfers and disenrollment

For more information and instructions for confirming eligibility, refer to Verifying eligibility, benefits and your network participation status in **Chapter 2: Provider responsibilities and standards**. For your state specific updates please refer to **UHCprovider.com** and the associated Quick Reference Guides that can be found under Health Plans by State > Health Plans by State> [your state] > [click on the Medicare tab].

Eligibility files

Eligibility reports are available for capitated or delegated contracted health care providers electronically either through a file transfer protocol or on **UHCprovider.com**. We provide full eligibility file information once per month consisting of all active members for the month at the time the file was run. We also provide update files that include member change transactions for prior and future periods, upon request. Weekly refresh files are the preferred frequency by most groups.

Upon request, we send each medical group/IPA a monthly eligibility list of all its assigned members. This list contains the members' identification information, their enrollment date and benefit plan information. This includes benefit plan type and effective date and any member cost-sharing.

Eligibility (Medicare Advantage)

Medicare beneficiaries who join an MA plan must:

- Be entitled to Medicare Part A and enrolled in Medicare Part B
- Reside in our MA service area. To maintain permanent residence, the beneficiary must not continuously reside outside the applicable service area for more than 6 months (9 months if using the UnitedHealth Passport® benefit).

MA plans include a Contract ID, Plan ID (the plan benefit package, or PBP) and Segment ID from CMS that corresponds to CMS filings. This will be on the individual member ID card or eligibility file.

You may identify a capitation/delegation plan or member by referring to the member ID card.

Change of membership status (Medicare Advantage)

If a Medicare beneficiary is an inpatient at these facilities when their membership becomes effective, the previous carrier pays for Part A services (inpatient facility care) until the day after the member is discharged to a lower level of care:

- Acute facility
- Psychiatric facility
- Long-term care (LTC) facility
- Rehabilitation facility

The member's assigned medical group/IPA pays for Part B services (medical care) on their membership effective date. If a member's coverage terminates while the member is an inpatient at any of these facilities, the medical group/IPA is no longer financially responsible for Part B (medical care) services. If the facility is a capitated health care provider, a capitated facility, the facility remains financially responsible for Part A (inpatient facility care) services until the day after the member's discharge to a lower level of care (e.g., home health). If the member is an inpatient at a SNF at the time of their effective date, the medical group/IPA and capitated facility are financially responsible for Part A and Part B services on the member's effective date.

Benefit plan changes

A benefit plan change occurs when the member:

- Moves from one service area to another. If an MA member permanently moves outside of the service area (regardless of state), or the plan receives indication that the member may have moved outside the service area, the plan will disenroll the member at:
  - The end of the month in which they report/confirm the move
  - The end of the month in which they move (if they report the move in advance)
    - If a member fails to respond to an address confirmation request, the plan will disenroll the member at the end of the sixth month following notification of potential move from the service area. See Chapter 2, sections 50.2-50.2.1.5 in the CMS Medicare Managed Care Manual for more information.
- Changes from one benefit plan to another. If the member does not return a completed form, they remain on the existing plan. The member may only change benefit plans using their CMS-defined annual enrollment period from Oct. 15–Dec. 7, or during the open enrollment period from Jan. 1–March 31 each year.
  - If the member has exhausted these elections and does not qualify for a Special Election Period, they are locked in the current benefit plan for the remainder of the calendar year.

CMS requires us to treat a member whose benefit plan changes as a new member, rather than as an existing member, for the purpose of determining the new plan's effective date. Therefore, the member's enrollment to another PCP or medical group/IPA is effective the first of the month following receipt of the completed form.

Enrollment

An applicant must enroll in a UnitedHealthcare MA plan. Completing an enrollment form does not ensure enrollment in a Medicare Advantage (MA) prescription drug plan. Enrollment may be denied for either the UnitedHealthcare MA plan and/or the MA prescription drug plan if eligibility requirements are not met. See *Chapter 2, section 20 of the CMS Medicare Managed Care Manual* or *Chapter 3, section 20 of the CMS Prescription Drug Benefit Manual* for eligibility information.

Enrollment periods

Individual

CMS has specific enrollment periods during which individual plan members may enroll in a health plan, change to another health plan, change benefit plans, or return to Medicare. Details on the types of enrollment periods and the requirements of each type are outlined on cms.hhs.gov.

Employer group plans

Enrollment periods for UnitedHealthcare Group MA members are dictated by the employer group's annual renewal date with us.

Employers may establish their own enrollment dates. See Chapter 2, section 30.4.4, item 1 - SEPs for Exceptional Conditions in the CMS Medicare Managed Care Manual for more information. An employer group plan annual enrollment period aligns with the employer's annual enrollment cycle.

Selection of PCP or medical group/IPA

For most plans, the member must select a PCP or medical group/IPA (some plan exclusions may apply). If not, we assign one automatically.

Transfer of members (Medicare Advantage)

According to CMS guidelines, a member may not change medical groups/IPAs or PCPs if:

- The member is an inpatient in a facility, a SNF or other medical institution at the time of the transfer request
- The change may have an adverse effect on the quality of the member's health care

- The member is an organ transplant candidate
- The member has an unstable, acute medical condition for which they are receiving active medical care

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

- The member calls to request a change within 30 calendar days of the effective date with UnitedHealthcare due to the wrong medical group/IPA or PCP being assigned
- The member calls to request a change within 30 calendar days of the effective date with UnitedHealthcare and has not received services with the originally assigned health care provider
- The member calls to request a change within 30 calendar days due to a household move over 30 miles, and the member has not received services with the originally assigned health care provider
- The member's plan EOC states a different timeframe for requesting PCP changes

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

- Acute care facility
- Critical access facility
- LTC facility
- Psychiatric facility
- Inpatient rehabilitation facility

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

For more information about transfers, including ambulance transfers, due to a medical group/IPA change while the member is an inpatient, go to **UHCprovider.com/policies** > For Medicare Advantage Plans > **Medicare Policies for Medicare Advantage Plans**.

Transfer due to termination of medical group/IPA, facility or health care provider

If the member's medical group/IPA, PCP, specialist or facility is terminated, we give written notice to members as applicable or when required by state or federal law. In such event, the member may qualify for continuation of care as outlined in the **Continuity of care** section of this supplement. For individual physician terminations, the medical group/IPA is responsible for providing the notice in the following circumstances:

- PCP terminations in medical groups where the medical group assigns members to the PCPs
- All specialist terminations

Each Medicare member can select another medical group/IPA, PCP or facility within the member's current medical group/IPA or in a new medical group/IPA.

When a member needs care, and their PCP terminated without proper notice, we transfer the member to another PCP. The new PCP will typically be in the same medical group/IPA.

Member removal (Medicare Advantage)

For information on PCPs removing MA members from rosters, refer to **Member dismissals initiated by a PCP (MedicareAdvantage)** in **Chapter 2: Provider responsibilities and standards**. The medical group/IPA is responsible for directing and managing all care until the change or transfer is effective.

Disenrollments

Member-elected disenrollment

If a member requests disenrollment from our benefit plan through you, refer them to Member Services. Once we process the disenrollment, we send the member a letter with the effective date. If the member submits a request for disenrollment during the month, the disenrollment is effective the first day of the following month.

Authorization guarantee (CA Commercial only)

Authorization guarantee procedure

Authorization guarantee procedure limits the medical group's/IPA's risk of incurring financial risk for services provided to ineligible members where the individual's lack of eligibility is only determined after services are provided. It offers reimbursement to the medical group/IPA providing covered services to a member who:

1. We identified as eligible before the date of service through our eligibility determination and verification processes and is later determined to be ineligible for benefits on the date of service
2. We provided an authorization to whom we confirmed as eligible prior to the date of service but later determined to have been ineligible on the date of service (authorization guarantee)

Authorization guarantee billing procedures

Medical group/IPA provides or arranges for health care services for an eligible member through our eligibility determination and verification processes. If authorization is provided, and the individual was not a member when the health care services were provided, medical group/IPA may seek reimbursement for such services.

The medical group/IPA must submit the following information to our health care provider dispute team for reimbursement consideration. Their address is in the **UnitedHealthcare West bulk claims rework reference table**. Include:

- Cover sheet
- Copy of authorization and the itemized bill for services rendered
- A record of any payment received from any other responsible payer
- Amount due based on medical group's/IPA's cost of care rate, less any payment received from any other responsible payer

Authorization guarantee reimbursement

The medical group/IPA must follow the authorization guarantee billing procedures. Eligible services must be reimbursed within 45 business days of receipt of information. Reimbursement should be at the cost of care rates listed in the contract, no greater than the full uncollected balance. The medical group/IPA must reimburse the health care provider.

Health care provider responsibilities

Demographic updates

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

For delegated health care providers – submit monthly provider roster changes or additions to designated submission pathway, which includes CAQH Provider Data Portal for Groups, Demographic API or My Practice Profile for Groups.

For non-delegated health care providers – visit **UHCprovider.com/mypracticeprofile**

For delegated MA health care providers, if you expect any significant changes to your network, notify your health care provider advocate of changes per your agreement. Additionally, please notify your health care provider

advocate prior to the third quarter of the calendar year. This helps our members select the correct health care provider during the annual enrollment period from October–December. It also reduces health care provider directory errors.

Electronic Data Interchange (EDI)

EDI is our preferred choice for conducting business transactions with health care providers and health care industry partners. We accept EDI claims submission for all our product lines. Find information and help with EDI on **UHCprovider.com/edi**.

ASC X12 technical report type 3/companion guides

The ASC X12 Technical Report Type 3 (TR 3 also known as HIPAA Implementation Guides) publications are the authoritative source for EDI Transactions. You may purchase the ASC X12 Technical Report Type 3 publications from Washington Publishing at wpc-edi.com.

We developed guides to provide transaction-specific information we require for successful EDI submissions. These companion guides are available at **UHCprovider.com/edi**.

The following table includes standardized HIPAA-compliant EDI transactions available at UnitedHealthcare:

ANSI ASC X12N transactions	HIPAA EDI transactions acceptable UnitedHealthcare versions	Available at UnitedHealthcare transaction descriptions
270/271	005010X279A1	Eligibility Benefits Inquiry and Response (Real Time and Batch)
275	006020X314	Unsolicited Claim Attachments
276/277	005010X212	Claim Status Inquiry and Response (Real Time and Batch)
278	005010X278	Health Care Services Review - Request for Review and Response (Real Time and Batch)
278	005010X216	Health Care Services Review - Notification and Acknowledgment (Real Time and Batch)
278	005010X215	Health Care Services Review - Inquiry and Response (Real Time and Batch)
820	005010X218	Premium Payment
834	005010X220A1	Benefit Enrollment and Maintenance
835	005010X221A1	Claims Payment and Remittance Advice
837	005010X222A1	Healthcare Claim/Encounter Professional
837	005010X223A2	Healthcare Claim/Encounter Institutional

Changes in capacity

The medical group/IPA must provide us with at least 90 calendar days written notice prior to any changes to the medical group/IPA or network providers. Include the following in the notice:

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

The medical group/IPA, its health care providers and other licensed independent health care professionals must continue to accept members during the 90-day notice. For purposes of this section, a new member may be a member who has switched health plans and/or coverage plans. This includes a member who switches from a fee-for-service (FFS) plan to a Commercial HMO/MCO plan.

California requirements for capacity reporting

We require capitated health care providers to give us updates within 5 business days if capacity changes affect your ability to accept new members. If we receive notification your information is inaccurate, you will be subject to corrective action.

Privacy

You must make reasonable efforts to limit Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to the minimum necessary when using or disclosing PHI. The minimum necessary standard should not affect treatment, payment or health care operations (TPO). The Privacy Rule requires written member authorization for uses and disclosure that fall outside of the TPO.

Member communication scope

The Managed Care Risk Entity is responsible for member communication that pertains to care providers. UnitedHealthcare retains the responsibility to provide timely and efficient member communication surrounding Explanations of Benefits (EOBs) and other product and plan-based communications.

Nondiscrimination

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

- Race
- Gender identity
- Ethnicity
- National origin
- Religion
- Sex and gender
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Claims experience
- Medical history
- Evidence of insurability
- Disability
- Genetic information
- Source of payment
- Medicaid status for Medicare members

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

Inclusion of notice of availability of language assistance in non-standard vital documents issued by delegated health care provider groups (CA commercial members only)

The delegated health care provider group must include the California Department of Managed Health Care's (DMHC) approved Notice of Availability of Language Assistance with each vital document containing member-specific information issued to the UnitedHealthcare Language Assistance Program members. The notice must be included in the UnitedHealthcare threshold languages (English, Spanish and Chinese). Vital documents include UM modification, delay or denial letters issued to our members by the delegated health care provider group. We review compliance with this requirement during the annual assessment of delegated medical management.

UnitedHealthcare worked with Health Industry Collaboration Effort to standardize the inclusion of the required notice. Contact your UnitedHealthcare clinical delegation oversight consultant for current UnitedHealthcare letter templates.

Hospital Incentive Program (HIP) professional capitation

In a professional capitation agreement, the medical group/IPA receives capitation for medical services. We pay selected facility services out of the HIP. The HIP provides an incentive for the medical group/IPA to appropriately and efficiently use facility services such as inpatient activity, in-area emergency services and other selected outpatient services provided to our members. The HIP calculates overages and deficits based on an annual comparison of accumulated actual costs based on the terms of the UnitedHealthcare medical group/IPA Agreement.

This section provides general information for a professional capitation arrangement on the following:

- How are HIP results calculated?
- What services are included in the HIP?
- What information is available to assess HIP performance?

Budget (CA only)

The Integrated Healthcare Association (IHA) P4P Value-Based Incentive Program for commercial members is not a component of your Agreement. It is under a separate letter of agreement.

The budget for the Medicare Advantage Hospital Incentive Program (MAHIP) for Medicare members is based on a percent of premium, less the reinsurance premium. Aside from the budget, all other aspects of the HIP apply to the MAHIP.

Reinsurance

Reinsurance is required to protect the HIP budget and medical group/IPA against catastrophic cases.

Actual costs

The Division of Financial Responsibility section of the Agreement defines the services that are included to make up the HIP costs. The HIP costs typically include the following:

- Inpatient costs for facility services rendered to our members by network providers valued at the actual costs we incur
- Other facility services given to our members by network providers other than inpatient services, valued at actual costs we incur
- The actual amount paid for facility services, which are rendered by non-network care providers
- A percentage of all facility services incurred during the period but not yet processed (for the interim calculation), minus:
  - Reinsurance recoveries
  - Third-party recoveries received during calculation

Monitoring performance

We monitor the medical group/IPA financial performance through:

- Records of authorized services
- Claims paid/denied reports
- HIP financial report for the settlement period. The report details:
  - Total number of member months
  - Total budget allocation for the member months
  - Total expenses paid during the period
  - A description of each amount of expense allocated to the risk arrangement by member ID number, date of service, description of service by claim codes, net payment and date of payment
  - Risk determination accuracy as identified through review of issue resolution data of risk disputes and risk reconsiderations

Settlement calculations

We perform interim settlements, the final settlement and reconciliation of the HIP.

We provide a quarterly incentive program report to the medical group/IPA within 45 calendar days of the close of each calendar quarter. The incentive program report contains the monitored information.

Split capitation

In a split capitation Agreement, the medical group/IPA receives capitation for the provision of medical services. The facility receives capitation for facility services and selected outpatient services. The medical group/IPA and facility may create and administer their own facility incentive program under a split capitation Agreement.

Monthly reporting

We either post online or distribute to each medical group/IPA, a monthly shared risk claims report. It lists the actual costs incurred and denied during the previous month for services included in the HIP. Review this report each month to make sure the claims were processed and/or paid correctly.

The following tools will help the medical group/IPA analyze the Shared Risk Claims Report:

- Claims Code Sheet
- Place of Service Mapping
  - This document cross-references the CMS place of service codes to the UnitedHealthcare internal place of service codes

Discrepancy report

Use the Discrepancy Report to request research of the payment or denial of a claim we processed. After reviewing the Monthly Shared Risk Claims Report, complete all fields in the Discrepancy report. Submit it electronically to our Network Management department. If all required fields are not completed, we return the files to the medical group/IPA. The required fields include:

- Member ID number (7-digit number)
- Member ID number suffix (2 digits)
- Claim number
- Expected health care provider reimbursement
- Health care provider comments – why the medical group/IPA is disputing the payment

Discrepancy report timely filing

The medical group/IPA must submit discrepancy reports monthly. We do not pursue recoveries of overpayments you submit late based on your Agreement with us or by state law.

We reserve the right to deny/reject any request for review submitted beyond the timely filing limit.

Individual stop loss and reinsurance programs (stop loss protection)

Individual Stop Loss (ISL)/Reinsurance limits the medical group's/IPA's/facility's financial risk for medical and facility services beyond a specified dollar amount per member, per calendar year. This program applies to services for which we capitated the medical group/IPA/facility.

The ISL program is updated annually. Each medical group/IPA/facility may take part each year. The medical group/IPA may purchase ISL/reinsurance from us or an outside carrier.

We determine our premium for ISL based on our experience. We convert the calculated premium for stop loss to either a percentage of premium or flat per member per month (PMPM) rate based on the medical group's/IPA's Agreement. Every month, we subtract the result from the total capitation.

We reimburse a medical group/IPA that purchases ISL through us for services that exceed the ISL deductible at the ISL program rates specified in the Agreement or the ISL election letter for the applicable contract year, minus the medical group's ISL coinsurance amount.

We reimburse a facility that purchases reinsurance through us for services that exceed the reinsurance deductible at the reinsurance program rates specified in the Agreement or the reinsurance election letter for the applicable contract year, less the facility's reinsurance coinsurance. The facility must identify all reinsurance claims before submission. The facility reinsurance program is updated annually.

The medical group/IPA or facility may elect to opt out of the UnitedHealthcare ISL/reinsurance program by purchasing ISL/reinsurance coverage through a third-party insurance carrier. Such coverage must be through an entity we approve of and in the amounts required by UnitedHealthcare and state and federal law. Refer to your Agreement for details.

Notification of ISL/reinsurance claims

The medical group/IPA or facility provides written notification to us when services for a member equal 50% of the ISL/reinsurance deductible. The written notification submission needs to be to us no later than the 15th day of the month following the month in which the claim amounts reach the 50% threshold.

ISL/reinsurance claims submission procedure

Submit all ISL/reinsurance claims having met the ISL/reinsurance deductible to us annually but no later than 90 calendar days after the end of the calendar year.

To receive reimbursement under the ISL/reinsurance program, follow these steps:

- Submit the ISL/reinsurance claims by spreadsheet to **individual_stoploss@uhc.com**. Scan and email all hard-copy images. Include these on the submission spreadsheet:
  - Service health care provider name
  - Date of service
  - Service description
  - Correct RBRVS or CPT codes and description of services if required
  - Billed charges
  - Place of service
  - Medical group/IPA paid amount
  - Other insurance information
  - Discount adjustments

  - ICD-10-CM diagnosis codes
  - Proof of payment (copies of canceled checks)
- Each spreadsheet submission sheet must be for 1 member only. We do not accept combined submissions for a family or for more than 1 member.
- For capitated services rendered outside the medical group/IPA/facility, we require copies of canceled checks showing actual amounts paid. Upon request, submit copies of all referral bills and/or copies of consultation and operative reports.
- We may ask you to submit a brief member history (copy of a consultant report and/or history dictation). We do not require lab results, X-ray results or records.
- These are excluded from the calculation of ISL/reinsurance claims:
  - Member copayment amounts
  - Noncovered services
  - Services paid by Workers' Compensation
  - Services paid by other health plans
  - Services paid through third-party reimbursement

Our Claims Production Unit reviews the claim for completeness and tells medical group/IPA/facility if it needs any other information. It may need supporting records for ISL/reinsurance claim verification. After review, if the claim is accepted, we make a payment within 60 calendar days. Submit ISL/reinsurance claims to **individual_stoploss@uhc.com**.

Delegated credentialing program

Delegated credentialing program

This information is supplemental to the credentialing requirements outlined in **Chapter 15: Credentialing and recredentialing**. Delegated entities and capitated health care providers are also subject to the following requirements.

We maintain standards, policies and procedures for credentialing and recredentialing of health care providers and other licensed independent health care professionals, facilities and other organizational health care provider facilities that provide medical services to our members. We may delegate credentialing activities to a medical group, IPA, PHO, hospital or other entity that complies with our Credentialing Plan. Delegation of credentialing may occur through a stand-alone Credentialing Delegation Agreement or through a Delegation Grid within the capitation agreement.

The delegate must maintain a written description of its credentialing program that documents the following activities, in a format that meets the Credentialing Entity's standards:

- Credentialing
- Recredentialing
- Assessment of network providers and other licensed independent health care professionals
- Subdelegation of credentialing, as applicable
- Review activities, including establishing and maintaining a credentialing committee

Confidentiality

Delegated entities must not share credentialing and recredentialing information with anyone without the health care provider's written permission or as required by law.

Delegate fraud, waste and abuse

UnitedHealthcare is committed to protecting the integrity of the health care program and the efficiency of operations by preventing, detecting and investigating fraud, waste and abuse. During delegation, the MCRE is responsible for preventing, detecting and investigating fraud, waste and abuse — and reacting in an ethical manner upon discovery.

Delegate action

Delegates are to withhold payment to any providers they are investigating for fraud and notify UnitedHealthcare of their findings. For a comprehensive resource, please see **Chapter 17**.

Term of FWA providers

Delegate is to submit terminations and appropriate legal and regulatory documentation for care providers who are investigated and found guilty of fraud, waste and/or abuse.

Initial credentialing process

When credentialing is delegated, applicants must use the delegate's application and process or as prescribed by law.

Delegation oversight

We perform an initial assessment to measure the delegate's compliance with the established standards for delegation of credentialing. Every year after that, we assess the delegate to monitor its compliance with established standards. This includes NCQA standards and state and federal requirements. If needed, we may conduct a focused assessment review based on specific delegate activity.

Improvement action plans

UnitedHealthcare has the right to institute an Improvement Action Plan (IAP) for identified deficiencies and will notify the delegate regarding specifics and timelines for corrective action. The delegate will develop and implement an IAP to address the findings. The IAP will include, but is not limited to:

- Root cause analysis (if applicable)
- Detailed work plan(s) to address identified action items
- Metrics to measure progress and completion
- Identified stakeholders
- Due dates
- Communication strategy
- Other standards as established by UnitedHealthcare

All IAPs shall be approved by UnitedHealthcare.

Credentialing reporting requirements for delegates

In addition to complying with state and contractual reporting requirements, we require all delegates to adhere to the following standards for periodic notification procedures.

Delegates are responsible for submitting at least 1 report each calendar month of additions, terminations, recredentialing activity and changes. Please refer to the UnitedHealthcare Delegate Roster Submission Data Dictionary at **UHCprovider.com** > Resources > **Resource library** for a list of the required data elements for each submission type.

Submit all changes per your designated submission pathway, which includes CAQH Provider Data Portal for Groups, Demographic API or My Practice Profile for Groups. If there is no activity of additions, terminations, recredentialing or changes to report during a calendar month, delegate must submit a roster template without any changes noted.

Compliance of monthly roster submissions is monitored regularly. It's also evaluated as part of the annual assessment and included in the final score. If 3 or more months of roster submissions are missed during a 12-month look back period, the annual assessment report will indicate this element as noncompliant and may require an Improvement Action Plan.

Notice of New Provider Adds – submit upon approval, but no more than 30 days, of the credentialing committee approval.

Notice of Provider Changes – submit upon awareness, but no more than 30 days, all provider demographic changes, open/closed status or product participation. When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers, who are not regularly available to provide covered services at an office or practice location, should not be listed at that address.

Notice of Recredentialing Activity – submit recredentialing activity within 30 days of the approval, which should be within 36 months of the previous credentialing approval.

Notice of Provider Terminations – submit all terminations of health care providers or other licensed independent health care professionals 90 calendar days before the termination effective date, or at minimum, within 5 business days of delegate's awareness. It is imperative we receive such notices on a timely basis to comply with our regulatory obligations related to the terminations of health care providers and other licensed independent health care professionals.

Effective dates of termination must be the last day of the month, unless otherwise approved by UnitedHealthcare, to properly support group capitation. We do not accept mid-month terminations.

Termination notice requires:

- Reason for termination
- Effective date of termination
- Direction for reassignment of members (for PCP terminations, if UnitedHealthcare does assignment)

When a PCP terminates affiliation with a delegate, our members have 2 options:

1. Stay with their existing medical group/IPA and change health care providers
2. Transfer to another medical group/IPA to stay with the existing health care provider

If the delegate fails to indicate the reassignment preference, we assign the member to another PCP within the same medical group/IPA, based on the medical group's/IPA's direction for reassignment. We make exceptions to this policy on a case-by-case basis. Members may change their health care provider as described in their benefit plan.

Negative actions reporting requirements – submit any change in a health care provider's status that results in any loss of license, restrictions, limitations, suspension or termination within 5 business days of the delegate's awareness or action.

Full provider rosters – submit full roster on a quarterly basis.

Virtual care services (commercial HMO plans – CA only)

Commercial HMO members can use Virtual Visits for 24/7 Virtual Visits (urgent care), Virtual Primary Care or through their selected PCP or medical group/IPA. Virtual Visits provide communication of medical information in real time between the member and a health care provider or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (e.g., home or work). When covered by a member's benefit plan, the Virtual Visit benefit has a separate defined copayment.

24/7 Virtual Visits – commercial members can connect to a doctor by video through **myuhc.com** or the UnitedHealthcare app. Doctors treat a wide range of health conditions (e.g., flu, pinkeye and migraines) and can even prescribe medication as needed. The 24/7 Virtual Visits treat many of the same conditions as in-person urgent care and utilizes the Designated Virtual Network Provider benefit. The network provider groups offering Virtual Visit services must comply with the service standards. If you provide Virtual Visits, these services must be accessible to

individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing so they receive them prior to their Virtual Visit.

Virtual Primary Care – Virtual Primary Care delivers many of the same services as traditional primary care, including preventive and regular exams, management of chronic conditions and acute nonemergency needs. It combines convenience with the potential advantages of seeing a doctor regularly who knows your employees' health history. Virtual Primary Care uses the physician office benefit.

We prefer members to access Virtual Visits through their selected PCP or medical group/IPA (local care), if available. Commercial HMO members may access Virtual Visits from a Designated Virtual Network Care Provider. If the member's medical group/IPA or PCP does not offer Virtual Visit services, we make a nationally contracted Virtual Visit health care provider available. The Designated Virtual Network Care Provider groups offering Virtual Visit services must comply with the service standards.

Service standards

Access – when the health care provider group develops Virtual Visit technology, it may offer services to assigned members who have the coverage as a part of their benefit plan. We pay for Virtual Visit primary care services delivered by health care providers covered under professional capitation. Not all benefit plans have the Virtual Visit benefit option. The health care provider group must confirm member eligibility and cost-share for Virtual Visit service. This applies only if medical group/IPA develops its own virtual visit technology.

24 hour/7 day availability – Virtual Visit technology services are available 24 hours a day, 7 days a week.

Staffing credentials – all professional staff are certified or licensed in their specialty or have a level of certification, licensure, education and/or experience based on state and federal laws.

Staff orientation and ongoing training – the health care provider group must take part in a written orientation plan with documented skill demonstrations. It must also have initial and ongoing training programs, including policies and procedures. The health care provider group will pursue accreditation of its Virtual Visit program with the American Telemedicine Association.

Service response time – within 30 minutes after a member requests a visit, the health care provider group contacts the member to either schedule or hold a Virtual Visit.

Technology security – the health care provider group conducts all member Virtual Visits using interactive audio and/or video telecommunications systems on a secure technology platform that meets state and federal law requirements for security and confidentiality of electronic member information. It maintains member records in a secure medium that meets state and federal law requirements for encryption and security of electronic member information.

Professional accreditation – the health care provider group pursues applicable accreditation by the American Telemedicine Association (or other mutually agreed upon accreditation body) to become accredited within 1 year after the accreditation program release date.

Continuous quality improvement (CQI) – the health care provider group must have a documented CQI program for identifying data opportunities for time-measured improvement in areas of core competencies. There must be demonstrated ties between CQI findings and staff orientation, training, and policies and procedures.

Member complaints – the health care provider group logs, by category and type, member complaints with specific improvement action plans for any patterns. There should be complaints registered on less than 2% of member cases.

Regulatory assessment results – if we ask, the health care provider will allow access to any applicable regulatory audit results.

Utilization – the health care provider group submits Virtual Visit encounters with proper coding as part of its existing encounter submission process.

Electronic billing/encounter coding – the health care provider group will submit Virtual Visit encounters or claims with proper coding as part of its existing encounter submission process.

Eligibility verification – the health care provider group uses existing eligibility validation methods to confirm Virtual Visit benefits.

Case communication – the health care provider group will support member records management for Virtual Visits using existing EMR systems and standard forms. Keep required medical information in EMR records, including referrals and authorizations.

Joint operating committee – the health care provider meets with us up to quarterly at our request to review data reports and quality issues. We also address any administration issues.

Professional environment – the health care provider group helps ensure that, when conducting Virtual Visits with members, the rendering health care provider is in a professional and private location. The health care provider group (rendering health care providers) may not conduct member Virtual Visits in vehicles or public locations.

Medical director – the health care provider employs or engages a licensed health care provider as medical director. The medical director is responsible for clinical direction.

Referrals and referral contracting

Direct access services

Members may receive certain services without prior authorization or referrals. Refer to **Chapter 6: Referrals** for details about direct access services.

Access to participating eye health care providers (select health care providers in CA commercial plans only)

If the medical group/IPA is delegated for vision services, it must allow the member direct access to any eye health care provider participating and available under the plan. An eye health care provider is a licensed network optometrist or ophthalmologist.

The medical group/IPA may require the eye health care provider to submit requests for approval of surgical vision-related procedures.

Access to participating chiropractor (WA commercial plans only)

If the medical group/IPA is delegated for chiropractic services, they must allow the member direct access to any participating chiropractor available under the plan. The medical group/IPA may use managed care cost and containment techniques.

PCP and health care provider responsibilities

We may assign each member a PCP at the time of enrollment if the member does not select one. The PCP coordinates the member's overall health care, including behavioral health care, and the appropriate use of pharmaceutical medications.

The delegated medical group/IPA sets its own policies regarding health care provider responsibilities.

Referral plans (Medicare Advantage)

Delegated providers of UnitedHealthcare Medicare Advantage referral plans may administer the referral process in a different manner than outlined in **Chapter 6: Referrals**. This includes the option to deny certain in-network specialist claims for missing referrals. Claims denied for no referral must be denied with provider liability.

Delegated providers should not require the member's PCP to submit referrals for members who travel outside their plan service area and access covered services using the National Network or their Passport benefit. To verify a member's participation in either National Network or Passport, look for the appropriate logo on the member ID card.

Out-of-network provider referrals

Commercial and Medicare Advantage HMO plans

When medically necessary, the PCP refers the member to in-network providers. If the needed health care provider is not available in-network, not available within the needed time frame or too far away, the PCP needs to request an out-of-network provider review. The delegated medical group/IPA reviews this request. If approved, the member is not responsible for costs over their applicable in-network cost-sharing.

Medicare Advantage PPO Plans

Medicare Advantage PPO plans do not have referral requirements. The PCP can refer the member to in-network providers as requested. Members also have the ability to visit out-of-network providers if the providers accept Medicare and agree to bill UnitedHealthcare, likely at a higher cost.

Referral contracts (Medicare Advantage)

We encourage the medical group/IPA to establish contracts with participating UnitedHealthcare Medicare Advantage health care providers so they may refer our members for specialty services. Each contract must have the specific parts described in this section. The medical group/IPA may establish written contracts with health care providers. They may use existing UnitedHealthcare contracts unless they are delegated for claims processing. Delegated medical groups/IPAs must negotiate their own contracts. These contracts must comply with this guide:

- No contractual arrangement between the delegate and any subcontracting health care provider may violate any provision of law
- The delegate helps ensure all provisions of its agreement with any health care provider who provides services to MA members includes all provisions required under the delegate's MA Agreement and regulatory requirements and applicable accreditation standards
- If a health care provider has opted out of the Medicare program, the delegate should not contract with them to provide services to MA members
  - If a medical group/IPA has a referral contract with a care provider who has opted out of the Medicare program, the medical group/IPA is responsible for notifying UnitedHealthcare that the care provider is no longer part of their referral network
  - For additional information regarding providers who have opted out of the Medicare program, refer to CMS guidelines

Establishing contracts for specialty services

Any medical group/IPA delegated to support referral services or for claims processing must negotiate contracts with individual specialists or group practices to facilitate the availability of appropriate services to members. All contracts must be in writing and comply with state and federal law, accreditation standards and the MA Agreement.

Depending upon the delegate's contract with us, this may include contracting for services with hospitals, home health agencies and other types of facilities.

Subcontract review (Medicare Advantage)

CMS requires us to check the written agreements the medical group/IPA has with its health care providers. We check them at least annually. We recommend the medical group/IPA reviews their subcontracts annually. These checks help ensure compliance with federal law and CMS regulations. We require an Improvement Action Plan (IAP) for any medical group/IPA who has non-compliant contracts. The IAP lists our findings and expected time frame to reach compliance.

Referral authorization procedure

The delegated medical group/IPA may initiate the referral authorization process when asked to refer a member for services. Refer to their Notification/Prior Authorization list. These capitated medical services may need a referral authorization:

- Outpatient services
- Laboratory and diagnostic testing (nonroutine, performed outside the delegated medical group's/IPA's facility)
- Specialty consultation/treatment
- Facility admissions
- Out-of-network services

The medical group/IPA, PCP and/or other referring health care provider verifies eligibility and participating health care provider listings on all referral authorization requests. This helps ensure they refer a member to the appropriate network provider. The medical group/IPA must comply with the following procedures:

- When a member requests specific health care provider services, treatment or referral, the PCP or treating health care provider reviews the request for medical necessity
- If there is no medical indication for the requested treatment, the health care provider discusses an alternative treatment plan with the member
- If the member's treatment option requires referral or prior authorization, the PCP or treating health care provider submits the member's request to the delegate's Utilization Management Committee or its designee for a decision. The PCP or treating health care provider includes appropriate medical information and referral notes about why the requested service is medically necessary. Information should include results of previous treatment.
- If the request is not approved in whole, the medical group/IPA (or if not delegated, UnitedHealthcare) issues a denial letter to the member. It states the requested services, treatment or referral and complies with applicable state and federal requirements.

Standing referral/extended referral for care by a specialist

The delegated entity must have specialty care referral procedures. Those procedures must outline the process and requirements for standing and extended referrals for specialists and specialty care centers. The entity needs a standing referral if the member requires:

- Continued care from a specialist or specialty care center for a prolonged time
- Extended access to a specialist for a life-threatening, degenerative or disabling condition

The referral may limit the number of specialist visits or time period for which services are authorized. The specialist may need to provide regular reports to the PCP.

For an extended specialty referral, the PCP and specialist must determine which health care service each manages. The PCP should handle primary care and keep records of the reason, diagnosis and treatment plan for the referral.

HIV/AIDS extended referrals (CA commercial only)

The medical group/IPA must have a written process for extended referrals to HIV/AIDS specialists when the PCP and medical group/IPA medical director agree the diagnosis and/or treatment of the member's condition requires an HIV/AIDS specialist's expertise. To comply with the state laws and regulations, the delegated medical group/IPA must identify health care providers within their group who qualify as HIV/AIDS specialists. If no such health care providers are in the medical group/IPA, the medical group/IPA must have a way to refer members to a qualified HIV/AIDS specialist outside of the group. The qualification of an HIV/AIDS specialist are outlined in the California Health and Safety Code 1374.16.

Referral and/or authorization forms

For commercial members, the delegate may design its own request for referral and/or authorization forms without our approval. When the forms communicate approvals to the member, use at least 12-point Times New Roman font.

If the form is not at least 12-point font, the delegate needs to send a written notification that is.

For MA members, we provide an approval template letter.

At a minimum, include all the following components in the form or written notice:

- Member identification (e.g., member ID number and birth date)
- Services requested for authorization, including appropriate ICD-10-CM and/or CPT codes
- Authorized services, including appropriate ICD-10-CM and/or CPT codes
- Proper billing procedures, including the medical group/IPA address
- Verification of member eligibility

The delegate provides copies of the referral and/or authorization form to the:

- Referral health care provider
- Member
- Member's medical record
- Managed care administrative office

Looking for more information about notification requirements? See section on **Nondiscrimination taglines for Section 1557 of the Affordable Care Act** in this supplement

Member or health care provider requests for services carved out of UnitedHealthcare or outside vendors (Medicare Advantage and commercial)

CMS regulations allow a member to make a direct request for services from either the MA plan or the entity making the determination, which is the utilization management/medical management delegated medical group/IPA. This applies to both standard and expedited preservice Initial Organization Determinations (IODs). The established requirements for preservice standard and expedited IODs apply.

Delegated medical groups/IPAs handle the timely processing of all preservice organization determination requests, including the delegate's requests that are the responsibility of UnitedHealthcare. The medical group/IPA must have explicit policies and procedures for the following:

- Starting the referral or authorization processes when a member contacts the delegate to request services, or when a health care provider requests a service of the delegate that is the responsibility of UnitedHealthcare. The medical group/IPA must use the date and time the member or health care provider first called as the received date and time of the request to comply with required turn-around times.
- Working with UnitedHealthcare on service referrals or authorizations where a member or health care provider has contacted us to request services. The medical group/IPA must use the date and time of the request to UnitedHealthcare as the received date and time of the request for compliance with turnaround times.

If the carved-out service is the responsibility of UnitedHealthcare, the delegated medical group/IPA will:

- Transfer member requests to the customer service number on the back of the member's ID card
- Transfer health care provider requests to Provider Services. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
- Stay on the line and explain the request

If the carved-out service is the responsibility of an outside vendor, the Primary Medical Group will locate vendor contact information through member Evidence of Coverage documentation or through **UHCprovider.com**, transfer member or provider calls to the appropriate vendor contact or submit the carve-out request to the appropriate vendor if not a call and document actions.

- Locate vendor contact information on **UHCprovider.com** or on the member's Evidence of Coverage (EOC) and transfer member or provider to the appropriate contact
- Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
  - Follow the IVR menu to reach correct department or obtain vendor information
  - Submit request directly to vendor and inform the member of vendor name and contact information

Medicare Advantage and Commercial delegated medical groups/IPAs cannot send a carve-out letter.

- Delegates on the NICE platform may submit the carve-out services as a prior authorization submission using the UnitedHealthcare Provider Portal Prior Authorization tool: **UHCprovider.com** > Sign In > Prior Authorizations

Looking for more information on referrals?
Additional detailed information and requirements for referrals can be found in **Chapter 6: Referrals**.

Coordination of care between medical and behavioral health care

Medical groups/IPAs providing behavioral health services must collect information about how to improve coordination of care with the behavioral health care providers. Based on the data collected, the medical group/IPA must work with those health care providers to make improvements. The medical group/IPA submits this report annually to their quality improvement or appropriate committee. The medical group/IPA must have procedures describing how it will complete this cycle. We look at the process and report during our annual review of the medical group/IPA.

A medical group/IPA providing behavioral health services must also review members' experiences at least annually. This includes a member survey. Based on the survey results, the medical group/IPA identifies areas for improvement and makes necessary changes. The medical group/IPA then measures the effectiveness of these changes. It submits this report to its quality improvement or appropriate committee. We look at the process and report during our yearly review.

Medical management

The protocols in this section are unique to capitated and/or delegated medical management entities. The protocols in **Chapter 7: Medical management** may also apply if we are financially responsible for the service.

If we are financially responsible for the service, or responsible for processing the claim, ask us if we require an authorization.

Clinical delegation oversight

We monitor compliance and performance against NCQA, federal, state and UnitedHealthcare business standards including those outlined in the core guide and supplement. We hold our delegates to the requirements outlined in the main guide and this supplement. We perform clinical assessments of those activities prior to the approval of delegation to make sure the potential delegate meets those requirements. Once we approve the delegate, and they are implemented, we make sure they remain compliant. We provide our delegates with information they need to meet regulatory and contractual requirements and accreditation standards.

Pre-contractual or pre-delegation assessments

When an entity – usually a medical group/IPA – expresses interest in contracting to perform delegated activities, we begin an assessment process to confirm the entity can perform those activities. Clinical reviewers request documented processes (e.g., programs, policies and procedures, work flows or protocols) and supporting evidence. Supporting evidence may include materials (e.g., letter templates, scripts, brochures or website) and reports (or the demonstrated ability to produce required reports). Clinical reviewers arrange a meeting to further assess systems and processes, staffing and resources. Assessment results and delegation recommendations are provided to internal committee(s), which determine whether to proceed with delegation.

Post-contractual or post-delegation clinical assessments

We conduct another assessment within 90 calendar days after the contract or delegation effective date. Assessments are based on documented processes, materials, reports and case records or files specific to the delegated activities. Further assessments are performed at least quarterly. The quarterly review process includes:

- A review of all updated policies and/or procedures
- File review (3-month look back from previous review period)
- Remediation plan, if appropriate

Quarterly review process

The quarterly review process includes new scoring guidelines for any deficiencies found. Any review items marked as not met will require remediation.

UnitedHealthcare has the right to institute an Improvement Action Plan (IAP) for identified deficiencies and will notify the delegate regarding specifics and timelines for corrective action. The delegate will develop and implement an IAP to address the findings. The IAP will include, but is not limited to:

- Root cause analysis (if applicable)
- Detailed work plan(s) to address identified action items
- Metrics to measure progress and completion
- Identified stakeholders
- Due dates
- Communication strategy
- Other standards as established by UnitedHealthcare

All IAPs shall be approved by UnitedHealthcare.

Criteria for determining medical necessity

UnitedHealthcare and medical groups/IPAs delegated for utilization/medical management review nationally recognized evidence-based criteria to determine medical necessity and appropriate level of care for services whenever possible.

UnitedHealthcare and delegates use several resources and guidelines to determine medical necessity and appropriate level of care.

Hierarchy of criteria use

When using criteria to make decisions about service requests, the delegate must use the following criteria appropriate to the benefit plan:

Commercial

- Eligibility and benefits
- State/federal laws and regulations
- Summary Plan Description/Certificate of Coverage

- UnitedHealthcare clinical determination guidelines
- UnitedHealthcare medical policies and review guidelines
- For medical necessity only:
  - Evidence-based criteria, such as InterQual guidelines

UnitedHealthcare West

- Eligibility
- Evidence of Coverage (EOC)/Schedule of Benefits (SOB)
- State/federal laws and regulations/UnitedHealthcare West benefit interpretation policies (BIPs)
- UnitedHealthcare West medical/drug policies or review guidelines
- MCG Care Guidelines/InterQual criteria
- Hayes

Medicare Advantage

1. Eligibility
2. Benefit document: Evidence of Coverage (EOC)
3. Medicare Coverage Database: National Coverage Determinations (NCD)
4. Medicare Coverage Database: Local Coverage Determinations (LCD)
5. Medicare Coverage Database: Local Coverage Articles (LCAs)
6. Medicare Benefit Policy Manual
7. UnitedHealthcare Medicare Advantage Medical Policies (MAMPs)
8. In circumstances where Medicare guidelines are silent or not fully established, delegates may use any of the following criteria:
   a. Nationally recognized third-party evidence-based clinical guidelines
   b. Internally developed clinical criteria

Note: When utilizing a or b above, use must be in accordance with Medicare rules and regulations and approved by the UnitedHealthcare Medicare Advantage utilization management committee. With limited exceptions, we do not reimburse for services that are not medically necessary, or when you have not followed correct procedures (e.g., notification requirements, prior authorization or verification guarantee process). Delegates may institute the same policy.

Accreditation standards require all health care organizations, health benefit plans and medical groups/IPAs delegated for utilization/medical management to distribute a statement to all members, physicians, health care providers and employees who make utilization management (UM) decisions stating:

- UM decision-making is based only on appropriateness of care and service and existence of coverage
- Practitioners or other individuals are not rewarded for issuing denials of coverage or service
- Financial incentives for UM decision-makers do not encourage decisions that result in under utilization

Regardless of the medical management program determination, the decision to render medical services lies with the member and the attending physician.

If you and a member decide to go forward with the medical service once UnitedHealthcare or the delegate has denied prior authorization (and issued a denial notice to the member and physician as appropriate), neither UnitedHealthcare nor the delegate reimburse for the denied services. Medical directors are available to discuss their decisions and our criteria with you. Find medical policies and guidelines on **UHCprovider.com/policies** or from the delegated medical group/IPA as applicable.

Level of specificity – use of codes

To track the specific level of care and services provided to its members, UnitedHealthcare requires you to use the most current service codes (i.e., ICD-10-CM, UB and CPT codes). We also require you to make sure the documented bill type is appropriate for the type of service provided.

Health care provider responsibilities for participation in medical management

You must participate, cooperate and comply with our medical management policies. You must render covered services at the most appropriate level of care, based on nationally recognized criteria.

We may delegate medical management functions to a medical group/IPA or other entity that demonstrates compliance with our standards. Health care providers associated with these delegates must use the delegate's medical management office and protocols. We may retain responsibility for some medical management activities, such as inpatient admissions and outpatient surgeries. When a health care provider is not associated with a delegate, or when we are responsible for the specific medical management activity, the health care provider must comply with our medical management procedures.

For medical management functions retained by us, you must receive authorization from us before rendering services for a member. If you have not requested a prior authorization, submit the request within 3 business days before providing or ordering the covered service. The exception is emergency or urgent services.

To confirm prior authorization has been approved by UnitedHealthcare, use the Prior Authorization and Notification tool at **UHCprovider.com** > Sign In > Prior Authorizations. If the member is assigned to a delegated medical group/IPA, check with that medical group/IPA for confirmation.

For urgent or emergent cases, we notify you within 24 hours of services rendered, or an admission.

If you don't get prior authorization when required or tell us within the appropriate time frame, we may deny payment. The delegated medical group/IPA sets its own policies about health care provider responsibilities.

If you do not get a prior authorization, neither we (or our delegate) nor our member can be held responsible to reimburse health care providers for medical services, admissions, inappropriate facility days and/or not medically necessary services. Receiving an authorization does not affect the payment policies or determining reimbursement.

Continuity of care

Continuity of care provides a short-term transition period so members may temporarily continue to receive services from a non-network provider. See general information under the CAA requirements detailed in **Chapter 2: Provider responsibilities and standards** of this guide.

A condition that warrants a request for continuity of care requires prompt medical attention for a short time. It is not enough that the member prefers receiving treatment from a former health care provider or other non-network care provider, even for a chronic condition. A member should not continue care with a non-network provider without formal approval by us or the delegate. Except for emergencies or urgent out-of-area (OOA) care, if the member does not receive prior authorization from us or the delegate, the member pays for services performed by a non-network care provider.

We (or the medical group/IPA delegated for continuity of care) review and document all requests for continuity of care on a case-by-case basis. We consider the severity of the member's condition and the potential clinical effect on the member's treatment and outcome of the condition under treatment, which may result from a change of health care provider. Document member specifics for consideration in case reviews as relevant clinical information.

Prior authorization protocol

For any service that requires a prior authorization, the health care provider initiates an authorization request online at least 3 business days prior to the scheduled date of service.

- You must complete and submit the appropriate prior authorization request forms as applicable to state and/or federal regulatory requirements. We do not accept incomplete or incorrect forms, or submissions with incomplete medical records. You may find the list of forms on **UHCprovider.com/priorauth**.
- Our medical management team documents the information, responds to the authorization request and provides a decision within required regulatory time frames. If approved, we issue an authorization number. If denied, we provide the reason for denial to you and the member.
- In the case of a denial, you may speak with a medical director to discuss the case
- The authorized health care provider who delivers care to the member should share documentation of the recommended treatment with the member's PCP
- Exception for AARP Medicare Advantage from UHC CA-026P plan. Providers do not need to obtain prior authorizations for select OON benefits and services.

The authorized health care provider submits a claim with the authorization number in the usual manner to the appropriate address.

If you are a network care provider for a delegated medical group/IPA, follow the delegate's protocols. Delegates may use their own systems and forms. They must meet the same regulatory and accreditation requirements as UnitedHealthcare.

Emergency services and/or direct urgent facility admissions

Tell us of a member's emergency admission within 24 hours of admission or as soon as the member's condition has stabilized. The medical management department receives admission notifications 24 hours a day, 7 days a week at:

EDI: Transaction 278N

Online: **UHCprovider.com** > Sign In > Prior Authorizations

Phone: 1-800-799-5252

Document member specifics for consideration in case reviews as relevant clinical information.

The delegate sets its own policies regarding notification and authorization for these services.

Service area

The medical group/IPA/facility is financially responsible for providing all approved medical and facility services within a designated service area as well as approved services rendered while a member is outside of the medical group's/IPA's contracted service area. The contract service area is typically defined as the collective service area covered by all counties for all plans included in the agreement but can be based on other contractual terms. Refer to your Agreement for your delegated entity service area. For MA members, refer to the CMS regulatory access requirements.

Urgent or emergency services provided within the medical group/IPA/facility service area are the financial risk of the capitated entity regardless of whether services are rendered by the medical group's/IPA's/facility's network of health care providers unless your Agreement states otherwise.

OOA medical services

OOA medical services are emergency or urgently needed services that treat an unforeseen illness or injury while a member is outside of the medical group's/IPA's contracted service area. These would have been the medical group's/IPA's financial responsibility if they had been provided within the medical group/IPA service area.

- UnitedHealthcare is accountable for managing OOA cases unless otherwise contractually defined. Refer to the Division of Financial Responsibility (DOFR) section of your Agreement to determine risk for OOA medical services.

- Medical services provided outside of the delegated medical group/IPA defined service area that the member's medical group/IPA arranges or authorizes are the delegate's responsibility. They are not considered OOA medical services. This includes out-of-network provider services referred by a health care provider affiliated with the delegated medical group/IPA, whether or not that health care provider received appropriate authorization. In such cases, the delegated medical group/IPA performs all delegated medical management activities, including issuing appropriate authorization and denials.
- Members referred by the delegated medical groups/IPA for out-of-network outpatient consultation, who are then found through their evaluation to require medically necessary inpatient care, are the referring medical group's/IPA's responsibility. They do not meet the OOA criteria.
- The delegated medical group/IPA must issue appropriate denials for member-initiated non-urgent, nonemergency medical services provided outside the medical group's/IPA's defined service area
- The medical group/IPA notifies UnitedHealthcare OOA department of all known OOA cases no later than the first business day after receiving member notification of an OOA admission, procedure and/or treatment
- Failure to notify us within this time frame may result in UnitedHealthcare holding the medical group/IPA financially responsible for the OOA care and service
- Once a UnitedHealthcare member's PCP- or medical group/IPA-identified specialist speaks with the OOA attending health care provider to determine the member's stability for transport to an in-area facility, member's PCP or medical group/IPA identified specialist:
  - Determines the appropriate mode of transportation and obtains any required authorization
  - Determines the appropriate level of care or facility for the member's care and obtains any required authorization
  - Arranges for a bed at the accepting in-area facility
- If the member is found stable for transfer to an in-area facility, the medical group/IPA must collaborate with the health plan to return the member to a network care provider and facility in a timely fashion
- The medical group/IPA facilitates the return of the member to a network care provider by making sure the following process occurs in a timely fashion:
  - The medical group is responsible for transfer and care coordination planning with the out-of-network care provider to an in-network care provider, as medically appropriate, as soon as the medical group is aware of the OOA admission
  - If the medical group/IPA delays the transfer of a member considered medically stable for transfer to move, we may hold the medical group/IPA financially responsible for any OOA charges incurred as a result of the delay
  - Coordinate ambulance transportation from the OOA facility to an in-area location with the health plan in accordance with the contractual and DOFR arrangement
  - The designation of OOA for urgent/emergent services is determined by the starting point of the event. If an accident or illness occurs within the medical group/IPA-contracted service area, and emergency personnel transport the member to a facility outside the contracted service area for treatment, such services are not considered OOA and are handled by the medical group/IPA in the same manner as in-area services. The medical group/IPA must authorize and direct the member's care as if the member were receiving services at the affiliated facility or health care provider facility.
  - If an accident or illness initiates or occurs outside the medical group/IPA contracted service area, the entire course of treatment may be considered OOA

Travel dialysis is not considered an OOA medical service unless contractually defined. Refer to your DOFR to determine if the medical group/IPA is responsible for travel dialysis.

Telehealth services are considered in area unless there is burden of proof to make a determination that the member was out of area or unless otherwise specified in your contract.

For contracts with OOA defined as a 30 mile radius, mileage is determined by UnitedHealthcare using an online navigation tool to calculate the most favorable outcome using the driving distance, where traffic, road closures and other factors do not impact outcome unless otherwise specified in your contract.

In the event the delegate holds financial risk on OOA claims including foreign claims that are in a foreign language, the delegate is responsible for all aspects related to language translation when processing the claim and medical records.

Injectable medication used in a member's home

The delegated medical group/IPA is responsible for authorizing and arranging medically necessary services. If the DOFR assigns risk for injectable medications to a medical group/IPA, the medical group/IPA authorizes and pays for all injectable medications, whether self-injected or given with the aid of a health professional in the home.

Trauma services

Trauma services are medically necessary, covered services rendered at a state-licensed, designated trauma facility or a facility designated to receive trauma cases. Trauma services must meet county, state and/or federal regulatory requirements as applicable. The medical group/IPA reviews and authorizes trauma services using the applicable provision review criteria.

Transplant services/case management

Optum serves as our transplant network for the majority of our medical group/IPAs. For medical groups/IPAs that have risk for transplant services, notify Optum and/or the delegate's transplant network case management department when a member is referred for evaluation, admitted for transplant, or if the member is deemed not a candidate for transplant. Medical groups/IPAs that do not have risk for transplant services must refer members into Optum transplant case management program who have been identified as:

- Requiring evaluation for a bone marrow/stem cell, including chimeric antigen receptor T-cell (CAR-T) therapy in certain hematologic malignancies or solid organ transplant
- Undergoing a transplant evaluation
- Receiving a transplant
- Receiving post-transplant care within the first year following the transplant

You may submit referrals to Optum by:

Phone: 1-888-936-7246

Fax (Commercial): 1-855-250-8157

Fax (Medicare): 1-855-250-7278

Fax (Medicare Secure Horizon only): 1-888-361-0502

Fax (Medicaid): 1-877-814-0488

Fax (Dual Special Needs): 1-877-814-0488 and 1-855-250-7278

For UnitedHealthcare West members, you may submit referrals to Optum by:

Phone: 1-866-300-7736

Fax: 1-888-361-0502

The transplant case manager works with the member's transplant team, PCP, and other clinicians to assess the member's health care needs and develop, implement and monitor a care plan. They also coordinate services and re-evaluate the member's care plan.

- Transplant evaluations and surgery must be performed at one of Optum Centers of Excellence or a facility approved by UnitedHealthcare/Optum medical directors
- For medical groups/IPAs who do not have risk for transplant services, Optum handles the authorization and management for all transplant-related care and services. This includes the evaluation, transplant procedure, and 1 year post-transplant, unless dictated by the member's benefit or federal/state law.

- Optum oversees the authorization of donor care and services related to transplants. This starts from the date of stem cell/bone marrow collection or 24 hours prior to organ donation surgery. It ends 60 calendar days after the transplant or as member's benefit plan or state law dictates.
- Optum will provide information about a member's eligibility for travel and lodging benefits. If the medical group/IPA has financial risk for transplants, they need to authorize and reimburse all travel expenses per the member's benefit plan in the same manner as Optum.
- Authorization and management of all non-transplant related services (i.e., medically necessary, covered services for the member) is the delegated medical group's/IPA's responsibility. Non-transplant related services include those services needed to treat the member's underlying disease and maintain the member until transplant can be completed (ventricular assist devices or mechanical circulatory support devices). Financial responsibility for non-transplant related, medically necessary covered services remain as described in the DOFR.
- Medical groups/IPAs must comply with our transplant protocols, policies and procedures. We may modify these protocols, policies and procedures from time to time.

Ventricular Assist Device (VAD)/Mechanical Circulatory Support Device (MCSD) services/case management

Notify the case management department when you refer a member for evaluation for VAD/MCSD and admit a member for VAD/ MCSD.

Perform VAD/MCSD evaluations and surgery at a facility in Optum VAD Network, or a facility approved by our medical directors, to align with heart transplant service centers.

Second opinions

Members have the right to second opinions. The delegate provides a second opinion when either the member or a qualified health care professional requests it. Qualified health care professionals must provide the member with second opinions at no cost. We also allow a third opinion.

When a member meets the following criteria, they may be authorized to receive a second opinion consultation from an appropriately qualified health care professional:

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

PCP second opinions

When the PCP is affiliated with a delegated medical group/IPA, and the member requests a second opinion based on care received from that PCP, the medical group/IPA is responsible for authorizing and paying for the second opinion. If delegated for claims, the medical group/IPA is responsible for claims payment.

A second opinion regarding primary care is provided by an appropriately qualified health professional of the member's choice from within the medical group/IPA group's network of health care providers.

- California regulations allow SignatureValue HMO members to obtain second and third opinions from out-of-network care providers. The delegate sends to UnitedHealthcare all requests for second and third opinions from health care providers not participating in the delegate's network.

If the request for a second medical opinion is denied, the medical group/IPA tells the member in writing and provides the reasons for the denial. The member may appeal the denial. If the member gets a second medical opinion without prior authorization from the delegate and/or UnitedHealthcare, the member is financially responsible for the cost of the opinion.

When the PCP is not affiliated with any participating medical group/IPA but is independently contracted with us, the member may request a second opinion from a health care provider or specialist listed in our health care provider directory on **myuhc.com**.

The approved health care provider documents the second medical opinion in a consultation report, which they will make available to the member and the treating participating health care provider. The second opinion health care provider reports any recommended procedures or tests they believe are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by UnitedHealthcare, and the delegate or UnitedHealthcare (as appropriate) determines if the recommendation is medically necessary, then the delegate or UnitedHealthcare arranges the treatment, diagnostic test or service.

Note: Although a second opinion may recommend a particular treatment, diagnostic test or service, this does not mean the recommended action is medically necessary or covered. The member is responsible for paying any applicable cost-sharing amount to the health care provider who gives the second medical opinion.

Specialist care second opinions

The member has the right to request a second opinion consultation based on care received through an authorized referral to a specialist within the medical group/IPA network.

The second opinion may be provided by any practitioner of the member's choice from any medical group/IPA within the UnitedHealthcare network care provider of the same or equivalent specialty.

- MA members – Second and third opinions, whenever possible, should be provided in-network. The delegate, or we, consider authorizing health care providers outside of the delegate's network if there is no available or appropriate network care provider.
- California regulations allow commercial HMO members to obtain second and third opinions from out-of-network care providers. The delegate sends to UnitedHealthcare all requests for second and third opinions from health care providers not participating in the delegate's network.

If the health care professional is part of the member's assigned medical group/IPA, the medical group/IPA authorizes the second opinion consultation. The medical group/IPA is also responsible to pay claims if it is delegated for claims.

If approved, we pay the claim for the nonparticipating health care professional's second opinion consultation.

A second opinion consists of 1 office visit for a consultation or evaluation only. The health care provider's opinion is included in a consultation report after completing the examination. The member must return to their assigned medical group/IPA for all follow-up care and authorizations.

If a second opinion consultation differs from the initial opinion, coverage for a third opinion must be provided if requested by the member or health care provider, following the same process as for second opinions.

If the request for a second medical opinion is denied, the medical group/IPA tells the member in writing and provides the reasons for the denial. The member may appeal the denial.

Turnaround time for second or third opinions

We process requests for second opinions in a timely manner to support the clinical urgency of the member's condition. We follow established utilization management procedures and regulatory requirements. When a member's health is seriously threatened, we (or the delegate) make the second opinion decision within 72 hours after receipt of the request. An imminent and serious threat includes the potential loss of life, limb or other major bodily function. It can also exist when a delay would be detrimental to the member's ability to regain maximum function.

Special Needs Plans

For provider groups delegated for Special Needs Plans (SNP), policies must define the SNP staff structure and the roles and responsibilities including oversight functions for both administrative and clinical staff, including, the plan for providing and monitoring initial and ongoing Model of Care (MOC) training and communication of training reports.

When delegated for transitions of care and/or Health Risk Assessment (HRA), all activities and documentation must comply with the NCQA standards for SNP MOC.

Staff structure

Staff roles and responsibilities, including oversight, for administrative and clinical, include:

- Description of how staff responsibilities coordinate with the job title as defined in MOC
- Description of contingency plans used to address ongoing continuity of critical staff functions

MOC training

Policies define the process for conducting, documenting, monitoring and communicating the information for initial and annual MOC training for new and existing employees. Organizations are encouraged to utilize UnitedHealthcare training; however, if the organization does not, it must supply an employee list documenting the full name and date of completion.

- Process for training, storage, communication and maintenance of records
- Point of contact for ongoing communication
- Documentation of professional credentials evidenced in care system
- Describes actions if staff does not complete
- Requires new employee completion of training within 30 calendar days of employment

UnitedHealthcare training courses are located at **UHCprovider.com/training**.

Assessing and coordinating care

Assess and coordinate care by administering a comprehensive assessment, developing Individualized Care Plans (ICP) and developing appropriate interdisciplinary care teams (ICT) for members referred to as the HRA, if delegated.

The HRA must include a comprehensive initial assessment and reassessment of the medical, psychosocial, cognitive, functional and mental health needs of the member. The initial HRA must be conducted 90 days before or after the enrollment effective date and annually thereafter.

If delegated to complete the HRA, the MOC must include how:

- The HRA is used to develop and update the ICP for each beneficiary
- The HRA information is conducted and communicated and used by the ICT
- Professional credentials are evidenced in care system documentation
- Detailed plan and rationale for reviewing, analyzing and stratifying (if applicable) the HRA results

If not delegated to complete the HRA, you must have a process that allows ingestion of information, such as a file feed, into the system or access to the UnitedHealthcare ICUE or LINK: Care Conductor.

Individual Care Plan

The organization completes an ICP for each member in accordance with its MOC and develops a comprehensive plan that addresses the needs of the member identified through the HRA. The ICP must show evidence of the goals and objectives identified in the HRA, as well as measurable outcomes with dates and frequency of visits documented.

Interdisciplinary care team

An ICP must be developed and implemented through an ICT that works in collaboration with the member to identify goals and objectives. The organization develops an appropriate ICT by including practitioners and staff with the proper clinical expertise, as defined in the MOC, to manage the ICP and address the member's health needs.

Face to face encounters

The organizations policy should outline how face to face (F2F) encounters are conducted between the member and their care team to ensure full compliance to meet the Jan. 1, 2024, CMS regulation requirements.

Administrative process

Policy describes process for selecting and evaluating personnel involved in member care and coordination across all health care settings, practitioners, providers and services assures continuity of care. Policy should address staff and professional credentials, in accordance with the MOC, and documentation that demonstrates the member care was managed by the ICT.

Transition of Care

The organization demonstrates in their policy and procedures how continuity of care is provided to members as defined in the MOC by developing and implementing care transition protocols. Policies should include:

1. Use of care transition protocols to maintain continuity of care for SNP beneficiaries
2. Personnel responsible for coordinating the care transition process
3. Process for transferring elements of the beneficiary's ICP between health care settings when the beneficiary experiences an applicable transition in care
4. Informing beneficiaries how to access personal health information to facilitate communication with providers in other healthcare settings
5. Educating beneficiary and/or caregiver(s) on the beneficiary's health status to foster appropriate self-management activities
6. Informing the beneficiary and/or caregiver(s) about the point of contact throughout the transition process

Vendor support for SNP management of care

The organization may use a contracted vendor(s) to assist in SNP management of care. The organization's MOC outlines the process to confirm that the vendor's policies and procedures align with the organization's goals and CMS requirements.

SNP Provider Network

The SNP Provider Network is a network of specialized health care providers who are contracted to provide health care services to SNP beneficiaries. Policies and procedures will provide evidence of the how the organization's MOC engages the SNP Provider Network. MOC training for the provider network should be described in a policy that outlines the oversight of the network.

Quality Improvement Program

The Quality Improvement Program outlines the process for monitoring and evaluating the effectiveness of the MOC through the collection of data, performance evaluation and evidence of acting on identified opportunities.

Monitoring and evaluating the MOC

Reports and materials demonstrate the effectiveness of its MOC, measured through the collection, aggregation, analysis and reporting of data that may include, but is not limited to, access to care, improvement in health status, staff implementation of the SNP MOC, ICP, provider network, delivery of services across the continuum, extra services and benefits that target specific needs of vulnerable populations, use of evidence-based practice guidelines, and use of integrated systems communications. Policies must demonstrate the process for developing the SNP program quality performance improvement plan.

Measurable goals and health outcomes for the SNP Program

Written policies must provide evidence of the process for their Measurable Goals and Health Outcomes for their SNP program as outlined in the NCQA Standards.

SNP Program member satisfaction

Written policy must provide evidence of the process for measuring patient experience of care as outlined in the NCQA Standards.

Ongoing performance improvement evaluation of the SNP Program

Must provide evidence of the process for their ongoing performance improvement evaluation of the SNP Program.

SNP Program

SNP Program description must describe:

1. How the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the SNP Program
2. How the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality
3. The organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the SNP Program performance evaluation
4. How the performance improvement evaluation of the SNP Program will be documented and shared with key stakeholders

Communication of quality improvement performance

Must outline the process for the dissemination of the SNP program quality performance as outlined in the NCQA standards.

State Medicaid Agency Contract (SMAC)
D-SNP only

Must outline the process for showing evidence how the D-SNP Delegate ensures they are compliant for the Annually Approved SMAC formal written agreement requirements between the MA organization and the State Medicaid agency. Policy must include documentation of roles and responsibilities outlined for each state(s) requirement for any applicable entity function for Clinical Care Management/Care Coordination, Utilization Management (UM) or Population Health Management (PHM) requirements.

Note: All above requirements are taken and paraphrased from NCQA requirements, Medicare Managed Care Manual, Chapter 5 Model of Care section, and the SMAC.

Clinical trials, experimental or investigational services

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

For capitated care providers, the member's health care provider is responsible for these tests, unless stated differently in your contract.

We only cover experimental/investigational services when they meet Medicare requirements. Delegates should not authorize or deny services and instead refer to one of the following:

Cancer Resource Services/Cancer Support Program Commercial

- **Phone: 1-866-936-6002**

Commercial

- **Fax:** 1-855-250-8157

Medicaid

- **Fax:** 1-877-814-0488

Medicare and Dual Special Needs

- **Fax:** 1-855-250-7278 and 1-877-814-0488

For all other clinical trials, contact the prior authorization department. Visit **UHCprovider.com** > Sign In > Prior Authorizations or connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Delegates on the NICE platform may also visit **UHCprovider.com** > Sign In > Prior Authorizations to submit carve-out services as a prior authorization submission, outlining commercial clinical trials request.

Looking for more information on clinical trials?

You can find additional information and requirements in the **Clinical trials, experimental or investigational services** section in **Chapter 7: Medical management**.

Commercial radiation therapy

(Commercial, for services carved out of capitation)

Certain radiation therapy services require prior authorization. Use the Prior Authorization and Notification tool at **UHCprovider.com** > Sign In > Prior Authorizations. You may also initiate your request by calling (only where telephonic submission is permitted): **1-888-397-8129** (8 a.m.–5 p.m. local time Monday–Friday).

Prior authorization staff will not process the request or decide until they receive all necessary information from the medical group/IPA. They make a decision and contact the medical group/IPA within the correct time frame compliant with state and federal law.

We authorize radiation therapy services following the member's benefit design, provided the member has not exceeded their benefit restrictions.

Looking for more information on radiation therapy?

Go to:

1. The UnitedHealthcare Provider Portal by clicking the Sign In button in the top right corner of **UHCprovider.com**
   - Go to Prior Authorization and Notification and select the Submission and Status link under the Radiology, Cardiology and Radiation Oncology section
   - Select service type Radiation Oncology
2. **UHCprovider.com/policies** > **For Commercial Plans** > Select Reimbursement Policies or Medical & Drug Policies for UnitedHealthcare Commercial Plans

Pharmacy

Pharmacy information and requirements for commercial and MA plans are in **Chapter 8: Specialty pharmacy and Medicare Advantage pharmacy**.

Medications not covered under capitation (Medicare Advantage)

We may delegate decisions to authorize specific pharmacy services based on your Agreement.

A member or health care provider may request authorization from you for medication carved out of your Agreement terms. Notify the member you are not responsible for the authorization of these services. Recommend the member refer to any Part D coverage they may have.

Prior authorization is necessary for payment to be processed

The medical group/IPA must request prior authorization for select drugs. Get prior authorization forms on **UHCprovider.com/priorauth** or by contacting your health care provider advocate or clinical contacts at UnitedHealthcare. Our staff will not process the request until we receive all necessary information. Once we make a determination, we notify you within the correct time frame compliant with state and federal law.

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

We fax the approval or denial back to you. For denials, we send a letter to the member and health care provider stating why we denied the requested medication. The letter outlines the process for filing standard and expedited appeals.

Prior authorization process for medications carved out of capitation

If UnitedHealthcare has financial responsibility for medications currently covered under the commercial member's medical benefit, this policy applies to those medications listed in your Agreement.

UnitedHealthcare uses a prior authorization process to review any medication carved out of capitation.

We review the administration of these medications for compliance with the National Comprehensive Cancer Network's Drugs & Biologics Compendium® (NCCN Compendium®) recommended uses for the drug, as it pertains to treatment regimen and/or line of therapy. Non-compliant services are not eligible for coverage or payment reimbursement by UnitedHealthcare. If the medical group/IPA does not receive prior authorization from us before administering these drugs, we deny reimbursement. This policy does not apply to bevacizumab (Avastin®) used for non-oncological indications.

Prescription drug appeals process

Members may initiate an appeal for coverage of a prescription drug if the initial determination is adverse to them. They may start an appeal in the following circumstances:

- The requested drug is not on the formulary
- The drug is not considered medically necessary
- The drug is furnished by an out-of-network provider pharmacy
- The drug is not a drug for which Medicare will pay under Part D
- A coverage determination is not provided in a timely manner
- The delay would adversely affect the health of the member
- A request for an exception is denied
- The member is dissatisfied with a decision regarding the copayment required for a prescription drug

Facilities

Notification requirements for facility admissions (delegated health care providers in shared risk groups)

Contracted facilities must provide timely notification to both the delegate and UnitedHealthcare within 24 hours of admission for all inpatient and observation status cases. This includes changes in level of care that affect billing category.

For maternity cases, provide notification before the end of the mandated period (48 hours for normal vaginal delivery or 96 hours for C-section delivery). We require notification if the newborn stays longer than the mother does. In all cases, we require separate notification immediately when a newborn is admitted to the NICU.

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

UnitedHealthcare and the medical group/IPA require timely notification of admission so we can verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning.

For emergency admissions, provide notification once the member's condition is stabilized in the emergency department. For timely and accurate payment of facility claims, we require proper notification on the day of admission.

Authorization log and denial log submission (delegated health care providers in shared risk groups only)

Submit authorization logs for all inpatient acute, observation status, SNF cases and denial logs at least twice a week to the Authorization Log Unit at **clinicaloperations@uhc.com** or EDI transmission.

We also require specific markets to submit outpatient prior authorization and denial logs to include services where UnitedHealthcare pays claims or where UnitedHealthcare is financially responsible for the services rendered. For new submitters, arrange a log delivery schedule with the Authorization Log Unit prior to the first submission.

The Authorization Log Unit must agree in writing and in advance with changes to your submission schedule. Any medical group/IPA undergoing a system change or upgrade that may affect delivery of authorization logs must notify the Authorization Log Unit prior to change date and work with us to help ensure a seamless transition.

Logs must be compliant with state and federal regulations and include all concurrent IP and SNF admissions between the previous and current log submission:

- Cases generated upon admission
- Length of stay changes/extensions
- Discharged cases
- Submit completed outpatient authorization cases on a separate log:
  - If there are no applicable cases to report, the medical group/IPA must submit a weekly authorization log indicating either no activity or no admissions for each of the designated admission service types for the applicable reporting time
- Logs must include the following:
  - Member name
  - Member ID
  - Member date of birth
  - Reason for denial
  - Authorization/reference number
  - Requesting health care provider (name, address, TIN or NPI)
  - Attending/servicing health care provider (name, address, TIN or NPI)
  - Facility health care provider (name, address, TIN or NPI)
  - Admitting diagnosis (ICD-10-CM or its successor code)
  - Actual admission date
  - Actual discharge date
  - Status (approved/denied)
  - Service start date

- Service end date
- Clearly defined level of care description (i.e., Acute IP, mental health, acute rehabilitation, LTAC, skilled nursing, observation, outpatient procedures at acute facilities, codes must be submitted with descriptions of LOC)
- Approved length of stay (number of days)
- Denied length of stay (number of days)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Planned admission date
- Planned discharge date
- Service type
- Medical group/IPA
- Insurance (Commercial/Medicare)

The medical group/IPA must have a clearly defined process for determining medical necessity and authorizing outpatient services. These services are paid as either shared risk or plan risk per the medical group/IPA contract.

The medical group/IPA must be capable of submitting, pursuant to our request, authorization or denials for all shared risk or plan risk services for which the group has authorized or denied care on behalf of UnitedHealthcare.

Medical observation

Typically, observation status rules out a diagnosis or medical condition that responds quickly to care. Facility observation status is generally designed to assess a member's medical condition to determine the need for inpatient admission, or to stabilize a member's condition. UnitedHealthcare or our delegate will authorize facility observation status when medically indicated and the case meets nationally recognized evidenced-based guidelines. A member's outpatient observation status may later be changed to an inpatient admission, if medically necessary and appropriate criteria have been met.

We expect our medical management delegates to support compliance with the review of criteria. The delegated medical group/IPA must issue a facility denial when the inpatient stay does not meet nationally recognized evidence-based guideline. This happens when:

1. It receives notification of the admission
2. It receives a post-service request for admission authorization prior to claims submission. It determines the admission does not meet medical necessity criteria, including relevant Medicare inpatient admission requirements and is not on the CMS list of HCPCS codes that would be paid only as inpatient procedures.
3. There is no inpatient order matching the date of the inpatient admission for Medicare members

Facility denial process

When we delegate services for authorization and concurrent review, we expect the delegate to issue a facility denial letter to the contracted facility when the facility's medical record or claim fails to support the LOC or services rendered. This may be determined through concurrent or retrospective review.

There are 3 types of facility denial letters:

- Delay in inpatient services
- Delay in change of LOC within the same facility
- Delay in facility discharge

The delegated medical group/IPA must comply with our protocols, policies and procedures for denials. This includes turnaround times for issuing, delivering and submitting facility denial letters to UnitedHealthcare.

When UnitedHealthcare is responsible for paying facility services, the delegated medical group/IPA must comply with the UnitedHealthcare protocols, policies and procedures for submitting facility denial letters to

UnitedHealthcare. Whether a denial is issued by UnitedHealthcare or its delegate, the UnitedHealthcare care provider dispute resolution process manages any facility disputes.

If the delegated medical group/IPA is responsible for paying inpatient facility services, then the delegate need not submit copies of facility denials to UnitedHealthcare. Facility denials are sent to the facility and must specifically exclude the member from liability for the denied LOC and/or services. Under these circumstances, the delegated medical group's/IPA's health care provider dispute resolution process manages any health care provider facility disputes.

Delegate must provide a copy of the facility denial letter to the member, if requested.

Radiation therapy services (Medicare Advantage)

(For services carved out of capitation)

This policy applies if UnitedHealthcare has financial responsibility for the following outpatient MA services. Prior authorization is required for certain radiation therapy services.

We use National Coverage Decision (NCD), Local Coverage Decision (LCD) and UnitedHealthcare medical policies and guidelines to determine eligibility of coverage. We require authorization before the start of therapy and each time a member starts a new treatment regimen.

Prior authorization required to process payment

Initiate a prior authorization request for outpatient radiation therapy services carved out of capitation on **UHCprovider.com** > Sign In > Prior Authorizations. We do not process the request or make determination until we have received all necessary information. Then we make a decision within the correct time frame compliant with state and federal law.

We authorize radiation therapy services based on the member's benefit design, provided the member does not exceed their benefit restrictions.

UnitedHealthcare may, at its sole discretion, use a nationally contracted vendor for utilization management to administer the prior authorization program for all radiation therapy services. The nationally contracted vendor uses the NCDs, LCDs and the UnitedHealthcare MA medical policies for managing the program.

For a list of CPT and HCPCS codes requiring authorization, refer to **UHCprovider.com/priorauth** > **Advance notification** > UnitedHealthcare Medicare Advantage, UnitedHealthcare West Medicare Advantage, and UnitedHealthcare Dual Complete / Peoples Health Prior Authorization Requirements.

Denials, delays or adverse determinations

Delegates that receive requests for services must make decisions and provide notification within applicable regulatory and accreditation time frames. We hold the delegate to the most stringent requirements for approvals, extensions of decision turnaround times, denials, delays, partial approvals and modification of requested services.

Find additional information in the **Medical management denials/adverse determinations** section in **Chapter 7: Medical management**.

Qualifications of who can deny or make adverse determinations

Only physicians or appropriately licensed clinical personnel can deny or make adverse determinations based on medical necessity. This reviewer may be a physician, doctoral level clinical psychologist or pharmacist as appropriate to the requested service.

The reviewer must have a current unrestricted license. Delegates must provide evidence of verification according to credentialing requirements.

For MA, the delegate must verify the reviewer has experience showing knowledge of Medicare coverage criteria. Evidence of verification may include content of curriculum vitae, training as part of onboarding process, training after onboarding, or interaction between our medical director and the delegate's reviewers. Evidence may also include review of denial records or files indicating appropriate use of criteria applicable to the request for services and member's condition.

Oral or verbal notification

We have various requirements for oral or verbal notification of approvals or denials. These may vary from state to state or by request type (such as preservice, expedited or concurrent). The delegate must document efforts to provide oral notification and meet written notification requirements as well.

Written denial notice

The written denial is an important part of the member's chart and the delegate's records. Regardless of the form used, the denial letter documents member and health care provider notification of:

- The denial, delay, partial approval or modification of requested services
- The reason for the decision, including medical necessity, benefits limitation or benefit exclusion
- Member-specific information about how the member did not meet criteria
- Appeal rights
- An alternative treatment plan, if applicable
- Benefit exhaustion or planned discharge date, if applicable

CMS requires the use of the CMS Integrated Denial Notice (IDN) for MA and Medicaid plan members. Do not alter this template except to add text to the requested areas.

Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare provides appropriate and approved templates to the delegates.

Minimum content of written or electronic notification

A notice to deny, delay or modify a health care services authorization request must include:

- The requested services
- A reference to the benefit plan provisions to support the decision
- The reason for denial, delay, modification or partial approval, including:
  - Clear, understandable explanation of the decision
  - Name and description of the criteria or guidelines used
  - How those criteria were applied to the member's condition
- A statement the member can get a free copy with the benefit provision, guideline, protocol or other criterion used to make the denial decision
- Contractual rationale for benefit denials
- Alternative treatments offered, if applicable
- A description of additional information needed to complete that request and why it is necessary (for delay of decision)
- Appeal and grievance processes, including:
  - When, how and where to submit a standard or expedited appeal
  - The member's right to appoint a representative to file the appeal
  - The right to submit written comments, documents or other additional relevant information
  - The right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable

- The name and phone number of the health care professional responsible for the decision included in the health care provider's notice. This is not required in the member's notification
- Any state-mandated language (commercial)
- ERISA information as applicable (commercial)
- Ombudsman information (commercial)

Find address and contact information for medical management appeals in the **Online resources and how to contact us** table in **Chapter 1: Introduction**, or similar tables in the applicable supplement.

CMS reasonable outreach

For information regarding reasonable outreach, refer to cms.gov

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

The MOC is the framework for care management processes and systems that enable coordinated care for SNP members. The MOC includes descriptions of the following:

- SNP population (including health conditions)
- Care coordination
- Provider network
- Quality measurement
- Performance improvement

The MOC helps ensure the unique needs of the population are identified and addressed through care management practices. We evaluate MOC goals on an annual basis to determine effectiveness.

To learn more, contact us at **snp_moc_providertraining@uhc.com**.

CMS requires initial and annual SNP MOC training for all providers who treat SNP members. The training is reviewed and uploaded annually to ensure that it reflects current practices related to the core MOC elements in the preceding list. The Annual SNP MOC Provider Training is available at **UHCprovider.com/training**. Updates about the annual training can be found at **UHCprovider.com/news**. To receive news updates by email, sign up at **UHCprovider.com/subscribe**.

Delegation of complex case management and disease management

We may delegate the functions of complex case management (CCM) or disease management. Requirements are based on Population Health Management NCQA accreditation standards.

If these functions are delegated to a medical group/IPA or other organization, we conduct pre-contractual and post-contractual assessments. If assessments identify deficiencies, we require delegates to undergo improvement action. The oversight process mirrors the delegation oversight process for medical management.

If these functions are not delegated to a medical group/IPA or other organization, you can refer members by submitting an Optum Universal Referral form to **provider_referral@optum.com**.

Nondiscrimination taglines for Section 1557 of the Affordable Care Act

The U.S. Department of Health and Human Services published final nondiscrimination rules from Section 1557 of the Affordable Care Act. The final rule clarifies and codifies existing nondiscrimination requirements and sets standards for including nondiscrimination notices on significant communications sent to health plan members. This includes member-facing letters (e.g., IDN, NOMNC, service denials), documents, notices, newsletters and brochures sent to the member.

April 2020: Medicare Tagline guidelines

To align with our clinical practices, delegates may use the short tagline for all significant written communications, regardless of length, to all UnitedHealthcare Medicare members.

Please note the following:

- Using the short tagline is not a requirement, but an option to align with UnitedHealthcare clinical practices
- You may continue to use the long taglines if it suits your clinical operations for communications of any length

Claim delegation oversight

Pre-contractual claim delegation assessments

We may delegate claims processing to entities that have requested delegation and have shown through a pre-delegation assessment they are capable of processing claims compliant with applicable state and/or federal regulatory requirements, and UnitedHealthcare requirements for claim processing.

Delegated entities must develop and maintain claims operational and processing procedures that allow for accurate and timely claim payments. Procedures must properly apply benefit coverage, eligibility requirements, appropriate reimbursement methodology and meet all applicable state and/or federal regulatory requirements, and health plan requirements for claim processing.

Medical claim review (delegated medical groups/IPAs)

A delegated medical group/IPA must implement and maintain a post-service/retrospective review process consistent with UnitedHealthcare processes.

We define a post-service/retrospective/medical claim review as the review of medical care treatments, medical documentation and billing after the service has been provided.

We perform a medical claim review to provide fair and consistent means to review medical claims and confirm delegates meet the following criteria:

- Medical necessity determinations
- Admission, length of stay and LOC are appropriate
- Eligibility was verified
- Follow-up for utilization, quality and risk issues was needed and initiated
- Billing is correct
- Claims-related issues as they relate to medical necessity and UnitedHealthcare claims payment criteria and/or guidelines are identified and resolved

We also perform medical claim reviews on claims that do not easily allow for additional focused or ad-hoc reviews, such as:

- High-dollar claims
- Claims without required authorization
- Claims for unlisted procedures
- Trauma claims
- Implants not identified on our implant guidelines used by our claim department
- Claim check or modifier edits based on our claim payment software
- Foreign claims
- Claims with level of service or LOC mismatch

The delegated medical group/IPA is accountable for conducting the post-service review of emergency department claims and unauthorized claims. Review presenting symptoms, as well as the discharge diagnosis, for emergency services.

Post-contractual claim delegation assessments

We have policies and procedures designed to monitor the performance of delegated entities' compliance with contractual, state, federal and UnitedHealthcare claims processing requirements. Our auditors perform ongoing claims processing compliance monitoring in addition to comprehensive operational assessments, which typically occur on an annual basis. Our auditors also review for:

- Assessment results indicating noncompliance
- Self-reported timeliness reports indicating noncompliance for 2 consecutive months
- Noncompliance with reporting requirements
- Lack of resources or staff turnover
- Overall performance trends (claims appeal activity, claims denial letters or member and health care provider claims-related complaints)
- Allegations of fraudulent activities or misrepresentations
- Information systems changes or conversion
- New management company or change of processing entity
- Established Management Service Organization (MSO) acquires new business
- Significant increase in members or volume of claims
- Regulatory agency request
- Significant issues concerning financial stability
- Timely implementation of material and/or system change requests
- Timely response to attestation requirements

As part of our ongoing claims processing performance monitoring, we require all delegated entities to submit a monthly claims activity report containing all processed claims during the month in addition to a claims data extract file of all pended (open) claims inventory as of close of business on the last day of the month. These files must be in the format defined by us and are due by the 15th calendar day of the following month. The delegates may be subject to the implementation of a Remediation Plan and/or financial consequences if it or any subdelegated entity fails to submit or meet the data requirements as outlined here in this guide and/or the delegates contractual agreement with UnitedHealthcare. As part of our comprehensive operational compliance audit, we may request additional claims reporting to facilitate our review. The auditor reviews the claims data and selects random claims for further review. The delegated entity must be ready for the auditor at the time of audit. Our procedures include an audit of the entire claims cycle, which includes validation/verification of the claim date received, acknowledged, processed and closed, and a virtual walk-through of the delegated entity's end-to-end claim operations is conducted. During our procedures we review:

- Claims timeliness audit for applicable claim element being reviewed
- Financial accuracy (including, but not limited to, proper benefit application, appropriate administration of member cost-share accumulation)
- Administrative accuracy
- Customer denial accuracy and denial letter review
- Health care provider denial audit
- Noncontracted and contracted health care provider payment dispute resolution (overturns and upholds) claims audit
- Fraud, waste and abuse inspection
- Claim operational policies and procedures
- Maximum out-of-pocket administration
- Timely forwarding of misdirected claims
- Significant decrease in membership and/or claim volume

Non-compliant audits

Either our ongoing operational monitoring or audits may reveal that a delegated entity is not compliant with contractual state and/or federal regulations, and/or UnitedHealthcare standards for claims processing.

Problems include, but are not limited to:

- Processing timeliness issues
- Failure to pay interest or penalties
- Failure to submit monthly/quarterly self-reported processing timeliness reports
- Canceling assessments/audits
- Failure to submit requested claims listings
- Failure to have all documentation ready for a scheduled assessment
- Failure to provide access to canceled checks or bank statements
- Failure to submit accurate reporting

When we put a delegated entity on a Remediation Plan, we place them on a remediation period. A remediation period is the time frame we give a delegated entity to demonstrate compliance. The remediation period is typically 30 to 60 days depending on the severity of the deficiency. The delegate must provide a remediation plan describing how the deficiencies will be corrected and the time frame to complete those efforts. We conduct frequent reviews during the remediation period to ensure progress is being made. Should the delegate fail to meet the compliance requirements, UnitedHealthcare Delegation Oversight will deploy its Claims Management Consulting Services (CMCS) to assist with remediation efforts. CMCS may consist of conducting an on-site or virtual operational assessment, frequent oversight, engagement and monitoring. We bill the delegated entity for all CMCS activities involving the remediation of the Remediation Plan. UnitedHealthcare will charge the delegate for all CMCS activities with an initial fee of $2,500 plus $100/hour for the first month of the Remediation Plan and $250/hour after the first month of the Remediation Plan until the Remediation Plan is closed.

If CMCS activities do not successfully correct the issues, additional actions such as revocation of delegation status and/or enrollment freezes may occur. In addition, notwithstanding the previously mentioned, UnitedHealthcare reserves the right to cancel the contract as defined in the Agreement.

Claim denial letters

When a delegated entity receives a claim for a commercial or MA member, they must assess the claim for the following before issuing a denial letter:

- Member's eligibility status with UnitedHealthcare on the date of service
- Responsible party for processing the claim (forward to proper payer)
- Contract status of the health care provider of service or referring health care provider
- Presence of sufficient medical information to make a medical necessity determination
- Covered benefits
- Authorization for routine or in-area urgent services
- Maximum benefit limitation for limited benefits
- Prior to denial for insufficient information, the medical group/IPA/capitated facility must document their attempts to get information needed to make a determination

Member denials

When a member is financially responsible for a denied service, UnitedHealthcare or the delegated entity (whichever holds the risk) must provide the member with written notification of the denial decision based on federal and/or state regulatory standards.

For MA members, the delegated entity must issue a member denial notice within the appropriate regulatory time frame.

The delegated entity must use the most current CMS-approved Notice of Denial of Payment letter template. The letter must accurately document the service health care provider, the service provided, the denial reason, the member's appeal rights and instructions on how to file an appeal.

For commercial members enrolled in a benefit plan subject to ERISA, a member's claim denial letter must clearly state the reason for the denial and provide proper appeal rights. The denial letter must be issued to the member within 30 calendar days of claim receipt.

For all other commercial plans, the denial letter must comply with applicable state regulatory time frames. For instance, in CA, denial letters must be sent within 45 working days.

The delegated entity remains responsible to issue appropriate denials for member-initiated, non-urgent/emergent medical services outside their defined service area. For all members, the delegated entity must use the most current Language Access Plan document to accompany the denial letter.

Health care provider denials

When the member is not financially responsible for the denied service, the member does not need to be notified of the denial. The health care provider must receive notification of the denial and their financial responsibility (i.e., writing the charges off for the claims payment).

UnitedHealthcare or the delegated entity's claims department (whichever holds the risk) is responsible for providing the notification.

The denial notice (letter, EOP or PRA) issued to any noncontracted health care provider of service must state:

1. Their appeal rights
2. The member is not to be balance billed

When the member has no financial responsibility for the denied service, the denial notice issued to any health care provider of service must clearly state the member is not to be billed for the denied or adjusted charges.

Time limits for filing claims

For commercial claims, submit clean claims per the time frame listed in your Agreement or per applicable laws. We, or our capitated care provider, allow at least 90 days for participating health care providers. For commercial plans, we allow up to 180 days for nonparticipating health care providers from the date of service to submit claims. For MA plans, we are required to allow 365 days from the through date of service for noncontracted health care providers to submit claims for processing. If we, or our capitated provider, are not the primary payer, we give you at least 90 days from the day of payment, contest, denial or notice from the primary payer to submit the claim.

If a network care provider fails to submit a clean claim within the outlined time frames, we reserve the right to deny payment for such claim. You cannot bill a member for claims denied for untimely filing. We have established internal claims processing procedures for timely claims payment to our health care providers.

Timely filing

The claims timely filing limit is the calendar day period between the claims last date of service or payment/denial by the primary payer, and the date by which UnitedHealthcare, or its delegate, receives the claim.

Determination of the date of UnitedHealthcare or its delegate's receipt of a claim, the date of receipt shall be regarded as the calendar day when a claim, by physical or electronic means, is first delivered to the UnitedHealthcare specified claims payment office, post office box, designated claims processor or to the UnitedHealthcare capitated health care provider for that claim. We use the following date stamps to determine date of receipt:

- UnitedHealthcare HMO claims department date stamp primary payer claim payment/denial date as shown on the Explanation of Payment (EOP)
- Delegated health care provider date stamp
- Third-party administrator date stamp

- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender
- Electronic date stamp

MA claims must use the oldest received date on the claim. Refer to the official CMS website for additional rules and instructions on timely filing limitations.

For commercial claims, refer to the applicable official state-specific website for additional rules and instructions on timely filing limitations.

Date stamp

Delegated entities must have a clearly identifiable date stamp for all claims they receive. Electronic claims date stamps must follow federal and/or state standards.

Date of receipt and date of service

Date of receipt means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the UnitedHealthcare capitated health care provider for that claim.

Date of Service, for the purposes of evaluating claims submission and payment requirements, means:

- **For outpatient services and all emergency services and care** – the date the health care provider delivered separately billable health care services to the member
- **For inpatient services** – the date the member was discharged from the inpatient facility. However, UnitedHealthcare or the capitated health care provider must accept separately billable claims for inpatient services at least biweekly.

Improvement Actions Plan (IAP)

UnitedHealthcare is responsible for establishing and maintaining adequate internal controls over delegates to comply with its contracts with the CMS, applicable federal laws, applicable state laws and/or UnitedHealthcare standards depending which lines of business are delegated. UnitedHealthcare will work with the delegate to monitor that the controls over timeliness, accuracy, completeness and performance are occurring, timely and effectively.

The delegate may be subject to the implementation of an IAP and/or financial consequences if it or any sub-delegated entity fails to submit or meet the requirements as outlined here in this guide and/or the delegate's contractual agreement with UnitedHealthcare.

In the event a delegate is not meeting any one of the performance standards, we will send a formal notification, a "warning letter," to the delegate and initiate a cure period. The cure period is the time frame we give the delegated entity to demonstrate compliance. The cure period could be 30 to 60 days depending on the severity of the deficiency. If the delegate fails to remediate within the defined cure period, UnitedHealthcare will send a formal notification with notice of an IAP. UnitedHealthcare may implement financial penalties and **UnitedHealthcare may** charge the delegate for IAP support activities until the IAP is closed. UnitedHealthcare will work with the delegate to develop and implement an IAP in conjunction with the health plan findings that will include but is not limited to:

- Root cause analysis
- Detailed work plan(s) to address identified action items
- Metrics to measure progress and completion
- Identified stakeholders
- Due dates
- Communication strategy

All IAPs shall be approved by the health plan.

Misdirected claims

UnitedHealthcare West (commercial and Medicare Advantage)

We identify and forward misdirected claims to the appropriate delegated entity following state and/or federal regulations. Note that UnitedHealthcare is transitioning to an entirely electronic method of forwarding claims, and delegates are expected to comply with these electronic intake requirements. Once electronic forwarding is available for the delegate, UnitedHealthcare will contact the delegate to begin onboarding. UnitedHealthcare will need to test the successful transfer of misdirected claims to the delegate's Payer ID(s). We expect the onboarding process to take no more than 6 months. Should you exceed the 6-month testing window without approval to move to sending production files, we may implement an IAP and possible financial penalties. If an IAP is implemented, UnitedHealthcare Data Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP and $250/hour after the first month of the IAP until the IAP is closed.

In order to adjudicate the claim properly, the delegate must ensure the division of financial responsibility is set up correctly and other information, including member eligibility, is updated timely.

If we forwarded a claim electronically in an EDI 837 format and that claim was rejected by the delegated entity or their designated clearinghouse/vendor, it will be the responsibility of the delegate to develop that claim with the submitter (billing/service provider) to ensure it is able to be logged and processed by the delegate's claim adjudication system.

If a delegate needs to change your Payer ID to which UnitedHealthcare should direct claims to, which could happen as the result of changing your clearinghouse or for various other reasons, the delegate must provide UnitedHealthcare 270 days advance notification, as outlined in the system/software upgrades, change in claims platforms, change to new clearinghouse section within this guide. UnitedHealthcare will need to test the successful transfer of misdirected claims to this new Payer ID. We expect this testing to take no more than 3 months. Should you exceed the 3-month testing window without approval to move to sending production files, we will implement an IAP and possible financial penalties. If an IAP is implemented, UnitedHealthcare Data Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP and $250/hour after the first month of the IAP until the IAP is closed.

If health care providers send claims to a delegated entity, and we are responsible for adjudicating the claim, the delegated entity must forward the claim to us within 10 working days of the receipt of the claim. Failure to comply with this requirement will lead to the implementation of a Remediation Plan and possible financial penalties.

The delegated entity must identify and track all claims billed to them received in error. Tracking must include, but is not limited to, the received date of the claim by the delegate, the date forwarded and the name of the entity where the claim was sent. The delegated entity must then forward the claims to the appropriate payer and follow state and/or federal regulatory time frames. When the claim is adjudicated, the delegated entity must notify the health care provider of service who the correct payer is, if known, using the EOP they give to the health care provider.

If you, the delegated entity, received a claim directly from the billing health care provider, and you believe that claim is the health plan's responsibility, forward it to your respective UnitedHealthcare Regional Mail Office P.O. Box, which is found on the back of the member's ID card. If the address on the back of the ID card is your (the delegate's) address, refer to the following table to identify where to send a copy of the claim along with any additional information received. If you are unsure which address is applicable, reach out to your health care Provider Advocate. For MA member claims only, include the timestamp of your original receipt date on the claim submission. If an electronic means of forwarding is available at a future date, UnitedHealthcare will notify the delegate of such and this will be our preferred means of forwarding. The delegate will be expected to comply with the electronic requirements as communicated by UnitedHealthcare.

State	Product	Address
Arizona	Medicare Advantage (MA)	P.O. Box 30965 Salt Lake City, UT 84130-0965
California	Commercial and MA	P.O. Box 30968 Salt Lake City, UT 84130-0968
	CALPERS commercial only	P.O. Box 30510 Salt Lake City, UT 84130-0510
Colorado	MA	P.O. Box 30983 Salt Lake City, UT 84130-0983
Nevada (For claims with dates of service prior to Dec. 31, 2022, only) UnitedHealthcare uses 2 delegated payers in Nevada. Refer to the member's ID card to confirm which delegate is assigned for that member's claims. All HMO claims are processed by delegated payers. Therefore, health care provider appeals are reviewed primarily by the delegated payer. Refer to the member's ID card to confirm which delegate is assigned for that member's claims.	MA	**Claim submission** • Intermountain Health P.O. Box 211375 Eagan, MN 55121 • OptumCare - NV P.O. Box 30539 Salt Lake City, UT 84130 **Rework and dispute resolution** • Intermountain Health P.O. Box 211375 Eagan, MN 55121 • OptumCare - NV P.O. Box 30539 Salt Lake City, UT 84130
Oregon (For claims with dates of service prior to Dec. 31, 2023, only)	MA	P.O. Box 30974 Salt Lake City, UT 84130-0974
Texas (For claims with dates of service prior to Dec. 31, 2023, only)	MA	P.O. Box 30975 Salt Lake City, UT 84130-0975
Washington (For claims with dates of service prior to Dec. 31, 2023, only)	MA	P.O. Box 30976 Salt Lake City, UT 84130-0976

Claim benefit category	Product	Address
Transplant member – services related to transplant	MA	Forward claim with cover sheet to: OptumHealth CMC P.O. Box 30758 Salt Lake City, UT 84130
Transplant member – non-transplant medical claim	MA	Forward claim with cover sheet to: UnitedHealthcare P.O. Box 31362 Salt Lake City, UT 84131
Behavioral	MA	Forward claim with cover sheet to: Optum Behavioral Health P.O. Box 30760 Salt Lake City, UT 84130
Supplemental dental (not covered by Medicare) **Note:** Submit Medicare-covered dental claims to the medical claims system.	MA	Forward claim with cover sheet to: UHC Dental P.O. Box 30567 Salt Lake City, UT 84130
Vision	MA	Forward claim with cover sheet to: UHC Vision P.O. Box 30978 Salt Lake City, UT 84130
Pharmacy	MA	Include OCN - received date stamp on the copy of the claim directly. Optum Rx ATTN: Escalated Claims P.O. Box 650287 Dallas, TX 75265-0287
Physical health (chiropractic, acupuncture, physical therapy, occupational therapy, speech therapy-related services)	MA	Forward claim with cover sheet to: Optum Physical Health - ACN P.O. Box 30525 Salt Lake City, UT 84130-0525
Hearing aids (hardware)	MA	Forward claim with cover sheet to: UnitedHealthcare P.O. Box 31362 Salt Lake City, UT 84131

Claim benefit category	Product	Address
Hearing screening	MA	Forward claim with cover sheet to: UnitedHealthcare P.O. Box 31362 Salt Lake City, UT 84131

If you, the delegate, receive a claim routed from UnitedHealthcare that you believe to be the financial responsibility of the health plan, and are requesting a reconsideration of the financial risk determination, please follow these instructions when submitting a financial risk reconsideration:

Please send the following documentation to:

P.O. Box 30984
Salt Lake City, UT 84130-0984

1. Copy of claim
2. Completed Misdirected Claim Returns to the Health Plan Coversheet which can be downloaded at **UHCprovider.com/claims** > Document and forms > **Misdirected claim returns to the health plan coversheets**
3. Explanation of why you, the delegate, believe the claim is not your responsibility, but is the health plan's responsibility. All fields must be completed on the template to be considered complete.

Non UnitedHealthcare West (Dual Special Needs Plans only)

We identify, batch and forward misdirected claims to the appropriate delegated entity, following state and/or federal regulations. Our preferred method of forwarding claims is electronically; however, claims may also be forwarded via secure email. Delegates are expected to comply with these intake methods.

In order to adjudicate the claim properly, the delegate must ensure the division of financial responsibility is set up correctly and other information, including member eligibility, is updated timely. If we forwarded a claim electronically in an EDI 837 format and that claim was rejected by the delegated entity or their designated clearinghouse/vendor, it will be the responsibility of the delegate to develop that claim with the submitter (billing/service provider) to ensure it is able to be logged and processed by the delegate's claim adjudication system.

If a delegate needs to change your Payer ID to which UnitedHealthcare should direct claims to, which could happen as the result of changing your clearinghouse or for various other reasons, the delegate must provide UnitedHealthcare 270 days advance notification, as outlined in the system/software upgrades, change in claims platforms, change to new clearinghouse section within this guide. UnitedHealthcare will need to test the successful transfer of misdirected claims to this new Payer ID. We expect this testing to take no more than 3 months. Should you exceed the 3-month testing window without approval to move to sending production files, we will implement an IAP and possible financial penalties. If an IAP is implemented, UnitedHealthcare Data Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP, and $250/hour after the first month of the IAP until the IAP is closed.

If you, the delegated entity, received a claim directly from the billing health care provider, and you believe that claim is the health plan's responsibility, forward it to your respective UnitedHealthcare Regional Mail Office P.O. Box, which is found on the member's ID card.

If the address on the back of the ID card is your (the delegate's) address, refer to the following table to identify where to send a copy of the claim along with any additional information received. Include the timestamp of your original receipt date on the claim submission. Please forward your claim to the respective addresses noted below, with the required information.

State claim benefit category product address

Texas: All claims except dental D-SNP
UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5270

Texas
Dental D-SNP
P.O. Box 2061
Milwaukee, WI 53201

Non-UnitedHealthcare West (Medicare Advantage and Dual Special Needs Plans)

When a claim has been determined to be the responsibility of the delegate, we will issue to the billing provider a provider remittance advice (PRA) or 835 when billing provider associated with the claim is enrolled for 835, informing them their claim has been forwarded to another entity. Claim charges that are determined to be the responsibility of the delegate will reflect a disallow remark code (PRA), or CARC/RARC (835), explaining that the claim was forwarded to the delegate and payer ID associated with the delegated entity. We forward misdirected claims to the proper payer following federal regulations.

Our preferred method of forwarding claims is electronically; however, claims may also be forwarded via secure email. Delegates are expected to comply with these electronic intake requirements.

In order to adjudicate the claim properly, the delegate must ensure the division of financial responsibility is set up correctly and other information, including member eligibility is updated timely.

If we forwarded a claim electronically in an EDI 837 format and that claim was rejected by the delegated entity or their designated clearinghouse/vendor, it will be the responsibility of the delegate to develop that claim with the submitter (billing/service provider) to ensure it is able to be logged and processed by the delegate's claim adjudication system.

If a delegate needs to change your Payer ID to which UnitedHealthcare should direct claims to, which could happen as the result of changing your clearinghouse or for various other reasons, the delegate must provide UnitedHealthcare 270 days advance notification, as outlined in the system/software upgrades, change in claims platforms, change to new clearinghouse section within this guide. UnitedHealthcare will need to test the successful transfer of misdirected claims to this new Payer ID. We expect this testing to take no more than 3 months. Should you exceed the 3-month testing window without approval to move to sending production files, we will implement an IAP and possible financial penalties. If an IAP is implemented, UnitedHealthcare Data Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP, and $250/hour after the first month of the IAP until the IAP is closed.

If health care providers send claims to a delegated entity, and we are responsible for adjudicating the claim, the delegated entity must forward the claim to us within 10 working days of the receipt of the claim. Failure to comply with this requirement will lead to the implementation of an IAP and possible financial penalties.

The delegated entity must identify and track all claims billed to them received in error. Tracking must include, but is not limited to, the received date of the claim by the delegate, the method the claim was received by the delegate (paper or EDI), the date forwarded and the name of the entity where the claim was sent.

The delegated entity must then forward the claims to the appropriate payer and follow state and/or federal regulatory time frames. When the claim is adjudicated, the delegated entity must notify the health care provider of service who the correct payer is, if known, using the EOP they give to the health care provider. The delegated entity must identify and track all claims billed to them received in error. Tracking must include, but is not limited to, the following relevant information:

1. The name of the entity to which the claim was sent
2. The received date of the claim by the delegate, and the date sent/mailed (date of forwarding the misdirected claim)

The delegated entity must then forward the claims to the appropriate payer and follow federal regulatory time frames. When the claim is adjudicated, the delegated entity must notify the health care provider of service who the correct payer is, if known, using the EOP they give to the health care provider.

In order to adjudicate the claim properly, the delegate must ensure the division of financial responsibility is set up correctly and other information, including member eligibility is updated timely. If we forwarded a claim electronically in an EDI 837 format and that claim was rejected by the delegated entity or their designated clearinghouse/vendor, it will be the responsibility of the delegate to develop that claim with the submitter (billing/service provider) to ensure it is able to be logged and processed by the delegate's claim adjudication system.

If a delegate needs to change your Payer ID to which UnitedHealthcare should direct claims to, which could happen as the result of changing your clearinghouse or for various other reasons, the delegate must provide UnitedHealthcare 270 days advance notification, as outlined in the system/software upgrades, change in claims platforms, change to new clearinghouse section within this guide. UnitedHealthcare will need to test the successful transfer of misdirected claims to this new Payer ID. We expect this testing to take no more than 3 months. Should you exceed the 3-month testing window without approval to move to sending production files, we will implement an IAP and possible financial penalties. If an IAP is implemented, UnitedHealthcare Data Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP, and $250/hour after the first month of the IAP until the IAP is closed.

If you, the delegated entity, received a claim directly from the billing health care provider, and you believe that claim is the health plan's responsibility, forward it to your respective UnitedHealthcare Regional Mail Office P.O. Box, which is found on the member's ID card.

If the address on the back of the ID card is your (the delegate's) address, refer to the following table to identify where to send a copy of the claim along with any additional information received. Include the timestamp of your original receipt date on the claim submission. Please forward your claim to the respective addresses noted below, with the required information. If an electronic means of forwarding is available at a future date, UnitedHealthcare will notify the delegate of such and this will be our preferred means of forwarding. The delegate will be expected to comply with the electronic requirements as communicated by UnitedHealthcare.

Claim benefit category	Product	Address
Medical	Medicare Advantage (MA)	Forward claim with cover sheet to: UnitedHealthcare P.O. Box 31362 Salt Lake City, UT 84131
Transplant member – services related to transplant	MA	Forward claim with cover sheet to: OptumHealth CMC P.O. Box 30758 Salt Lake City, UT 84130
Transplant member – non-transplant medical claim	MA	Forward claim with cover sheet to: UnitedHealthcare P.O. Box 31362 Salt Lake City, UT 84131
Behavioral	MA	Forward claim with cover sheet to: Optum Behavioral Health P.O. Box 30760 Salt Lake City, UT 84130

Claim benefit category	Product	Address
Dental	MA	Forward claim with cover sheet to: UHC Dental P.O. Box 30567 Salt Lake City, UT 84130
Vision	MA	Forward claim with cover sheet to: UHC Vision P.O. Box 30978 Salt Lake City, UT 84130
Pharmacy	MA	Include OCN received date stamp on the copy of the claim directly. Optum Rx ATTN: Escalated Claims P.O. Box 650287 Dallas, TX 75265-0287
Physical health (chiropractic, acupuncture, physical therapy, occupational therapy, speech therapy-related services)	MA	Forward claim with cover sheet to: Optum Physical Health - ACN P.O. Box 30525 Salt Lake City, UT 84130-0525
Hearing aids (hardware)	MA	Forward claim with cover sheet to: UnitedHealthcare P.O. Box 31362 Salt Lake City, UT 84131
Hearing screening	MA	Forward claim with cover sheet to: UnitedHealthcare P.O. Box 31362 Salt Lake City, UT 84131

If you, the delegate, receive a claim routed from UnitedHealthcare that you believe to be the financial responsibility of the health plan, and are requesting a reconsideration of the financial risk determination, please follow these instructions:

Please send the following documentation via secure email to **delegatedclaims_resolution@uhc.com**.

For each request, please include the following documentation:

1. PDF copy of claim
2. Complete the **Claim Reconsideration form**, including an explanation of why you, the delegate, believe the claim is not your responsibility, but is the health plan's responsibility. All fields must be completed on the template to be considered complete. You can download the form at **UHCprovider.com/claims** > Document and forms > Claim reconsideration form - single claim.
3. Email subject line: COSMOS Delegated Claim Reconsideration Submission.
   Note: Do not put any other information in the subject line.

Note: Send 1 email per claim when requesting a financial risk reconsideration. If you have more than 1 claim for the same issue, please submit separate emails with separate completed forms. If you have 20 or more claims for the same issue, please reach out to your Provider Advocate to discuss alternative submission solutions.

Non-UnitedHealthCare West (Commercial Only)

We identify, batch and forward misdirected claims to the appropriate delegated entity, following state and/or federal regulations. Our preferred method of forwarding claims is electronically; however, claims may also be forwarded via secure email.

In order to adjudicate the claim properly, the delegate must ensure the division of financial responsibility is set up correctly and other information, including member eligibility is updated timely. If we forwarded a claim electronically in an EDI 837 format and that claim was rejected by the delegated entity or their designated clearinghouse/vendor, it will be the responsibility of the delegate to develop that claim with the submitter (billing/service provider) to ensure it is able to be logged and processed by the delegate's claim adjudication system.

If a delegate needs to change your Payer ID to which UnitedHealthcare should direct claims to, which could happen as the result of changing your clearinghouse or for various other reasons, the delegate must provide UnitedHealthcare 270 days advance notification, as outlined in the system/software upgrades, change in claims platforms, change to new clearinghouse section within this guide. UnitedHealthcare will need to test the successful transfer of misdirected claims to this new Payer ID. We expect this testing to take no more than 3 months. Should you exceed the 3-month testing window without approval to move to sending production files, we will implement an IAP and possible financial penalties. If an IAP is implemented, UnitedHealthcare Data Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP, and $250/hour after the first month of the IAP until the IAP is closed.

If health care providers send claims to a delegated entity, and we are responsible for adjudicating the claim, the delegated entity must forward the claim to us within 10 working days of the receipt of the claim. Failure to comply with this requirement will lead to the implementation of a Remediation Plan and possible financial penalties.

The delegated entity must identify and track all claims billed to them received in error. Tracking must include, but is not limited to, the received date of the claim by the delegate, the method the claim was received by the delegate (paper or EDI), the date forwarded, and the name of the entity where the claim was sent.

The delegated entity must then forward the claims to the appropriate payer and follow state and/or federal regulatory time frames. When the claim is adjudicated, the delegated entity must notify the health care provider of service who the correct payer is, if known, using the EOP they give to the health care provider.

If you, the delegated entity, received a claim directly from the billing health care provider, and you believe that claim is the health plan's responsibility, forward it to your respective UnitedHealthcare Regional Mail Office P.O. Box, which is found on the back of the member's ID card. If the address on the back of the ID card is your (the delegate's) address, refer to the following table to identify where to send a copy of the claim along with any additional information received. Include the timestamp of your original receipt date on the claim submission. Please forward your claim to the respective addresses as provided by your provider advocate.

If you, the delegate, receive a misdirected claim routed from UnitedHealthcare that you believe to be the financial responsibility of the health plan, and are requesting a reconsideration of the financial risk determination, please partner with your provider advocate for details on how to submit risk reconsiderations to UnitedHealthcare.

Individual and Family Plans (IFP)

We identify, batch and forward misdirected claims to the appropriate delegated entity, following state and/or federal regulations. Our preferred method of forwarding claims is electronically; however, claims may also be forwarded via Secure email. Delegates are expected to comply with these electronic intake requirements.

In order to adjudicate the claim properly, the delegate must ensure the division of financial responsibility is set up correctly and other information, including member eligibility is updated timely. If we forwarded a claim electronically in an EDI 837 format and that claim was rejected by the delegated entity or their designated clearinghouse/vendor,

it will be the responsibility of the delegate to develop that claim with the submitter (billing/service provider) to ensure it is able to be logged and processed by the delegate's claim adjudication system.

If a delegate needs to change your Payer ID to which UnitedHealthcare should direct claims to, which could happen as the result of changing your clearinghouse or for various other reasons, the delegate must provide UnitedHealthcare 270 days advance notification, as outlined in the system/software upgrades, change in claims platforms, change to new clearinghouse section within this guide. UnitedHealthcare will need to test the successful transfer of misdirected claims to this new Payer ID. We expect this testing to take no more than 3 months. Should you exceed the 3-month testing window without approval to move to sending production files, we will implement an IAP and possible financial penalties. If an IAP is implemented, UnitedHealthcare Data Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP, and $250/hour after the first month of the IAP until the IAP is closed.

If health care providers send claims to a delegated entity, and we are responsible for adjudicating the claim, the delegated entity must forward the claim to us within 10 working days of the receipt of the claim. Failure to comply with this requirement will lead to the implementation of a Remediation Plan and possible financial penalties.

The delegated entity must identify and track all claims billed to them received in error. Tracking must include, but is not limited to, the received date of the claim by the delegate, the method the claim was received by the delegate (paper or EDI), the date forwarded, and the name of the entity where the claim was sent.

The delegated entity must then forward the claims to the appropriate payer and follow state and/or federal regulatory time frames. When the claim is adjudicated, the delegated entity must notify the health care provider of service who the correct payer is, if known, using the EOP they give to the health care provider.

If you, the delegated entity, received a claim directly from the billing health care provider, and you believe that claim is the health plan's responsibility, forward it to your respective UnitedHealthcare Regional Mail Office P.O. Box, which is found on the back of the member's ID card. If the address on the back of the ID card is your (the delegate's) address, refer to the following table to identify where to send a copy of the claim along with any additional information received. Include the timestamp of your original receipt date on the claim submission and how the claim was received (paper or EDI). Please forward your claim to the respective addresses noted below, with the required information. If an electronic means of forwarding is available at a future date, UnitedHealthcare will notify the delegate of such and this will be our preferred means of forwarding. The delegate will be expected to comply with the electronic requirements as communicated by UnitedHealthcare.

State	Claim benefit category	Product	Address
Texas	All claims except dental	IFP	UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402-5270
Texas	Dental	IFP	P.O. Box 2061 Milwaukee, WI 53201

If you, the delegate, receive a claim routed from UnitedHealthcare that you believe to be the financial responsibility of the health plan, and are requesting a reconsideration of the financial risk determination, please follow these instructions when submitting a financial risk reconsideration:

Please send the following documentation via secure email to **vbrifpdelegateddisputeresolution@uhc.com**.

1. PDF image of claim
2. Completed Claim Reconsideration Form, including an explanation of why you, the delegate, believe the claim is not your responsibility, but is the health plan's responsibility. All fields must be completed on the template to be considered complete. You can download the form at **UHCprovider.com/claims**.

Note: Send 1 email per claim when requesting a financial risk reconsideration. If you have more than 1 claim for the same issue, please submit separate emails with separate completed forms. If you have 20 or more claims for the same issue, please reach out to your provider advocate to discuss alternative submission solutions.

Out of area (OOA) urgent or emergent claims

In several contractual arrangements, UnitedHealthcare has financial responsibility for urgent or emergent OOA medical and facility services provided to our members. We follow laws and regulations regarding payment of claims related to access to medical care in urgent or emergent situations. If we determine the claims are not emergent or urgent, we forward the claims to the capitated/delegated health care provider for further review. Medical services provided outside the medical group's/IPA's defined service area and authorized by the member's medical group/IPA are the medical group's/IPA's responsibility and are not considered OOA medical services.

Payment methodology

Health care provider delegates must ensure appropriate reimbursement methodologies are in place for noncontracted and contracted health care provider claims.

For payment of noncontracted network provider services, the letter, EOP or PRA issued must notify them of their dispute rights if they disagree with the payment amount. You may not bill members for the difference of the billed amount and the Medicare allowed amount. MA contracted health care provider claims must be processed following contract rates and within state and federal regulatory requirements.

Interest payment

Health care provider delegates must automatically pay applicable interest on claims based on state and/or federal requirements.

Maximum out-of-pocket (MOOP)

Delegated entities must have a method of tracking individual member out-of-pocket expenses in their claim processing system. In addition, member cost-share may not be applied once a member has met their out-of-pocket maximum. This helps ensure members pay their appropriate cost-sharing amount. For more information, see the **Member out-of-pocket/deductible maximum** section of this supplement.

ERISA claims processing

For claims falling under the Department of Labor's ERISA regulations, you must issue denials within 30 calendar days of receipt of the complete claim. You must issue payments within 45 working days or within state regulation, whichever is more stringent. The legislation does not differentiate between clean or unclean, or between participating and nonparticipating claims. Interest must be automatically paid on all uncontested claims not paid within 45 working days after receipt of the claim. Interest accrues at the rate established by state regulatory requirements, per annum, based on 365 days for a standard year and 366 days for a leap year, beginning with the first calendar day after the 45 working day period. It must be included with the initial payment. If interest is not included, there is an additional penalty paid to the health care provider in addition to the interest payment.

Submission of claims for medical group/IPA reimbursement

Insured services

Insured services are those service types defined in the Agreement to qualify for medical group/IPA reimbursement, assuming the qualifications of certain designated criteria. The medical group/IPA pays the claim and submits it to UnitedHealthcare for reimbursement. Examples of an insured service could include authorization guarantee or preexisting pregnancy.

Indemnified services

UnitedHealthcare may retain financial risk for services (or service categories) that cannot be submitted through the regular claims process due to operational limitations. These limitations include ambiguous coding and/or system limitations, which may cause the claim to become misdirected. Misdirected claims are a risk to both organizations in terms of meeting regulatory compliance and inflating administrative costs.

Claims for insured or indemnified services qualify for payment to the capitated entity as defined in the medical group/IPA or facility Agreement. Should you have additional questions surrounding this process, speak with your health care provider advocate.

Medicare Advantage claim processing

MA contracted health care provider claims must be processed based on agreed-upon contract rates and within applicable federal regulatory requirements. Participating health care provider claims are adjudicated within 60 calendar days of oldest receipt date of the claim.

Medicare Advantage noncontracted health care provider claims are reimbursed based on the current established locality-specific Medicare Physician Fee Schedule, DRG, APC and other applicable pricing published in the Federal Register. Noncontracted, clean claims are adjudicated within 30 calendar days of oldest receipt date. Unclean claims are adjudicated within 60 calendar days of oldest receipt date. Clean and unclean claim definition is based on CMS guidelines.

Medicare Advantage interest payment requirements

CMS requires an interest payment on clean claims submitted by noncontracted health care providers if the claim is not paid within 30 calendar days. Find information on this requirement on cms.gov.

Medicaid reclamation claims

Entities with Dual Special Needs Plan (D-SNP) delegation must develop and implement a Medicaid reclamation claims process to help ensure compliance with state-specific reclamation requests.Medicaid reclamation occurs when a state/agency contacts UnitedHealthcare to recover funds they believe they paid in error and are now seeking reimbursement in the form of Medicaid reclamation claims. Medicaid reclamation claims requirements are state-specific and vary by state.

Claims disputes and appeals

Contracted health care provider disputes

Contracted health care providers who have a claim dispute with a delegated medical group/IPA must make sure they have followed all guidelines set forth by the medical group/IPA.

- A clear explanation of what is being appealed
- Proof the delegated medical group/IPA directed provider to appeal to UnitedHealthcare
- Copy of delegated medical group/IPA PRA
- Proof delegated medical group/IPA upheld denial/payment on first level appeal on second level appeals

Overpayment reimbursement for a medical group/IPA/facility (CA only)

A request for reimbursement for any overpayment of a claim completed in compliance with state and/or federal regulations must:

- Provide a clear, accurate, written explanation
- Be issued within 365 calendar days from the last date of payment for the claim
- Commercial claims – give the health care provider 30 working days to send written notice contesting the request for reimbursement for overpayment

Medicare Advantage noncontracted health care provider disputes

Noncontracted health care provider disputes — CMS noncontracted health care provider payment dispute resolution process (applicable to noncontracted Medicare Advantage paid claims)

A noncontracted health care provider can use the CMS noncontracted health care provider Payment Dispute Resolution (PDR) process for any decision where they contend the amount paid by the organization (i.e., the delegated entity) for a covered service is less than the amount which would have been paid under Original Medicare. This PDR process also includes disagreements between a noncontracted health care provider and the delegate about the delegate's decision to pay for a different service than that billed (i.e., rate of payment, DRG payment dispute). The health care provider must submit a payment dispute within 120 calendar days from the date of the original claim determination. At a minimum, the delegate must have the following requirements and processes in place when handling claim payment disputes with an MA noncontracted health care provider:

- Well-defined internal payment dispute process that includes:
  - A system for receiving PDRs
  - Proper identification of payment disputes. Health care providers must clearly state what they are disputing and why, supply relevant information that will help support their position, including description of the issue, copy of submitted claim, supporting evidence to demonstrate what Original Medicare would have allowed for the same service, etc.
  - A system for tracking disputes
  - Monitoring their PDR claims inventory
- A requirement to communicate the time frame of 120 calendar days from the original claim determination to submit a payment dispute to the noncontracted health care provider at time of claim payment
- Information on how to submit an internal claim payment dispute to the organization communicated to the noncontracted health care provider at time of claim payment, including their mailing address for submitting disputes and other dispute information (e.g., email addresses, phone numbers)
- Requirements to process and respond (i.e., to finalize the PDR claim) to the noncontracted health care provider within 30 calendar days from the date the PDR claim is received (oldest received date of the PDR claim)
- Help ensure correct calculation of interest payments on overturned PDRs. Interest payment is required on a reprocessed, noncontracted health care provider clean claim if the group made an error on the original determination. Interest is only applied on the additional amount paid if the original claim was clean and calculated from the oldest receive date of the original claim until the check mail date of the additional amount paid.
- Provide a complete and clear rationale to the noncontracted health care provider for upheld PDRs
- Help ensure the PRA, EOP and uphold PDR determination letter have the right information and meet requirements
- Include information on how to contact the organization in notices of upheld or overturned payment disputes if the noncontracted health care provider has questions
- Include information in the notices of upheld or overturned payment disputes on how to contact the organization if the noncontracted health care provider has questions
- If the root-cause of overturned PDRs is system-related, have a process in place to update their claims system so future claims will reimburse appropriately
- Have a process in place that identifies trends that contract year for any noncontracted health care provider who submitted a payment dispute to help ensure they are paid correctly
- Have an ongoing training program in place for any piece of the internal claim PDR process that educates all areas of the organization, such as customer service, claims and appeals
- Monitor internal compliance to help ensure CMS requirements are met
- Follow an end-to-end quality review process. It should start when a dispute is received from the noncontracted health care provider until the dispute decision is sent to the noncontracted health care provider

Excluded from the payment dispute resolution

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

- Instances in which a member filed an appeal and you filed a dispute regarding the same issue. In these cases, the member's appeal takes precedence. You can submit a health care provider dispute after the member appeal decision is made. If you are appealing on behalf of the member, the appeal processes as a member appeal.
- An Independent Medical Review initiated by a member through the member appeal process
- Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply good cause for the delay
- Any delegated claim issues not reviewed through the delegated payer's claim resolution mechanism
- Any request for a dispute, which involves reviews by the delegated medical group/IPA/payer or capitated facility/health care provider and does not involve an issue of medical necessity or medical management

Delegated claims reporting

All states – use the most updated Medicare Advantage (MA) and Commercial Monthly Timeliness Report (MTR) you received from the Delegate Claims Oversight Department.

1. MTR forms and monthly reports are due by the 15th calendar day of each month or the following business day if the due date falls on a weekend or holiday
2. Claims Activity Reports/data files are due on the 15th calendar day of each month or the following business day if the due date falls on a weekend or holiday
3. DR Upheld and Overturn reports are due on the 15th calendar day of each month or the following business day if the due date falls on a weekend or holiday.

   PDR summary quarterly reports are due:

   - First Quarter: April 30
   - Second Quarter: July 31
   - Third Quarter: Oct. 31
   - Fourth Quarter: Jan. 31

   If the due date for the PDR falls on a weekend or holiday, provide the following business day.

Note: Submit Claims Activity Reports in the template or format UnitedHealthcare requests. This includes existing methods of submitting reports and any enhancements made throughout the year to meet regulatory and/or health plan requirements.

Delegated entities must complete a Remediation Plan and submit it to the health plan for submitting untimely reports or reports containing inaccurate or incomplete information.

All delegated entities must upload their Claims Activity Reports, claims data files and MTR forms to the **ECG Connect Portal**.

Upload monthly MTR forms to the ECG Connect Portal by the 15th calendar day of each month. Upload Claims Activity Reports to the ECG Connect Portal by the 15th calendar day of each month.

Reporting due dates may change, and you must submit reports to the health plan by the established due date(s).

Based on either state regulatory requirements (CA), or other contractual requirements, UnitedHealthcare shall verify on a quarterly basis that our delegated entities have the administrative and financial capacity to meet contractual obligations through routine reviews of financial indicators and monitoring financial solvency deficiencies. UnitedHealthcare requires delegated entities to provide copies of quarterly financial statements, including a balance sheet, income statement and statement of cash flow. Prepare these based on generally accepted accounting principles within 45 calendar days of the end of each calendar quarter.

Submit copies of assessed annual financial statements together with copies of all auditors' letters to management in connection with such reviewed annual financial statements submissions within 150 calendar days of the end of each fiscal year. If these financial statement submissions have deficiencies in financial solvency grading criteria defined

by state regulations, submit a self-initiated CAP proposal in an electronic format (template may be found on the Iceforhealth.org website) to UnitedHealthcare within 45 calendar days of the end of the reporting period for which the deficiency was reported. In addition, submit quarterly progress reports to UnitedHealthcare within 45 calendar days of the end of each subsequent reporting period until compliance with all financial grading criteria achievement.

Email financial statements and IAP to UnitedHealthcare at **financialstatementsubmission@uhc.com**.

Both UnitedHealthcare and the delegated entity must provide compliance oversight of the delegated entity's financial reporting IAP.

CA Commercial NPI

The California Department of Managed Health Care (DMHC) Timely Access to Nonemergency Health Care Services Regulation applies to California Commercial HMO membership only. The regulation establishes time-elapsed standards or guidelines to make sure members have timely and appropriate access to needed health care services, including a 24/7 telephonic triage or screening requirement. Health plans must comply with certain provisions of the regulation and provide an annual report detailing the status of the plan's network care provider and enrollment, which includes the health care provider's NPI. To comply with this regulation, UnitedHealthcare requires all California Commercial HMO health care providers to include their NPI with all health care provider additions or when submitting a claim.

PDR requirements for delegated commercial claims (CA only)

A delegated entity that is contractually delegated to process claims or approve referrals for service must have a fair, fast and cost-effective dispute resolution mechanism. This process must help manage contracted and noncontracted health care provider disputes based on state and federal regulations.

If the dispute request is for services payable by the delegated entity, we determine if the appropriate payer has reviewed the request for dispute. If the appropriate payer has not reviewed the dispute request, we forward the dispute request to the appropriate payer. We notify the health care provider of service of the forwarding dispute request to the delegated entity for processing.

The delegated entity must submit all required information to us and the appropriate state agency based on state and federal regulations. All delegated claims processing entities are required to report PDR processing compliance results quarterly, based on state and federal regulations. Submit quarterly reports no later than the last day of the month following the end of the quarter.

We regularly conduct a compliance assessment of the PDR process of each delegated entity, typically on an annual basis.

As part of the compliance assessment, we request data files and related reports of Delegated Entity Provider Disputes. The auditor reviews the dispute data and randomly selects finalized disputes for review. The auditor also requires a copy of the delegated entity's PDR Policy and Procedures and evidence of the availability of the PDR mechanism. If the medical group/IPA or facility is non-compliant with UnitedHealthcare, state or federal requirements, the delegated entities must develop a Remediation Plan designed to bring them back into compliance. If the delegate entity does not achieve compliance, UnitedHealthcare will employ its Claims Management Consulting Services (CMCS) model. The delegate is charged for all CMCS activities associated with remediation. For further details, see the **Non-compliant audits** section.

If you continue to have a commercial claims dispute with the delegated entity related to medical necessity and utilization management, forward all claim information and correspondence between the delegated entity and you to UnitedHealthcare for review. We do not begin the review until we receive the supporting documentation.

Commercial health care provider claims must be processed based on agreed-upon contract rates or member benefit plan and within state and federal requirements.

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

Commercial interest rates and time frames for processing may vary, depending on the applicable state requirements. In some states, an additional penalty for late claims payments may also apply and be paid by the delegated medical group/IPA/facility.

Contractual and financial responsibilities

Compliance with CMS

As an MA plan, UnitedHealthcare and its network providers agree to meet all laws and regulations applicable to recipients of federal funds. The medical group/IPA and capitated facility acknowledge they must comply with certain laws applicable to entities and individuals receiving federal funds.

Routine/supplemental vision

The Vision – Routine/Supplemental Refraction (non-medical) DOFR line item requires the use of a UnitedHealthcare vision provider. If this service is provided by a provider who is not a UnitedHealthcare vision provider, the service is considered a medical benefit and the financial responsibility would follow the Vision - Medical Treatment line item.

In order to determine the participation status for a routine vision provider, visit **UHCprovider.com/findprovider** > **Vision Directory**.

Changes in risk status during inpatient admissions

An inpatient admission includes:

- Inpatient acute care
- SNF
- Detoxification
- Medical rehabilitation
- All related services

Partial risk to shared risk

If a member's assigned health care provider is partial risk at the time of admission and then changes to shared risk prior to the member's discharge, all claims related to this confinement from admission through discharge are processed according to the partial risk DOFR in effect at the time of the admission.

Shared risk to partial risk

If a member's assigned health care provider is shared risk at the time of admission and then changes to partial risk prior to the member's discharge, all claims related to this confinement from admission through discharge processed according to the shared risk DOFR will be in effect at the time of the admission.

Collection of fees

When a member needs one of the following forms for reasons other than medical, you may collect a fee, in addition to the office visit copayment, for completion of these forms (unless the member's benefit plan or applicable law dictates otherwise):

- DMV forms
- Camp or school forms
- Employment or insurance forms
- Adoption form

You cannot collect an additional fee, copayment or surcharge for:

- Completion of Prior Authorization form for non-formulary drugs
- Completion of disability forms
- Missed appointments/no shows or late cancellations
- Times when a member cannot pay office visit copayment at the time of visit for basic health care services. The

medical group/IPA may reschedule the member's appointment. If the member requires urgently needed care or emergency care, the medical group/IPA must render care.

You can collect copayments when professional services are rendered by a:

- Licensed medical doctor or doctor of osteopath as defined by the state
- Physician assistant
- Nurse practitioner

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

- Injections administered by a nurse or medical assistant
- Routine immunizations administered by a nurse or medical assistant

Member out-of-pocket/deductible maximum

We are required to monitor and track each member's annual individual out-of-pocket/deductible maximum amount. The member's annual individual out-of-pocket/deductible maximum accumulation is calculated through the member's cost-share data collected from all or some of the following sources:

- Medical group/IPA/capitated hospital encounters
- Prescription related encounters
- Behavioral health-related encounters
- Claims processed by UnitedHealthcare or its delegates

UnitedHealthcare and its capitated health care providers share responsibility to monitor the member's individual out-of-pocket/deductible maximum. For additional information on reporting available from UnitedHealthcare, see **Chapter 11: Compensation** of this guide.

UnitedHealthcare monitors the capitated health care provider's compliance with this policy to help ensure all requests for claims reprocessing and member reimbursement are completed timely. Failure to comply with all requirements will result in an Improvement Action Plan (IAP) that may lead to financial penalties and potential loss of delegation responsibilities if not cured.

If necessary, we work with the capitated health care provider to help ensure each member is reimbursed for any amounts collected in excess of the member's annual individual out-of-pocket/deductible maximum amounts as specified in the member's benefit plan.

If the capitated health care provider fails to reimburse a member for amounts collected in excess of the member's annual individual out-of-pocket/deductible maximum, we may reimburse the member directly and recover the payment by capitation deduction as specified in your Agreement.

In the event a delegate is not meeting any one of the performance standards, we will send a formal notification to the delegate and initiate a cure period. The cure period is the time frame we give the delegated entity to demonstrate compliance. The cure period could be 30–60 days. If the performance standard(s) are not cured within the defined cure period, an IAP will be issued, and financial consequences could be implemented. UnitedHealthcare MOOP Oversight will require regularly scheduled meetings with the delegate to ensure progress is being made toward meeting those requirements. Should the delegate fail to meet those requirements within the allotted time frame, UnitedHealthcare MOOP Oversight may bill the delegated entity for all activities surrounding the remediation of the IAP. UnitedHealthcare MOOP Oversight will charge an initial fee of $2,500 plus $100/hour to assist the delegate for the first month of the IAP, and $250/hour after the first month of the IAP until the IAP is closed.

Member cost-share operational overview

- Cost-share information comes from different sources derived through claims and encounter data submissions
- Delegated entities can view up-to-date cost-share information, including various reports that they can download on **UHCprovider.com**. Reach out to your health care provider advocate for further details.

- Delegated entities can contact **oopoutreach@optum.com** for any member out-of-pocket inquiries
- To help ensure members are not over-charged for copayments, coinsurance or deductibles, member cost-share may not be applied once a member has met their out-of-pocket maximum by one of the mechanisms below, whichever occurs first:
  - Delegate entities must have a method to track individual member out-of-pocket expenses in their claim processing system. Member cost-share may not be applied once a member has met their out-of-pocket maximum in the delegate claim processing system.
  - Delegate entities are responsible for updating their systems within 2 business days of receiving a notification from UnitedHealthcare that a member has met their out-of-pocket maximum

When a member/family meets their annual out of pocket/deductible maximum, UnitedHealthcare notifies the member's delegate. Delegates must work with UnitedHealthcare to address member issues related to out of pocket balances. This includes:

- Responding to a UnitedHealthcare request for data on care services provided to a member:
  - For formal complaints, respond by the date/time provided on the UnitedHealthcare email request 100% of the time. Examples of formal complaints include: Complaints to Medicare (CTM), Department of Managed Healthcare of California (DMHC) or Department of Insurance (DOI).
  - For escalated issues, respond within 2 business days 95% of the time
  - For standard issues, respond within 5 business days 95% of the time

If the requested information is unable to be provided within the requested time frame, communication must be sent prior to the deadline outlining the reason for delay and the expected completion date.

- For claims identified by UnitedHealthcare to be reprocessed by the delegated entity:
  - Within 7 calendar days, adjusting cost-share amounts, reprocessing the claims and confirming transactions with UnitedHealthcare
  - Within 14 calendar days, submitting the corrected encounter data per the instructions on the reprocessing request. Failure to comply with these requirements may result in an Improvement Action Plan (IAP) that may lead to financial penalties and loss of delegation if not addressed appropriately. Please refer to the non-compliant assessments section for further information on the IAP and the associated employment of the CMCS model.

Financial risk disputes between UnitedHealthcare and the delegated entity

To help ensure timely processing of service health care provider claims, delegated entities are responsible for working with UnitedHealthcare to address financial risk dispute issues. This includes:

- When UnitedHealthcare requests data from the delegated entity on claim processing status and/or clarification on claim financial risk determinations or when UnitedHealthcare identifies claims to be re-processed by the delegated entity to resolve service health care provider or member issues, you must respond within:
  - 24-48 hours for escalated issues (i.e., regulatory or urgent member/provider issues)
  - Reprocess the claims and confirm transactions with UnitedHealthcare within 7 calendar days
  - Submit the corrected encounter data within 14 calendar days
- When UnitedHealthcare identifies claims: In the event no response to this request is received within defined timeline above, the claim will be processed without further notification and we will seek recovery through capitation or settlement deduction

We continuously monitor dispute and inquiry submissions for quality and quantity. Our delegated groups should meet or exceed current established thresholds, as defined by the UnitedHealthcare Issue Resolution Operations Team.

Timeliness metrics:

- Health plan resolution requests responses timely > = 95%
- Formal complaints responses timely > = 98%

Accuracy metrics:

- Percentage of disputes resulting in cap deducts < = 5%
- Percentage of disputes resulting in an overturn < = 10%

The delegate may be subject to the implementation of an Improvement Action Plan (IAP) and/or financial consequences if it or any subdelegated entity fails to submit or meet financial risk dispute requirements as outlined here in this guide or the delegates contractual agreement with UnitedHealthcare.

In the event a delegate is not meeting any one of the performance standards, we will send a formal notification to the delegate and initiate a cure period. The cure period is the time frame we give the delegated entity to demonstrate compliance. The cure period could be 30 to 60 days depending on the severity of the deficiency.

Our Operations Team will require regularly scheduled meetings with the delegate to ensure progress is being made toward meeting those requirements.

If compliance is not met by the end of the cure period, UnitedHealthcare will charge the delegate for all activities with and initial fee of $2,500 plus $100/hour for the first month thereafter, and $250/hour for each subsequent month until the IAP is closed.

Encounter data requirements

Professional and institutional encounter data consist of an itemization of medical group/IPA/capitated facility, capitated and sub-capitated services provided to our commercial or MA members.

We require you to transmit your encounter data daily. If daily submissions are not possible, we would expect multiple weekly submissions. In the event you are not able to transmit your encounters for any reason, please notify our Encounter Operations team immediately. Frequent encounter submissions allows us to support various state and federal regulatory requirements for reporting, such as risk adjustment reporting for Medicare reimbursement from CMS, member out-of-pocket costs, member explanation of benefits, STARS reporting and NCQA and HEDIS reporting.

We request that you use one of our preferred clearinghouses to transmit your encounters. Contact **encountercollection@uhc.com** for a list of preferred clearinghouses. Once selected, your clearinghouse will provide the appropriate payer ID to use to send your encounters.

We continuously monitor encounter data submissions for quality and quantity. Our delegated groups should meet or exceed current established thresholds, as defined by the UnitedHealthcare Encounter Operations Team. To ensure 100% completeness of encounter data, we expect all delegates to submit a monthly data extract file, via ECG, of all finalized claims processed (paid and denied) no later than the 15th of the month for the previous month. UnitedHealthcare will reconcile those against encounters we have logged and or rejected, to determine what data has not been received.

Upon request, delegates are required to make available the mapping of their claims processing reason codes to the industry standard claim adjustment reason codes (CARCs) presented on the 837P and 837I for review by UnitedHealthcare. As you are processing claims on our behalf, we expect all encounter data submissions to accurately reflect the original claim received from the provider as well as accurate CARC description as to how the claim was processed. CARC usage must align to the Washington Publishing guidelines. Delegates must map CARCs using the most accurate description when adjudicating claims.

Delegates are required to send replacement or void encounters for both commercial and MA lines of business, if applicable. Delegates send a replacement encounter when information on the original logged encounter at

UnitedHealthcare needs to be corrected. A void submission is required to eliminate a previously submitted logged encounter at UnitedHealthcare. Delegates should not send replacements and voids when the original encounter is rejected by a clearinghouse or by UnitedHealthcare.

For examples of when a replacement or void encounter should be submitted and the required details on submitting them within the 837P and 837I ASC X12 EDI format, refer to section 6.1 of the Electronic Claim Submission Guidelines in the UnitedHealthcare Companion Guides or contact **encountercollection@uhc.com**. All encounter data submitted to UnitedHealthcare are subject to state and/or federal audit. We have the right to perform routine medical record chart assessments on any or all of the medical group's/IPA's network providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data ICD-10-CM and CPT coding. We notify the medical group/IPA in writing of audit results for coding accuracy.

The delegate may be subject to the implementation of an Improvement Action Plan (IAP) and/or financial consequences if it or any subdelegated entity fails to submit or meet encounter data element requirements as outlined here in this guide and/or the delegates contractual agreement with UnitedHealthcare.

In the event a delegate is not meeting any one of the performance standards, we will send a formal notification to the delegate and initiate a cure period. The cure period is the time frame we give the delegated entity to demonstrate compliance. The cure period could be 30 to 60 days depending on the severity of the deficiency.

Encounter Operations will require regularly scheduled meetings with the delegate to ensure progress is being made toward meeting those requirements.

If the delegate fails to remediate within the defined cure period, UnitedHealthcare will implement financial penalties and UnitedHealthcare will charge the delegate for all Inbound Encounter Data team IAP support activities with an initial fee of $2,500 plus $100/hour for the first month of the IAP and $250/hour after the first month of the IAP until the IAP is closed. If your contractual agreement allows, the $2,500 initial fee and hourly fees will be deducted from your capitation payments.

Timeliness

- 95% of encounters received within 90 days of the date of service. If less than 95% for 3 consecutive months, cure period will be enforced.
- 98% of encounters received within 10 calendar days of the delegate's claim adjudication date. If less than 98% for 3 consecutive months, cure period will be enforced.

Accuracy

- ≤ 2% of encounters rejected as a % total encounter submissions based on the most current month's submissions for current year's dates of service reporting period
- = < 5% edits aged over 45 days from the date of rejection for current year's dates of service reporting period

Completeness

- = > 98% of encounters received within 2 months from the initial month where it was identified that encounters were not received based on monthly claims processed by the delegate

System/software upgrades, change in claims platforms, change to new clearinghouse

When system/software upgrades occur, you will be required to test your encounter files. Changes/modifications to the platforms and applications used to process claims and encounters will be required to complete testing with your clearinghouse and UnitedHealthcare. You will be required to test your files with your clearinghouse and UnitedHealthcare for the following:

- A brand new delegate
- Implementing a new claims or encounters management platform*
- Software upgrades
- Change in risk level

*270-day advance notice is required to your UnitedHealthcare provider advocate and encounter data business analyst. To ensure notification has been received, you should also contact **encountercollection@uhc.com**.

- Adding a line of business
- Claims/encounters system mapping changes
- Change to a new clearinghouse*

Our expectation is that the exchange of post go-live test files between the clearinghouse and UnitedHealthcare should not exceed 2 months for new delegates. Should you exceed the 2-month testing window without approval to move to sending production files, we will implement an Improvement Action Plan (IAP), which will include monthly financial penalties for noncompliance of encounter data submission requirements until compliance is reached. UnitedHealthcare will charge the delegate for Inbound Encounter Data team IAP support at $250/hour until the IAP is closed. We expect that test file results for HIPAA level edits to be = < 2% of total submitted to move to production encounter submissions.

If changing to a new clearinghouse, you are required to obtain approval from UnitedHealthcare Encounter Operations Team. If you are implementing a new claim or encounters management platform, you are required to notify the UnitedHealthcare Encounter Operations team. There is special advance setup required at UnitedHealthcare and your new clearinghouse for encounters to be transmitted and processed successfully at UnitedHealthcare. Please include your UnitedHealthcare provider advocate and encounter data business analyst in your 270-day advance notification to UnitedHealthcare. To ensure notification has been received, you should also contact **encountercollection@uhc.com**. In the event the advance notification is not provided, a penalty of $5,000 will be charged. Following these guidelines will ensure your data is 837 5010 EDI compliant and reduce gaps in your weekly encounter submissions.

Refer to the **Notification of platform transitions or migrations** section for more information.

Commercial encounter data requirements

The medical group/IPA, or other submitting entity, must certify the completeness and truthfulness of its encounter data submissions as required by the state regulatory agency. The medical group/IPA, or other submitting entity, must submit all professional and institutional encounter data for UnitedHealthcare members to:

- Comply with the Affordable Care Act for Essential Health Benefits (EHB) and NCQA-HEDIS® reporting requirements
- Enhance member and health care provider service quality
- Provide the medical group/IPA, or other submitting entity, with comparative data
- Facilitate settlement calculations, if applicable, and oversight of utilization management and quality management
- Report member out-of-pocket maximums including supplemental data
- Reporting service limit benefits

We require medical groups/IPAs and facilities to submit timely and compliant encounter data. Include the member cost-share amount on the encounter data submissions based on the member's benefit plan, not the amount the member paid at the time of service. The encounter should clearly distinguish between copayment, coinsurance and deductible amounts within the Claim Adjustment Segments (CAS) segment of Loop 2430, as indicated on the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned commercial members.

The Affordable Care Act dictates reporting requirements. To comply with those requirements, we require all contracted health care providers to submit all diagnosis and procedure codes to the highest level of specificity relevant to the encounter data submission. If the encounters do not include required data elements, or data elements are invalid or missing, the clearinghouse will reject them.

For more information on UnitedHealthcare encounter data submission requirements, refer to the UnitedHealthcare **EDI Companion Guides** or email **encountercollection@uhc.com**.

Medicare Advantage encounter data requirements

CMS reimburses all MA plans based on the member's health status. They use the diagnosis codes from the MA claims and/ or encounter data (inpatient, outpatient and health care provider) to establish each member's health status or

hierarchical condition category (HCC). CMS uses the HCC to help calculate Medicare reimbursement payments for each member.

As a result, we are required to send all adjudicated claims and capitated encounter data including supplemental data for MA members to CMS.

These claims and encounters must pass all the edits CMS applies to its fee-for-service HIPAA 5010 837 and CMS-1500 and UB-04 submissions.

CMS may at any time audit our submissions. The medical record must support the diagnoses you submit. Only the health care provider can change or submit new CMS-1500 or UB-04 data, so your cooperation is required for us to submit the correct data.

We require the medical group/IPA/capitated facility or other submitting entity to submit all professional and institutional claims and/or encounter data for MA members to:

- Comply with regulatory requirements of the CMS Balanced Budget Act and NCQA-HEDIS reporting requirements
- Enhance member and health care provider service quality
- Submit to us for risk adjustment reporting and accurate Medicare reimbursement so we can submit to CMS
- Provide the submitting entity with comparative data
- Facilitate utilization management oversight, quality management oversight and settlement calculation, if applicable
- Support Services 75 FR 19709-Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B

To comply with the CMS regulation 75 FR 19709 to report member cost-sharing as well as out-of-pocket maximums, we require contracted health care providers to submit current, complete and accurate encounter data. This includes member cost-sharing/ revenue, within the CAS segment of the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned MA members. Check with your clearinghouse to verify the appropriate payer ID to use to send your encounters to them, or contact **encountercollection@uhc.com**.

CMS requires EOBs for Part C benefits to report total costs incurred by the health plans (UnitedHealthcare) for capitated and/or delegated health care provider services.

Medicare Advantage organizations (MAOs) are required to report the total costs incurred for capitated and/or delegated health care provider services. MAOs must populate dollar amounts for capitated and/or delegated health care providers in the Total cost and Plan's share columns in the monthly EOB. The Total Cost field on the member EOB includes what the member pays (Your Share on the EOB) and what the health plan (Plan Paid on the EOB) pays.

The MAOs, medical groups, facilities and ancillary health care providers must submit the payer amount paid at the claim level, the Service Line Paid Amount, and the member cost-sharing for all professional and institutional Medicare encounter data.

We also refer to the payer amount paid as the contracted rate, Medicare fee schedule rate, or calculated capitation rate less any applicable member responsibility. For more information on CMS EOB requirements, refer to cms.gov > Medicare > Health Plans.

All encounter data submitted to UnitedHealthcare are subject to state and/or federal assessment. We have the right to perform routine medical record chart assessments on any or all of the medical group's/IPA's network providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data, ICD-10-CM and CPT coding. We notify the medical group/IPA in writing of audit results for coding accuracy.

For further details on UnitedHealthcare encounter data submission requirements, refer to the UnitedHealthcare **EDI Companion Guides** or email **encountercollection@uhc.com**.

Customer service requirements between UnitedHealthcare and the delegated entity (Medicare Advantage)

To help ensure timely support for member customer service requests, the delegated entity is responsible for working with UnitedHealthcare to address member service requirements, member/patient communication, and data sharing requests.

This includes:

- Specific toll-free number for service-related inquiries where you must respond with:
  - An average monthly service level at 80% or higher
  - Average speed of answer (ASA) within 30 seconds or less
- When UnitedHealthcare requests data from the delegated entity requiring additional research on claim processing status and/or clarification on claim financial risk determinations and/or utilization management processing status, you must respond within:
  - 2 business days on escalated issues
  - 5 business days on standard issues
- Providing details related to specific member/patient communication on programs offered by the delegated entity. Failure to comply with all requirements could result in financial penalties and/or loss of delegation responsibilities.

OptumCare Care Delivery Organization customer service specific requirements

The delegated entity is responsible for working with UnitedHealthcare to address member service requirements, member/patient communication and data sharing requests.

This includes:

- Dedicated phone line for service-related inquiries where you must respond with:
  - An average monthly service level at 80% or higher
  - ASA within 30 seconds or less
  - Weekly/monthly call metrics with UnitedHealthcare leadership including call volume, calls per 1,000 members, service level, ASA, transfer rate and experience (post-call survey)
- Online chat capability between UnitedHealthcare member service advocates and OptumCare advocates
  - Sharing online chat metrics between UnitedHealthcare and OptumCare advocates
- When UnitedHealthcare requests data from the delegated entity requiring additional research on claim processing status and/or clarification on claim financial risk determinations and/or utilization management processing status, you must respond within:
  - 1 day on escalated issues
  - 2 days on standard issues
- Providing details related to specific member/patient communication on programs offered by the delegated entity, including outbound call campaigns

Capitation reports and payments

Capitation reports

UnitedHealthcare runs capitation reports by process month for both commercial and MA products. Typically, each month's capitation report and payment reflects all current activity and retroactivity up to the standard 6-month system window. The Agreement may define a non-standard eligibility window for less than the standard 6-month system window. This non-standard eligibility window will override the standard 6-month system window. For MA plans, the non-standard eligibility retro window will not limit the retroactivity related to premium increases/decreases from CMS.

Capitation reports and first-of-the-month eligibility reports run from the same snapshot of membership data. The actual date of this snapshot varies but typically occurs on or around the 15th calendar day of the prior month for commercial and during the last week of the prior month for MA.

The reports mentioned throughout this section are available online and provide detailed information regarding each health care provider's capitation payments. The types of reports available include:

- **Flat file** – contains approximately 198 data elements in CSV (comma separated value) format
- **Image reports** – in PDF format and are at both the member and summary levels
- **Supplemental health care provider reports** – details any non-standard deductions from capitation (i.e., claims that are the financial risk of the health care provider and paid by UnitedHealthcare)

Reports are available on **UHCprovider.com/reports** on the date specified in your Agreement. If the due date falls on a non-business day, the reports are available the next business day.

- **Reports** – view image reports in a PDF format (Adobe Acrobat is required) or download the file
- **Data files** – download the flat files from a zipped file format
- **All** – download image reports and flat files in 1 zipped file

Claims withhold reports and data files

Supplemental health care provider Reports for Claims Withhold are available online. These reports have 2 capitation reporting options described in the following section: Reports and data files.

Medical drug benefit reports and data files

Medical Drug Benefit reports are available online.

The Claims Withhold and Medical Drug Benefits reports are 1 month behind the current Capitation Report month. For example, all claims on the Claims Withhold and Medical Drug Benefit reports that paid in April will process in May capitation. To reconcile May capitation, view the April Claims Withhold and April Medical Drug Benefits Reports.

The Shared Risk Claims Report is also dated 1 month behind the current Capitation Report month. For example, all Shared Risk claims paid in May will process in the June capitation.

We maintain capitation and eligibility reports online for the current month and the previous 2 months.

We recommend you complete your capitation download in a timely manner to make sure you have complete and accurate capitation information.

Hierarchical Condition Category and capitation reporting

CMS payments are based on the Hierarchical Condition Category (HCC) Reporting. This payment methodology requires MA health plans to submit accurate diagnosis information at the greatest level of specificity available.

CMS HCC risk adjustment

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

Access health care provider reports on **UHCprovider.com/reports**, or visit **UHCprovider.com** > Sign In > Documents & Reporting > Document Library.

Capitation processing

Capitation is typically a PMPM payment to a medical group/IPA or facility that covers contracted services for assigned members. This is an alternative to the fee-for-service arrangement. Capitation payments made whether or not the member seeks services from the capitated health care provider.

- Under a shared risk arrangement, the medical group/IPA receives capitation for professional services rendered to its assigned members
- Under a partial risk contract, the facility also receives capitation for institutional services rendered to their assigned members

Refer to the Division of Financial Responsibility (DOFR) grid in your Agreement for a detailed listing of capitated services.

Services not specifically excluded from capitation are included in the capitation payment made to the medical group/IPA or facility.

Facility and regulatory surcharges

The Managed Care Risk Entity is responsible for calculating all facility and regulatory surcharges that may be incurred by their member panels.

15/30 rule

The capitation system uses a 15/30 rule to determine whether capitation is paid for the full month or not at all. If the effective date of a change falls between the first and 15th of the month, the change is effective for the current month and capitation paid for that month. However, if the effective date falls on the 16th or later, the change reflected the first of the following month and capitation paid for the following month.

For capitation payments, we add members on the first day of the month or terminate on the last day of the month. Newborns are added on their dates of birth. We pay or recoup commercial capitation for full months.

Retroactive add

A member added retroactively between the first and the 15th of the month would generate a capitation payment for the entire month. However, a member added on the 16th or later would not generate a capitation payment for that month even though they would be considered eligible for services.

Retroactive term

A member retroactively terminated between the first and 14th of the month would generate a capitation recoupment entry for the capitation previously paid for the entire month. However, a member retroactively terminated on the 15th or later would not generate a capitation recoupment entry for the capitation previously paid for the entire month.

Capitation payments

We make monthly capitation payments to the medical groups/IPAs and capitated facilities for providing and arranging covered services to our members.

We deliver capitation payments through check or electronic funds transfer on the date listed in the Agreement. If the due date falls on a non-banking day, we deliver the capitation payment the next banking day.

Electronic funds transfer (EFT)

To receive capitation payments through EFT, we require a signed EFT Payments form detailing the bank account and bank routing information. It takes 3 weeks for the EFT initial setup, or a change in banking information, to take effect.

We deposit capitation payments through EFT by the end of the banking/business day on the date specified in the Agreement.

Note: Most financial institutions charge a per transaction fee on EFTs.

For detailed instructions on EFT enrollment, click here.

Additional information and requirements for claims payment options can be found in **Chapter 10: Our claims process**.

Capitation calculation methods (Commercial)

Capitation calculation methods are detailed in your Agreement. For commercial products, we use 5 capitation calculation methods:

1. **Flat rate calculation** – a flat rate (PMPM) capitation calculated by applying the flat rate for each member to yield the standard services capitation amount. The flat rate is detailed in your Agreement. Both the flat file and the image reports display each member-level transaction.
2. **Fixed rate age/gender adjusted calculation** – fixed rate age/gender adjusted capitation uses age/gender factors to modify the flat base rate up or down to align standard services capitation with age-weighted risk. The flat base rate multiplied by the age/gender factor yields the standard services capitation amount.
   - Age/gender factors work to weight for age/gender risk consideration with respect to the demographic population. UnitedHealthcare actuarially develops age/gender factors. The age/gender factors may vary among medical groups/IPAs and are included in the Agreement.
   - We report the age/gender factors and standard services capitation amount at the member level on the flat file. Only the standard services capitation amount is reported on the image reports.
3. **Fixed rate age/gender/benefit adjusted calculation** – fixed rate age/gender/benefit adjusted capitation contains 3 components: flat base rate, age/gender factor and benefit factor
4. **Fixed rate age/gender/copayment adjusted calculation** – copayment adjustment works to evaluate the member's copayment made directly to the health care provider. We actuarially derive the copayment adjustment for each copayment level.
   - We add or subtract the copayment adjustment from the flat base rate. The sum of flat base rate +/- copayment adjustment multiplied by the age/gender factor to yield the standard services capitation amount. We report the flat base rate, age/gender factor, copayment adjustment and standard services capitation amounts at the member level on the flat file. The image reports only show the standard services capitation amount.
5. **Professional Risk Capitation Model** – base capitation rate × risk adjustment factor (Optum Symmetry Episode-Related Group [ERGs]) × benefit plan factor × geographic factor)

Commercial capitation contracts with multiple rates

The capitation source system can administer a single commercial contract with multiple rates, if the contract requires a different rate for members enrolled in a specific plan or in-network. These contracts are identified by the Primary Care Provider Network Indicator (PCPNI). The first 4 capitation calculation methods described in the Capitation Calculation Methods section apply. This option is available for commercial contracts. It allows you to manage your capitation under 1 medical group/IPA number.

Capitation transactions reports can be summarized or detailed. All individual transactions are summarized by PNI code and reported on several capitations image reports. There are also detailed health care provider PNI transactions reports on both the flat file (CP7810, column U, field 21) and image reports (CP7210, CP7230). Member PNI is reported on the flat file (CP7810, column AP, field 42).

Capitation calculation for Medicare Advantage

For MA products, we use 3 capitation calculation methods:

1. **Flat rate** – a rate is paid PMPM. We calculate the flat rate capitation by applying the flat rate for each member to give us the standard services capitation amount. The Agreement details the flat rate. Both the flat file and image reports display each member level transaction.
2. **Percent of premium** – the percent of CMS premium calculation begins with the premium identified from the CMS Monthly Membership Report (MMR), less any premium adjustments, and multiplied by the contracted percentage
   - The net of all adjustments is the CMS premium. The flat file (1 R record type), shows the CMS premium at the member level with the field name Cap_Premium_Gross_Cap.
   - Medical groups/IPAs and capitated facilities with a percentage-of-premium contract receive their contracted percentage rate of this cap premium gross cap amount as the standard services capitation amount for each member
   - The flat file (1 R record type) shows the standard services capitation amount at the member level by summing the fields Group_Capitation_Amt plus Facility_Capitation_Amt. Image reports also show the standard services capitation amount at the member level.
3. **Risk adjusted fixed rate** – we calculate capitation using the base rate detailed in the Agreement, multiplied by various factors

It contains 3 components:

1. **Base rate** – as detailed in the Agreement
2. **Risk Adjusted Factor** – the score for each MA plan member taken directly from CMS' Monthly Membership Report (MMR). This factor is reported on the flat file and image reports.
3. **Health status variables** – the base rate adjusted for members categorized as ESRD or Hospice by CMS on the MMR. For details on the ESRD and Hospice adjustments, see your Agreement.

The risk-adjusted fixed rate capitation amount will vary monthly resulting in changes in the risk adjustment factor and demographic factors for MA plan members for that month. Both the flat file and image reports show each member-level transaction. The risk-adjusted fixed rate capitation has the standard 6-month system retro window. Payments made by CMS outside the 6-month retroactivity window are not included.

Medicare Advantage capitation contracts with multiple rates

The capitation source system can administer a single MA contract with multiple percent of premium rates, if the contract requires a different rate for members enrolled in a specific plan or network. These contracts are identified by the PCPNI. The capitation calculation methods described in the capitation calculation section apply.

This option is available for MA contracts. It allows you to manage your capitation under 1 medical group/IPA number. Capitation transactions reports can be summarized or detailed. All individual transactions are summarized by PNI code and reported on several capitations image reports. There are also detailed health care provider PNI transactions reports on both the flat file (CP7810, column U) and image reports (CP7010, CP7030). Member PNI is reported on the flat file (CP7810, column AP).

CMS premiums and adjustments

CMS premium

We use the premium reported on the MMR from CMS as the first step in development of the premium used for the percent of premium calculation. The algorithm, methodology-blend percentage and rates/factors are posted on the CMS website at cms.gov for all periods.

Unpaid CMS premium

If we do not receive payment from CMS for a particular member, we do not pay capitation for that member. Typically unpaid CMS premiums occur in the first month of eligibility. The payment is usually received within 60 calendar days.

If the medical group/IPA has unpaid premiums, it must continue to arrange for the member's medical care and pay for services accordingly.

If CMS does not retroactively pay the premium within 120 calendar days, the medical group/IPA should notify its provider advocate with specific information for that member. That way, the non-payment can be pursued with CMS.

Out-of-area premium

We receive premium from CMS based, in part, on the member's State and County Code (SCC) as reported by CMS. We use the premium CMS reports as a basis for percent of premium capitation.

CMS may report a member in a different state than the state their assigned medical group/IPA is located. As an example, CMS may report a member's SCC as Washington, yet their assigned medical group/IPA is in Oregon.

Once the CMS system updates SCC, CMS pays the correct SCC going forward. Typically, CMS does not retroactively adjust premium for changes in SCC.

End-stage renal disease (ESRD) premium

ESRD premiums are paid using a risk-adjusted model. The model provides a 3-tier approach: dialysis status, receiving a transplant and functioning graft status. CMS communicates these tiers using the customer's risk-adjusted factor type code.

In addition to the ESRD flag, the flat file reports the member-level risk-adjusted factor type code to help the medical group/IPA identify their ESRD patient who is our member. The risk-adjusted factor type code is not reported on the image reports. Find more information on cms.gov.

Working aged premium adjustment

The working aged adjustment shows as a member-specific adjustment in the premium payment we receive from CMS. CMS calculates the working aged adjustment based on a yearly Medicare Secondary Payer (MSP) factor CMS determines. We show this adjustment at the member level on the flat file (1 R record type for adjustments within the 6-month retro window and the 3M record type for adjustments beyond the 6-month retro window). Find specifics on the CMS Working Aged Program on cms.gov.

CMS user fee premium adjustment

CMS deducts a user fee from all MA plans to fund various education programs for Medicare-eligible persons. The user fee adjustment shows as a non-member-specific adjustment in our payments from CMS. Every member is allocated the user fee adjustment. CMS might modify the rate monthly; however, typically, the percentage changes 3 times per year. We show this adjustment at the member level on the flat file, 1 R record type, with the field name CMS_User_Fee.

Sequestration premium adjustment

The UnitedHealthcare MA plans reduce health care provider capitation payments for MA membership by 2%. The 2% sequestration reduction is reported at the member level on the flat file, 1 R record type, with the field name called the MSBP.

This is a result of the CMS-announced sequestration reductions of Medicare payments to health care providers, facilities and other health care professionals and impacts health care provider, facility, ancillary health care provider and other professional payments in our MA plans, including Medicare Advantage Dual Special Needs Plans (D-SNP).

Part D buy-down adjustment

The exclusion/inclusion of the Part D Basic and Supplemental Rebate for UnitedHealthcare MA plans is based on the medical group/IPA contract language. This information is included on the flat file (1R and 3M record type, column AT).

The following indicators are used:

- I - Part D Buy-Down Premium is included
- E - Part D Buy-Down Premium is excluded
- C - Part D Buy-Down PMPM rate as specified by the contract

Sample member capitation assessment

Capitation reports reflect the cap premium gross cap amount. A medical group/IPA and/or capitated facility with a percent of premium contract can request a sample member capitation assessment.

For MA plans, the review reflects the premium received from CMS. It also shows the transactions outlined in the preceding CMS premium sections to calculate the standard services capitation payment.

You may request a sample member capitation assessment no more than once a year.

A medical group/IPA or capitated facility may request 1 member capitation assessment, covering 1 month within the past 12-month period, for no more than 6 members per contract year.

Confidentiality

Sample member capitation review results include confidential and proprietary information. The medical group/IPA or capitated facility must sign a confidentiality agreement before receiving a sample member capitation assessment. We only present this information in one of our offices. The confidentiality agreement states that assessment results may not be removed from the premises.

Capitation reconciliation

UnitedHealthcare produces capitation using 2 separate systems:

- Core transaction processing system — information from this system reflected in the capitation flat file and on the image reports. The summary reports, CP7030 or CP7010, go to the payment summary.
- Payment system — information from this system reflects the sum of the core transaction system, system transaction plus any non-system manual adjustments

We provide a capitation payment summary to each medical group/IPA to allow the medical group to reconcile the monthly capitation payment. The payment amount is the sum of the amount from the core transaction processing system, plus any non-system adjustments.

Capitation adjustment codes

We use capitation adjustments in a variety of circumstances. Each adjustment consists of a 3-character Capitation Adjustment Code. Each adjustment code has a corresponding description. We use adjustment codes to administer a specific system-generated payment or carve-out per your Agreement. We also use a code for a non-system adjustment.

The flat file contains only the capitation adjustment code. However, the CP7020 image report contains both the capitation adjustment code and corresponding description.

We give health care providers documentation, as specified in this guide, in support of each capitation payment.

Non-system manual adjustments

An electronic format of non-system manual adjustments and corresponding backup documentation are available on **UHCprovider.com**. Each adjustment is reported as a separate line item on the payment summary. To force these

adjustments through the system, we reverse them in the next processing-period, processed as a system adjustment and reported on the flat file and image reports.

Provider remittance advice (PRA)

The invoice number on the PRA is an indication of the source system from which the transaction originated. Each transaction originated from either the core transaction processing system (NICE) or payment system as a non-system manual adjustment (ORACLE). Each of the source systems follows an invoice numbering convention as follows:

- Core transaction: YYMMPPNNNNSSDD (Example: 1701CO 00013301). This amount will foot to the CP7030 or CP7010 [image reports]:
  - YY – last 2 [4] digits of the year (06)[(2006)]
  - MM – month (06)
  - PP – product type (CO) Commercial [(SH) Medicare]
  - NNNN – computer generated sequential number (0001)
  - SS – UnitedHealthcare State code (33)
  - DD – UnitedHealthcare division code (01)
- Non-system manual adjustment: YYM M PPAAACTN N N N N N I IOSSDD (Example: 0606COALG 1101 [SHQMB] 2345JSC [ZZC] 3301). This amount will not be included in the Capitation Reporting:
  - YY – last 2 digits of the year (06)
  - MM – month (06)
  - PP – product type (CO) Commercial [(SH) Medicare]
  - AAA – adjustment code (Example MBR would be for a member adjustment.)
  - C – transaction count (1)
  - T – contract type (1) values include; 1-Primary Care, 2-Facility, 3-Subcap, 4-Third Party
  - NNNNNN – health care provider number (01 2345)
  - II – internal document tracker (JS) [(ZZ)]
  - ORACLE system indicator (C)
  - SS – UnitedHealthcare state code (33)
  - DD – UnitedHealthcare division code (01)

Extended retro process (Medicare Advantage)

CMS sends MA premium payment adjustments to UnitedHealthcare that may span over a 72-month time frame on the Monthly Membership Report (MMR). Our capitation processing engine can only process retroactivity up to 48 months, regardless of contractual or eligibility limitations on retroactive changes. We apply the premium capitation calculation methodology. These extended retro process adjustments appear on the capitation flat file, 3M record type with the following adjustment codes:

- **MMR** – standard retroactive premium payment adjustments
- **MME** – adjustments represent transactions outside of the 6-month retro window that error out during the processing of the MMR
- **MMX** – adjustments represent transactions for members that could not be identified during the processing of capitation or are beyond the 48-month system limitation
- The MME and MMX adjustments processed in subsequent months after they occur, due to the research involved to complete these transactions

Delegate performance management program

We conduct an analysis of clinical, quality and health outcomes to identify potential variations in care delivery to support the best quality care and outcomes for our members. By comparing data that is risk-adjusted when appropriate, identifying variations from peer benchmarks and sharing that information with you, we can collaborate to improve value for our members.

Together, we get a clearer picture of measures that may provide opportunities for improving quality and care experiences for our members. We account for standards of care, evidence-based guidelines and Choosing Wisely® recommendations from the American Board of Internal Medicine Foundation, supported through partnerships with more than 70 national medical specialty societies. Any changes to care programs not previously communicated to the Delegation Oversight Committee should be raised during annual review.

Performance domains

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

Delegate performance domains include:

- Clinical UM
- Clinical quality including STARS, HEDIS and member satisfaction
- Encounter data performance management
- Financial performance management
- Compliance with UnitedHealthcare, federal and state requirements

Performance domains are evaluated regularly, compared with peer benchmarks, and communicated to the delegate in performance reports.

Improvement action plans

We may require the delegate to develop an improvement action plan designed to bring the delegate into compliance with performance standards.

Delegates who do not achieve compliance within the established time frames may require continued oversight until they achieve compliance.

Continued noncompliance or failure to perform may result in removing the delegate from the services.

Notification of platform transitions or migrations

During our initial review of a delegate's operational capabilities, we also review the delegate's information systems or transaction platforms to validate their ability to comply with our operational and regulatory requirements and connectivity standards.

Therefore, we request the delegate provide at least 270 calendar days advance written notice to their UnitedHealthcare delegation oversight representative and their UnitedHealthcare contract administrator or provider advocate of the intent to either:

- Change administrative platform(s) for impacted delegated function(s), including migrations, version upgrades or conversions
- Make material changes in existing administrative platforms that might impact delegated functions. If you are unsure of what a material change is, contact your delegation oversight representative.

Most changes require pre-cutover evaluation and testing by the UnitedHealthcare delegation oversight team(s) to ensure continued compliance with all regulatory compliance and data sharing capabilities. Failure to adhere to these notification requirements may result in financial penalties and/or loss of delegation responsibilities.

Appeals and grievances

Member grievance and appeals

The member appeals process is never delegated. Network providers are required to:

- Immediately, within 1 hour of receipt, forward all member grievances and appeals (complaints, appeal, quality of care/service concern, whether oral or written) to us for processing to:

  UnitedHealthcare
  P.O. Box 6106
  Mail Stop CA 124-0157
  Cypress, CA 90630

  Fax: 1-888-517-7113

  uhc.com/medicare
- Respond to our requests for information about the member's appeal or grievance within the designated time frame. For expedited appeals, submit the requested information within 2 hours. For standard appeals, submit within 24 hours (no exceptions or delays due to weekend or holidays). Time frames apply to every calendar day of the year.
- Comply with our final determinations regarding member appeals and grievances
- Cooperate with us and the external independent medical review organization. This means promptly forwarding copies of all medical records and information relevant to the disputed health care service in your possession to the external review organization, and/or any newly discovered relevant medical records or any information in your possession, requested by an external review organization. Respond to our requests for proof of claim payment or a copy of the preservice authorization of overturned appeals: expedited appeals, within 2 hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Time frames apply to every calendar day of the year.
- Provide us with proof of claim payment or a copy of the preservice authorization within the stipulated time frames on reversals of adverse determinations. Respond to requests for proof overturned appeals were resolved: expedited appeals, within 2 hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Time frames apply to every calendar day of the year.

UnitedHealthcare West member grievances

CA commercial

Members may use a UnitedHealthcare West Grievance Form to file their grievance. We do not delegate authority or responsibility for processing member grievances, appeals or complaints to our network providers. However, we do require our network providers help resolve grievances, appeals or complaints.

For more information regarding disputes and grievance processes for UnitedHealthcare West members (AZ, CA, CO, NV, OK, OR, TX, WA), refer to the **UnitedHealthcare West Supplement**.

Empire Plan supplement

Applicability of this supplement

This supplement applies to providers contracted directly for The Empire Plan as well as providers contracted for UnitedHealthcare commercial plans who see Empire Plan patients. There are some specific protocols and requirements included here that apply only to directly contracted providers and home care providers, as noted.

The Empire Plan is a health insurance program developed by New York State and its employee unions, especially for employees of New York State and their families. It is the most selected group health insurance option under the New York State Health Insurance Program (NYSHIP), covering more than 1 million employees, retirees and eligible dependents from more than 740 participating employers and agencies. There are member populations nationwide with larger concentrations located in New York, Arizona, California, Connecticut, Delaware, Florida, Georgia, Massachusetts, Maryland, North Carolina, New Jersey, Nevada, Pennsylvania, South Carolina, Tennessee, Texas and Virginia.

Multiple carriers/vendors are involved in plan administration:

- Medical/Surgical Program is administered by UnitedHealthcare. It includes a PPO network for its Participating Provider Program. Certain hospital services are included in this coverage.
- Hospital Program is administered by Anthem Blue Cross
- Mental Health and Substance Use Disorder Program is administered by Carelon Behavioral Health Solutions
- Prescription Drug Program is administered by CVS Caremark

Referrals

The Empire Plan does not include requirements for a PCP to coordinate referrals for specialist care. Members may self-refer to any health care provider for covered services and receive appropriate in-network or out-of-network benefits based on the network status of the health care provider. The benefit level for services from non-network physicians and health care professionals may be less than that for services from network physicians and health care professionals.

Anesthesia services

You will ensure all covered anesthesia services rendered at your practice location are performed by participating health care providers for as long as the Agreement is in effect.

Laboratory services

We only reimburse for laboratory services you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services if you don't have the applicable CLIA certification.

Specimens collected for evaluation elsewhere must be directed to a network commercial laboratory.

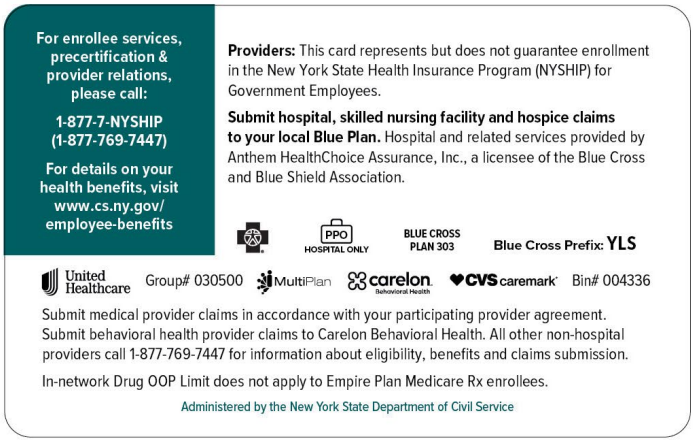
Other services

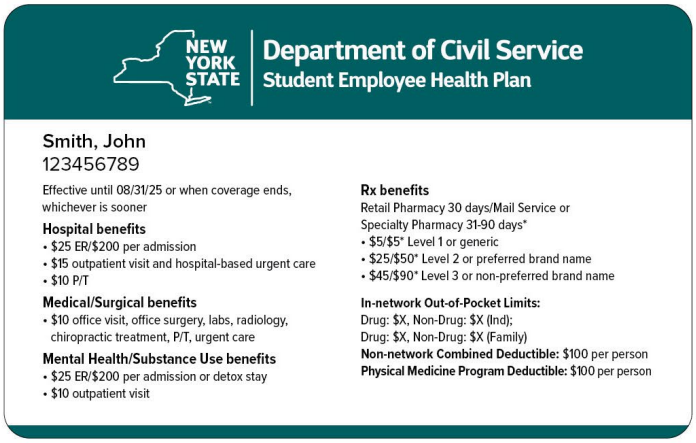
If you determine a member requires treatment or services from another health care provider, you must use reasonable efforts to refer them to a network provider.

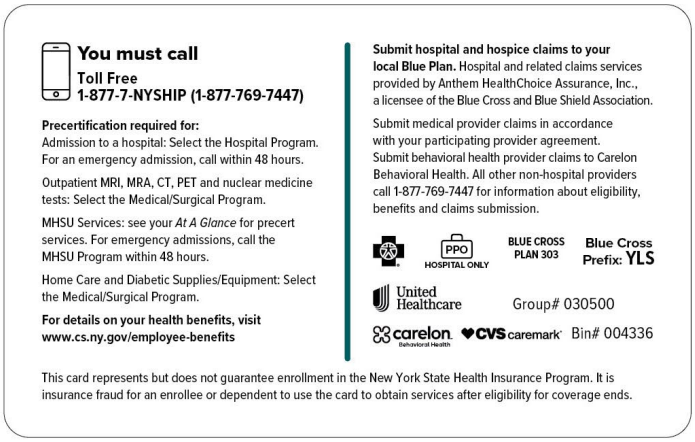
ID cards

Empire Plan participants are given NYSHIP ID cards by the State of New York Department of Civil Service, The Empire Plan policyholder. Current versions of NYSHIP ID cards are displayed on the following page. Prior versions also remain

in circulation. Some list The Empire Plan name and/or carriers involved in coverage; others do not. All are valid Empire Plan ID cards.







Eligibility

UnitedHealthcare will verify a plan participant's eligibility based on the data available at the time the request is made. Subsequent changes to eligibility may not be available at the time of the request and may alter the plan participant's eligibility on that particular date. Accordingly, verification of eligibility is not a guarantee of coverage.

Eligibility under a benefit contract may change retroactively if:

- We receive information that an individual is no longer a plan enrollee
- The individual's policy/benefit contract has been terminated
- The enrollee decides not to purchase continuation coverage; or
- The eligibility information we receive is later determined to be false

If you have submitted a claim(s) that is impacted by a retroactive eligibility change, a claim adjustment may be necessary. The reason for the claim adjustment will be reflected on the EOB.

Prior authorization and notification requirements

The advance notification/prior authorization list referenced in **Chapter 7** of this guide does not apply to The Empire Plan. The Empire Plan requires advance notification of the procedures and services listed in the following

chart. These services are likely to identify members with unmet health care needs who will benefit from the UnitedHealthcare programs, or those of other Empire Plan vendors. In general, depending on the program, members are responsible for either notifying Empire Plan program vendors of certain services or for using network providers for these services. However, home care providers are required to make these notifications for their services, and other network physicians/providers are encouraged to be aware of when their services require notification and notice from the physician/provider is accepted.

Call 1-877-7-NYSHIP (1-877-769-7447) and follow the prompts to notify the appropriate program carrier/vendor as outlined on the following page, or go to **UHCprovider.com** > Sign In > Prior Authorizations.

This notification list may be modified. The presence or absence of a procedure or service on this list does not mean that benefit coverage exists for that procedure or service. The member benefit contract will determine whether a procedure or service is covered.

Service	Contact
Advanced diagnostic imaging services • MRI • MRA • CT scan • PET scan • Nuclear medicine test	UnitedHealthcare Benefits Management Program
Alcoholism treatment	Carelon Behavioral Health Solutions Mental Health & Substance Use Disorder Program
Chiropractic services	Managed Physical Network, Inc. (MPN) Managed Physical Medicine Program
DME and integral supplies • Mastectomy prosthetics over $1,000 • Diabetic shoes (when The Empire Plan is primary coverage) • DME items listed on the DME Notification List at **UHCprovider.com** > Prior Authorization > Advance notification > Empire Plan Notification Lists > **Empire Plan Durable Medical Equipment (DME) Notification List for Members with Primary Empire Plan Coverage**	UnitedHealthcare Home Care Advocacy Program
Enteral formulas for home use (except administration of enteral formula through a tube for patients whose primary coverage is Medicare)	UnitedHealthcare Home Care Advocacy Program
Home skilled nursing services (not including infusion administration) • More than 4 hours (or 2 visits) per day	UnitedHealthcare Home Care Advocacy Program

Service	Contact
Hospital admissions • Elective • Emergency/urgent (within 48 hours)	Anthem Blue Cross Benefits Management Program
Mental health services	Carelon Behavioral Health Mental Health & Substance Use Disorder Program
Physical/occupational therapy	MPN Managed Physical Medicine Program
Prescription drugs as noted in Preferred Drug List or Flexible Formulary List	CVS Caremark Prescription Drug Program
Skilled nursing facility admissions	Anthem Blue Cross Benefits Management Program
Substance use disorder services	Carelon Behavioral Health Mental Health & Substance Use Disorder Program

Billing

Patient not initially identified as a plan participant

While participants are advised to present their identification cards before services are rendered, this is not required for your participating provider agreement to be binding. And, there is no penalty imposed upon the patient for failure to do so if that patient is otherwise eligible for coverage. A patient may be billed directly if it cannot be proved that a patient is a plan participant at the time of service. If it is later determined that the patient is a plan participant and has paid for rendered services, which are covered under his or her benefit plan, you must refund the plan participant any amounts collected in excess of applicable copayments no later than 20 days from the date you first learn of the overpayment.

Copayments

A copayment is a specific dollar amount paid by a plan participant for covered services under the benefit plan (e.g., physician office services.)

For Empire Plan members, services that require a copayment are classified into 4 basic categories:

- Therapeutic/diagnostic office treatment
- Office surgery
- Diagnostic tests – laboratory services
- Diagnostic tests – radiology services

For most plan enrollees, there is a maximum of 1 copayment for all of the above services performed on the same date. A limited number of members have a maximum of 2 copayments for the above services performed on the same date — 1 copayment for office treatment and office surgery on the same date, and 1 copayment for laboratory and radiology services on the same date.

For questions or confirmation of copayment requirements for a specific patient, go to **UHCprovider.com** > Sign In > Eligibility or call 1-877-7-NYSHIP. An Empire Plan Medical Program Copayment Guide is also available; contact Empire Plan Network Management for a current copy if needed.

At the time of service, plan participants can be charged the indicated copayment for billable services performed. A copayment should be collected only for services that are reimbursable under the plan participant's benefit plan.

- If the copayment is more than your contracted fee for the service, collect the contracted fee rather than the copayment amount
- If the plan participant is covered by more than one benefit plan, see COB and Fee Schedule concerning collection of copayments
- Certain covered services are excluded from copayment requirements under The Empire Plan. These are listed on The Empire Plan Copayment Guide and include:
  - Allergy immunizations/serum
  - Chemotherapy
  - Hemodialysis
  - Home Care Services covered under the Home Care Advocacy Program
  - Prenatal care
  - Radiation therapy
  - Well-child care
  - Services defined as Essential Preventive Services by the Patient Protection and Affordable Care Act, also known as Federal Health Care Reform
- No copayment should be collected for services that are not normally identified/billed separately. Some examples of these services for which no copayment should be collected include:
  - Prenatal visits and 6-week checkup after delivery
  - Surgical visits included within the global period
  - Minor services that would not be normally billed
  - Dispensing of prescription drugs

Copayment requirements are subject to change, and changes will be communicated via **UHCprovider.com**.

Copayment or coinsurance waiver

A copayment is an expense that the plan participant is legally obligated to pay. Physicians and providers must collect copayments and coinsurance as defined by the plan participant's benefit plan.

Non-notification

Varying levels of benefit reductions are applied when required notifications are not made.

- Home care providers. You are responsible for the notification requirements that apply to your services and cannot bill the patient for any notification reductions applied to your services.
- Other providers. You are encouraged to assist your patients with program compliance, but enrollees are responsible for fulfilling notification requirements where necessary. You may bill the patient for any notification reduction amount applied to your services.

Incomplete/missing claim information

A plan participant may not be billed for services for which a claim submission has been returned to the physician or provider for lack of information or where a claim has never been submitted.

Claims submitted late

When payment is denied because the claim was submitted late, the participating provider cannot bill the patient for the services in question beyond the copayment typically collected at the time of service.

Timely filing

Submit the claim no later than 120 days after the end of the calendar year in which covered services are rendered.

Coding criteria

The UnitedHealthcare standard is to accept current CPT®, ICD and HCPCS codes and modifiers. This is the accepted methodology for coding all claim submissions. However, acceptance of a code or modifier does not imply payment or additional payment for the service or situation identified by that code or modifier.

Impact of Medicare

Retired employees and/or their dependents

If a retired employee or dependent is eligible for primary coverage under Medicare – even if s/he fails to enroll – covered medical expenses will be reduced by the amount that would have been paid by Medicare, and UnitedHealthcare will consider the balance for payment, subject to applicable copayments. When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal or, in some cases, state regulations rather than the network fee schedule.

Active employees and/or their dependents

The Empire Plan will automatically be the primary payor for active enrolled employees, regardless of age, and for the employee's enrolled dependents (except for domestic partner eligible for Medicare due to age) unless end-stage renal disease provisions apply. Medicare will be secondary payer. (Note for domestic partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes eligible due to disability, The Empire Plan is primary.)

Disability

Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must enroll in Parts A and B of Medicare and apply for available Medicare benefits. Empire Plan benefits are reduced to the extent that Medicare benefits could be available.

End-stage renal disease

For those eligible for Medicare due to end-stage renal disease, whose coordination period began on or after March 1, 1996, The Empire Plan will be primary for the first 30 or 33 months of treatment, depending on the situation. Then, Medicare becomes primary. Benefits are reduced to the extent that Medicare benefits could be available.

Medicare Advantage HMOs

If an Empire Plan enrollee enrolls in a health maintenance organization under a Medicare Advantage contract, The Empire Plan will not provide benefits for any services available through the HMO or services that would have been covered by the HMO if the patient had complied with the HMO's requirements for coverage. Covered medical expenses under The Empire Plan are limited to expenses not covered under the Medicare Advantage Contract with the HMO. If the HMO Medicare Advantage Contract has a point-of-service option that provides partial coverage for services received outside the HMO, covered medical expenses under The Empire Plan are limited to the difference between the HMO's payment and the amount of covered expenses under The Empire Plan.

COB and fee schedule

When Medicare or another primary carrier pays benefits first, the total of the primary payer's payment, the UnitedHealthcare payment, and the plan participant's copayment represents payment in full to participating providers. This remains true even if the total paid is less than the amount initially billed and/or the primary payer applies all or a portion of its approved amount to a deductible and pays $0 or a nominal amount.

When the patient is covered by more than 1 plan, you should not collect charges that may be covered through coordination of benefits. This would include not collecting copayments. By following this procedure, you will save the

time and expense of reconciling payments and remitting reimbursement checks to plan participants who have dual coverage. However, if you do collect payments from the plan participants in error, you are required to reimburse the plan participant.

Termination and transfer of plan participants

Physicians and providers may not seek or request termination of an Empire Plan member's coverage, transfer of their coverage to another health benefit program, or transfer of their care to another health care provider due to the plan participant's medical condition or amount, variety or cost of covered services required by the plan participant.

If your network participation terminates for any reason, and your patient chooses to transfer to a different physician/provider, you are required to participate in the transition of your patient toward timely and effective care.

Post-payment audits

Post-payment audits may be conducted by UnitedHealthcare, the UnitedHealthcare customer (e.g., New York State), or a UnitedHealthcare representative. In such cases, an independent audit firm may be employed by to conduct the audit. You must make the necessary information available (e.g., patient's medical and billing records) to ensure a successful audit. **UnitedHealthcare will not pay administrative fees for or connected with audit purposes.**

Retrospective review

UnitedHealthcare may conduct retrospective review of services provided to an Empire Plan enrollee. Retrospective review of any case may include:

- Review of the appropriateness of care if not reviewed previously
- Review of coding accuracy of diagnoses and procedures
- Review for any quality concerns or opportunities to improve the care or outcome

Medically necessary or medical necessity

For The Empire Plan, covered health care services and supplies must be medically appropriate, and:

- Necessary to meet the basic health needs of the covered person
- Rendered in the least intensive and most appropriate setting for the delivery of the service or supply
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare
- Consistent with the diagnosis of the condition
- Required for reasons other than the comfort or convenience of the covered person or his/her physician
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - Safe with promising efficacy for treating a life-threatening sickness or condition, in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health

(For the purpose of these criteria, the term life-threatening is used to describe sicknesses or conditions that are more likely than not to cause death within 1 year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or pregnancy does not mean that it is a medically appropriate covered medical expense as defined in the covered person's benefit contract. These criteria relate only to coverage and may differ from the way in which a physician engaged in the practice of medicine may define a medically appropriate service.

Services and supplies that do not meet these criteria are not covered and will not be paid. Billing the member for services not paid are subject to the process outlined in **Chapter 11: Charging members for noncovered services**.

There may be instances when a medical director will review the medical treatment plan of a member with you. The medical director may discuss the reasoning or indication that led you to the proposed or performed procedure/treatment.

Care coordination activities

UnitedHealthcare care coordination activities are designed to help facilitate and coordinate requested health care services to achieve care that is:

- Consistent with evidence-based standards of medical care
- Provided at the appropriate level of care and service
- Rendered without delays in service
- Timely in meeting the needs of the enrollee
- Effective in identifying gaps in care, and opportunities to improve care and reduce readmissions
- Covered under the enrollee's benefit plan

These activities focus on assisting members to facilitate and coordinate access to care by offering timely health education programs, helping identify and prevent delays in service(s) and working to eliminate gaps in care while providing support to members with health care needs. For The Empire Plan, UnitedHealthcare care coordination activities include:

Home Care Advocacy Program (HCAP)

The UnitedHealthcare Empire Plan Care Coordination Unit administers the Home Care Advocacy Program (HCAP). This program is designed to facilitate the implementation of the physician's treatment plan by helping coordinate timely access to home care services, including durable medical equipment/supplies, home nursing and home infusion. An enhanced level of benefits is available, when Empire Plan participants call HCAP to arrange for certain services/items and use HCAP-approved providers. Services/items covered by HCAP include:

- Durable medical equipment and integral supplies
- Home skilled nursing services
- Home infusion and enteral therapy

No copayment is required for covered home health services; payment is made in full directly to the in-network home care provider according to contracted rates. Copayments may be collected for medications covered under The Empire Plan's Prescription Drug Program.

Site of Care program for infusions

When The Empire Plan is the primary coverage, The Empire Plan Hospital Program will review the setting for certain infusion services. If clinically appropriate, the Hospital Program and the UnitedHealthcare Care Coordination Unit will work with you and your patient to transition those services from an outpatient hospital setting to a new location. Alternate settings include freestanding infusion suites, a doctor's office or the patient's home. There are no Medical/Surgical Program or Prescription Drug Program copayments when patients use an alternate setting. Enrollees may choose to continue infusion services in an outpatient hospital setting when clinically appropriate or when there is no alternate setting available within 30 minutes or 30 miles of their home.

Infertility Benefit Management Program

The Empire Plan Infertility Benefit Management Program is designed to facilitate and coordinate access to infertility specialists. The primary components are the UnitedHealthcare Care Coordination Unit and Centers of Excellence. If there is a member for whom you are recommending infertility related services, including the initial evaluation, advise the member to contact UnitedHealthcare prior to services being rendered.

The UnitedHealthcare Empire Plan Care Coordination Unit helps facilitate and coordinate:

- Eligibility and benefit review
- Network education and guidance
- Health care services

Centers of Excellence provide Empire Plan enrollees with access to a network of respected specialists that have demonstrated clinical excellence in the field of infertility. Current infertility services under contract through Centers of Excellence include patient education/program orientation, diagnostic testing, ovulation induction/hormonal testing, surgery to enhance reproductive capability, and certain specialized procedures that facilitate pregnancy but do not treat the cause of infertility.

Disease management

The UnitedHealthcare disease management programs consist of interventions designed to help improve the outcome of members with specific chronic diseases by:

- Providing information and education on the member's disease
- Assisting the member in prevention of exacerbations
- Managing the course of their disease

The programs focus on education, self-care, compliance and health status. The defined interventions are based on nationally recognized, evidence-based guidelines. The clinical objective of these programs is to work with the member and their physician or other health care providers to achieve desired clinical outcomes.

For The Empire Plan, UnitedHealthcare provides a comprehensive and integrated disease management program for the most prevalent chronic conditions of diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, and co-morbid conditions of hyperlipidemia, hypertension, depression and obesity. The program is completely voluntary and available to Empire Plan non-Medicare enrollees and their dependents.

Program design features include:

- All members have access to online condition-specific information
- Low and moderate acuity members receive self-care materials, including targeted evidence-based information, program overviews, tracking tools and health logs
- High acuity individuals gain access to a personal nurse with expertise who can assess and address gaps in care, transfer skills and knowledge, and drive meaningful improvements in individual health
- Scheduled calls with a nurse
- Outreach depending on risk stratification and individual needs
- Integration and coordination with other clinical resources including NurseLine℠, case management, behavioral health and hospital discharge planners

Activities by other Empire Plan vendors

The following programs are administered by other vendors or other vendors in partnership with UnitedHealthcare:

Prescription Drug Program

Many Empire Plan members are covered by the New York State Empire Plan Prescription Drug Program. The program includes participating pharmacies, copayments, mandatory generic substitution, supply and coverage limits, prior authorization for certain drugs, and mail service pharmacy services. Empire Plan drug lists are available.

Empire Plan network physicians are expected to:

- Prescribe generic drugs whenever therapeutic equivalent drugs are available and/or let your patient know that an equivalent generic drug may be substituted for brand drugs under the benefit program
- Attempt to use a network pharmacy when sending a prescription to a pharmacy

- Accept the call from a network pharmacy to notify you of a problem or ask a question regarding the prescribed drug
- Participate in the prior authorization process when needed

Mental Health and Substance Use Disorder Program

The Empire Plan Mental Health and Substance Use Disorder Program provides comprehensive coverage for mental health and substance use disorder care, including alcoholism and eating disorders. To receive the maximum benefits available under the program, plan participants must call the program administrator before seeking treatment and must follow the administrator's recommendations. Limited benefits may be available for medically appropriate care when they do not. The program includes a participating provider network, certification of covered services, and concurrent review.

Managed Physical Medicine Program

The Empire Plan Managed Physical Medicine Program covers medically appropriate services typically performed by a chiropractor or physical therapist. Other providers, such as osteopaths and occupational therapists, may also provide these services. The provider must be licensed to perform such services in the state where the service is received, and physical therapy must be prescribed by a doctor. To receive the maximum benefits available, plan participants must use a provider in the administrator's network who is responsible for certifying medically appropriate care, or they must follow the administrator's recommendations when a network provider is not available. Limited benefits may be available for medically appropriate care when they do not.

Practitioners participating in the UnitedHealthcare Empire Plan network may also render services covered under this program. If so, you are required to comply with reviews conducted by the program administrator.

Additional notes for Empire Plan directly contracted providers

Notify Empire Plan Network Management in writing via the fax number or address found later in this supplement. Be sure to include the appropriate IRS Form W-9 (available at irs.gov) for Tax Identification Number changes; changes in name, ownership, or control; or adding a physician or health care provider to your practice.

Additional notes for network home care providers

Home health care/nursing claim requirements

- Include nursing shift hours. Use the shaded area above each service line in section 24 of the CMS-1500 (08-05) form. For electronic claims, use the 2400 loop, NTE segment with an ADD qualifier in the NTE01 element; then enter the hours in the NTE02 element.
- Identify partial nursing hours by billing a prorated fee for the partial hour and clearly noting the shift hours as outlined above
- Weekly billing cycles. The standard week for Empire Plan authorizations is Sunday 12 a.m.–Saturday 11:59 p.m. If you use a weekly billing cycle that does not follow this standard, we will adjust the hours submitted to fit our standard week when comparing the number of hours authorized.
- Overnight shifts. Each date of service runs from 12 a.m.–11:59 p.m. Be sure to bill each hour of service on the date it was actually rendered. For example, a shift from 11 p.m. on Monday to 7 a.m. on Tuesday encompasses 2 dates of service and would result in 1 hour billed for Monday and 7 hours billed for Tuesday.
- Location of service. Location of service identified on the claim must accurately reflect the location where services were actually performed. One circumstance where errors are often made in reporting location of service relates to services provided while a child is in school. These are often incorrectly reported with a location of '12,' which represents home, while the correct location for School is 03.

Network benefit

Covered home care services rendered by a network provider are paid in full. No deductible or copayment is required. Payment is sent directly to the network provider. Failure to comply with the Notification Requirement detailed on the following page will result in non-payment for those services, except in the case of an emergency. (Note: Services covered under other Empire Plan programs, such as prescription drugs, may be subject to copayments as required by the provisions of those programs.)

Services/items considered eligible expenses under HCAP when prescribed by a physician and determined by UnitedHealthcare to be covered under The Empire Plan include:

- **Durable Medical Equipment (DME) & Integral Supplies** – medical equipment that is for repeated use and is not a consumable or disposable item, is used to serve a medical purpose, is appropriate for use in the home, and is generally not useful to a person in the absence of a sickness or injury. When appropriate, HCAP benefits are provided for the rental or purchase of durable medical equipment. Also covered are supplies that are an integral part of durable medical equipment such as tubing, masks and filters for CPAP, BiPAP, and nebulizers and batteries and electrodes for TENS units. Items not covered under HCAP may be eligible for coverage under the Basic Medical Portion of the Plan unless provided by a network provider as explained below. Coverage is also provided for any repairs and necessary maintenance not covered under a manufacturer's warranty. For Medicare primary members, if Medicare approves a DME item, The Empire Plan will cover the balance after Medicare's payment at 100%. If payment for a DME item is denied by Medicare because their requirements were not followed, The Empire Plan will also deny payment.
- **Home Nursing Services** – skilled nursing visits are covered when prescribed by and rendered under the supervision of a physician. Inpatient nursing visits will not be considered a covered expense. Services must require the skills of nursing care when that care is needed to manage medical problems of acutely ill patients. Assistance with daily living, companionship or any other service, which can be given by a less skilled person, such as a home health aide is not covered.
- **Home Infusion Therapy** – coverage under HCAP includes intravenous therapy such as chemotherapy and pain management. Care must be prescribed by and under the supervision of a physician. Prescription medications used in therapies such as chemotherapy and pain management and dispensed by a licensed pharmacy are subject to the provisions of The Empire Plan prescription drug program.
- **Certain other home health care services and prescription drugs when the home care arranged through HCAP** – this includes physical medicine services such as physical therapy, occupational therapy and chiropractic. However, physical medicine services are coordinated by The Empire Plan's Managed Physical Medicine Program.

Covered non-HCAP items

Empire Plan participants may request certain medical items that do not require notification but can be provided by a home health care provider. This includes items such as wound care supplies, urinary catheter supplies, tracheostomy supplies, braces, aerochambers, erectaids, etc.

Requests by Empire Plan participants for covered medical items not included under HCAP should be provided, if available, at the time of the call. Claims for these items can be billed directly to UnitedHealthcare and will be reimbursed under the provider network agreement according to the established reimbursement rate. The plan participant is not responsible for any copayments.

Notification requirement

Network home care providers are responsible for the home care service notifications outlined under prior authorization and notification requirements prior to the delivery of such services.

Most determinations are made at the time of the initial call to the CCU; however, certain services may require further review.

For ongoing care, a subsequent call to HCAP is required to determine eligibility for continued benefit coverage (concurrent review). This call must be made prior to the expiration of the original authorization period.

In an emergency or urgent situation, the plan participant may seek and receive necessary care without prior notification to HCAP. In the case of emergency services rendered without prior notification, the network home care provider must provide notification the next business day or as soon as reasonably possible. If HCAP determines that the urgent or emergency care was an eligible expense, a benefit will be available for covered services and/or items.

Online resources and how to contact us

The following outlines Empire Plan specific contact information that may differ from the standard contacts and tools outlined earlier in this guide.

Resource	Where to go
Advance notification and prior authorization (submit and get status information)	**EDI:** See EDI transactions and code sets on **UHCprovider.com/edi** **Online: UHCprovider.com** > Sign In > Prior Authorizations **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Admission notification	Anthem Blue Cross **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Cancer resource services	**Phone: 1-866-936-6002**
Chiropractic/Physical therapy/ Occupational therapy services	Empire Plan Managed Physical Medicine Program/Optum **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Claims (filing, payments, reconsiderations, grievances)	**EDI: UHCprovider.com/edi** Payer ID: 87726 **Online: UHCprovider.com** > Sign In > Claims & Payments **Paper:** Empire Plan Claims UnitedHealthcare, PO Box 1600 Kingston, NY 12402-1600 **Information: UHCprovider.com/claims** (policies, instructions and tips) **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Contractual practice changes	**Directly contracted** **RightFax:** 1-844-897-5439 **Mail:** Empire Plan Network Management UnitedHealthcare, PO Box 2300 Kingston, NY 12402-2300 **Commercial:** See standard contact information outlined earlier in this guide and at **UHCprovider.com**
Credentialing	See standard contact information outlined earlier in this guide and at **UHCprovider.com**
Customer care	Empire Plan Medical/Surgical Program/UnitedHealthcare **Phone:** 1-877-7-NYSHIP (1-877-769-7447)

Resource	Where to go
Demographic changes	See standard contact information outlined earlier in this guide and at **UHCprovider.com**
Health information and support resources	Empire Plan NurseLine **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Home care services	Empire Plan Home Care Advocacy Program/UnitedHealthcare **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Hospital services	Empire Plan Hospital Program/Anthem Blue Cross **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Infertility services	UnitedHealthcare/Home Care Advocacy Program **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Kidney resource services	**Phone: 1-866-561-7518**
Member/customer care	**Online: myuhc.com** **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Mental health and substance use disorder services	Empire Plan Mental Health and Substance Use Disorder Program/Carelon Behavioral Health **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Overpayment refunds	**Mail:** Empire Plan Claims, PO Box 1600, Kingston, NY 12402-1600
Pharmacy services	Empire Plan Prescription Drug Program/CVS Caremark **Phone:** 1-877-7-NYSHIP (1-877-769-7447)
Provider directory	**empireplanproviders.com**

Leased Networks supplement

This may apply to health care providers in Hawaii, Kentucky, Michigan, Puerto Rico and the U.S. Virgin Islands. Refer to your Agreement.

Applicability of this supplement

The Leased Network supplement applies to physicians, health care professionals, facilities and ancillary providers who participate through a leased network for certain products accessed by UnitedHealthcare in an area where we do not have a direct network.

These participating health care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For topics not referenced in this supplement, refer to main guide.

Leased supplement

For these certain products, the mention of a health care provider's "Agreement with us" refers to your agreement with the entity operating the leased network (your "Master Contract Holder").

For the following processes, follow your Master Contract Holder Agreement to:

- Update demographic information
- Submit NPI information
- Submit credentialing/recredentialing information

Level2 supplement

Applicability of this supplement

You are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location. Refer to the main guide for anything not found in this supplement.

How to contact Level2

Group Number: 921728

Resources	Where to go	What you can do there
Cardiology Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/cardiology** **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient cardiology prior authorization protocol** section of **Chapter 7: Medical management**
Claims submission	**Online: UHCprovider.com** > Sign In > Claims & Payments **Payer ID:** Refer to the number listed on the member's ID card **Information: UHCprovider.com/claims**	
Genetic and molecular testing	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need.	Verify eligibility and benefits of enrolled members
Outpatient injectable chemotherapy and related cancer therapies	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Phone: 1-888-397-8129**	Policies and instructions
Pharmacy services	**Prior authorizations phone: 1-800-711-4555** **Benefit information:** Call the number on the back of the member's ID card.	For information on the Prescription Drug List (PDL), **myallsaversconnect.com**

Resources	Where to go	What you can do there
Prior authorization and notification	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/priorauth** **Phone (only where telephonic submission is permitted): 1-800-999-3404**	Prior authorization and notification is required as described in **Chapter 7: 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** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient radiology prior authorization protocol** section of **Chapter 7: Medical management**.

Health plan ID cards

Level2 members receive health plan ID cards with information that helps you to submit claims. The cards list the claims address, copayment information and phone numbers.

A sample ID card and more information is in the health plan identification (ID) cards section in **Chapter 2**.

Claims process

Follow these steps for fast payment:

1. Notify Level2
2. Prepare a complete and accurate claim form
3. For Level2 members, submit electronic claims using payer ID number listed on the member's ID card. Submit paper claims to the address on the member's ID card.
4. For contracted care providers who submit electronic claims and would like to receive electronic payments and statements, call Optum Financial Services Customer Service line at **1-877-620-6194** or visit **optumbank.com** > Partners > **Providers**

Claim reimbursement (adjustments)

If you think your claim was processed incorrectly, call the number on the member's ID card. If you find a claim where you were overpaid, send us the overpayment within 30 calendar days. If we find a claim was overpaid, payment is due within 30 calendar days.

If you disagree with our decision regarding a claim adjustment, you may appeal.

Claim reconsideration, appeals and disputes

Claim reconsideration does not apply to some states based on applicable state legislation.

There is a 2-step process available for review of your concern. Step 1 is a claim reconsideration. If you disagree with the outcome of the claim reconsideration, you may request a claim appeal (step 2).

How to submit your reconsideration or appeal

Claims payment issues or outcome of a reconsideration review

If you disagree with claim payment issues or the outcome of your reconsideration review, submit your request using our electronic tools:

Online: **UHCprovider.com** > Sign In > Claims & Payments

API: Submit reconsiderations and appeals (with attachments) using API. Go to **UHCprovider.com/api** for more information.

Overpayment recoveries, pharmacy, medical management disputes or contractual issues

If you disagree with overpayment recoveries, pharmacy, medical management disputes, or contractual issues send a letter requesting a review to:

UnitedHealthcare Level2 members:

Mail:
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Fax: 1-801-478-5463
Phone: 1-866-661-1167

Time frame

You must submit your claim reconsideration and/or appeal to us within 12 months (or as required by law or your Agreement), from the date of the original EOB or denial. The 2-step process allows for a total of 12 months for timely submission, not 12 months for step 1 and 12 months for step 2.

What to submit

As the care provider of service, you submit the dispute with the following information:

- Member's name and health plan ID number
- Claim number
- Specific item in dispute
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved. If you disagree with the outcome of the claim appeal, you may file for an arbitration proceeding. (A description of this process is in your Agreement.)

Refer to Claim reconsideration and appeals process section in **Chapter 10: Our claims process**, for more information.

Mid-Atlantic Regional supplement

Applicability of this supplement

This Mid-Atlantic Regional supplement applies to services provided to members enrolled in:

- MD-Individual Practice Association, Inc. (M.D.IPA) and M.D.IPA Preferred
- Optimum Choice, Inc. (Optimum Choice), Optimum Choice Preferred and Optimum Choice Small Business Health Options Program (SHOP)

It may apply to health care providers in Delaware, Washington, D.C., Maryland, Pennsylvania, Virginia and West Virginia; reference your Agreement for applicability.

Health care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For protocols, policies and procedures not referenced in this supplement refer to appropriate chapter in the main guide.

A complete list of Mid-Atlantic Health plan protocols pertaining to M.D.IPA, M.D.IPA Preferred, Optimum Choice and Optimum Choice Preferred may be located on **UHCprovider.com/en/health-plans-by-state/maryland-health-plans/md-commercial-plans.html**

The term prior authorization referenced in this supplement is also referred to as preauthorization. We use both terms in this supplement. They mean the same.

Product summary

This table provides information about M.D.IPA and Optimum Choice products for the Mid-Atlantic Region.

Attributes	M.D.IPA and Optimum Choice	M.D.IPA Preferred and Optimum Choice Preferred
How do members access physicians and other health care professionals?	Members choose a PCP who arranges or coordinates their care, except emergency services, network OB/ GYN, routine eye refraction care and behavioral health care services.	**Network benefits:** Members choose a PCP who arranges or coordinates care, with the exception of emergency services, network OB/GYN, routine eye refraction care and behavioral health care services. **Out-of-network benefits:** Members are not required to have care arranged or coordinated by a PCP.
Does a PCP have to write a referral to a specialist?	**Yes,** except for visits to a network OB/GYN, routine eye refraction care, emergency services and behavioral health care services.	**Network benefits:** Yes, except for visits to a network OB/ GYN, routine eye refraction care, emergency services and behavioral health care services. **Out-of-network benefits:** No referral needed.

Attributes	M.D.IPA and Optimum Choice	M.D.IPA Preferred and Optimum Choice Preferred
Is the treating physician required to obtain prior authorization for procedures or services?	Yes; view the section on **Prior authorizations** process located within this supplement. Find a complete list of codes requiring prior authorization on **UHCprovider.com/priorauth** > Advance notification > Advance Notification and Clinical Submission Requirements > **UnitedHealthcare Mid-Atlantic Plans Prior Authorization Requirements**.	**Yes;** view the section on **Prior authorizations** process located within this supplement. Find a complete list of codes requiring prior authorization on **UHCprovider.com/priorauth** > Advance notification > Advance Notification and Clinical Submission Requirements > **UnitedHealthcare Mid-Atlantic Plans Prior Authorization Requirements**.

UnitedHealthcare Optimum Choice SHOP

For more information, refer to **Chapter 4: Individual Exchange plans**.

Key points	Optimum Choice SHOP Exchange
Product name	Optimum Choice, Inc.
How do members access physicians and other health care professionals?	For each covered family member, members choose a network PCP, or are assigned a PCP, to manage the member's care and generate referrals to network specialists when required.
Is a special referral required?	**Yes**, on selected procedures. See guidelines in the **Referrals** section of this supplement.
Are treating physicians and/or facilities required to request prior authorization when providing certain services?	**Yes**, on selected procedures. See guidelines in the Prior Authorization List located on **UHCprovider.com/priorauth**.

UnitedHealthcare Optimum Choice HSA Plan

The Optimum Choice and Optimum Choice Preferred HSA benefit plans are high-deductible medical benefit plans that combine our traditional gated HMO benefit plans with an HSA option. Expenses under this benefit plan are the member's responsibility until their deductible is reached. HSA benefit plans require reimbursement for services provided to members are based on a fee-for-service reimbursement methodology.

Key points	Optimum Choice, Inc. health savings account
PCP requirement	The Optimum Choice HSA product requires each UnitedHealthcare member to choose a PCP.
PCP referrals to network specialists	The member's PCP generates referrals for specialty care and facility care.

Key points	Optimum Choice, Inc. health savings account
Reimbursement	Services for members enrolled in Optimum Choice HSA are excluded from your capitation payment and are paid on a fee-for-service (FFS) basis per the All Payer Payment Appendix included in the UnitedHealthcare Physician Agreement.
Optimum Choice HSA member health plan ID card	The Optimum Choice HSA product name and member's PCP are indicated on the member's ID card. Specialist referral requirements are on the back of the ID card. Go to **UHCprovider.com** > Sign In > Eligibility.

Provider responsibilities

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

Eligibility and health plan ID cards

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

Before seeing a member, it is important you verify their eligibility and benefits in the **UnitedHealthcare Provider Portal**, as well as the member's PCP selection, to avoid payment issues. Go to **UHCprovider.com** > Sign In > Eligibility.

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

- Laboratory provider information is located on the front of the cards; see the **Laboratory requirements** section of this supplement
- Radiology county information is located on the front of the cards; see the **Radiology services** section of this supplement
- Information regarding the necessity of referral and prior authorization requirements is now listed on the back of the cards

Laboratory requirements

M.D.IPA and Optimum Choice members must use the medical laboratory noted on their ID card for medical laboratory services. Any specimens collected in the office MUST be sent to the laboratory indicated on the member's ID card. Depending on where the member lives, the ID card shows:

- LAB = LABCORP (Laboratory Corporation of America)
- LAB = PAR (may use any participating outpatient commercial medical laboratory). Our online directory of health care professionals is available on **UHCprovider.com/findprovider**

See additional information here: **UHCprovider.com/content/dam/provider/docs/public/policies/protocols/Laboratory_Services.pdf**

Radiology services

M.D.IPA and Optimum Choice members may have ID cards specifying a county for radiology services, meaning such services are subject to geographic restrictions. For additional information, please visit **UHCprovider.com/content/dam/provider/docs/public/health-plans/mid-atlantic/MIDATL-MDIPA-Optimum-Choice-Radiology-Services-Protocol.pdf**.

Copays

Verify the member's copayments when verifying their eligibility.

Member PCP requirements

A PCP is defined as a physician specializing in family practice, internal medicine, pediatrics or general practice. Other health care providers will be included as primary physicians as required by state mandates. Some PCPs have multiple TINs but may not participate under each of those TINs for the member's benefit plan. Before scheduling an appointment, verify the member's assigned PCP and TIN (listed on the Patient Eligibility screen) matches the TIN address where the member will be seen. Submit your address online at **UHCprovider.com** > Sign In > Practice Management > My Practice Profile or call the phone number on the back of the member's ID card before seeing the member.

For requests about panel status (e.g., Open/Closed to New/Existing Patients), contact your network account representative 30 calendar days before any action. To find your network account representative, go to **UHCprovider.com/contact-us** > State-specific health plan and network support > Select your state. Members are required to select a network PCP. If a member does not select, or delays choosing, a PCP, a pseudo-PCP is assigned. In these cases, the pseudo-PCP allows claims to be processed for emergency and urgent care only.

Direct access services

Female members may receive OB/GYN physician services directly from a participating OB/GYN, family practice physician, or surgeon identified by the medical group/IPA or UnitedHealthcare as providing OB/GYN physician services. This means the member may receive these services without prior authorization or a referral from the member's PCP. In all cases, the physician must be affiliated with the member's assigned medical group/IPA and participating with UnitedHealthcare.

Referrals

For referral process information, check the Mid-Atlantic Health Plan Referral Protocol located on **UHCprovider.com/plans** > Choose a location > Commercial Plans > Mid-Atlantic Health Plan > Referral Protocol for M.D.IPA, M.D.IPA Preferred, Optimum Choice, and Optimum Choice Preferred for:

- Referral submission requirements
- Maximum number of referral visits
- Exceptions for specific specialists or treatments

Referrals are not required when M.D.IPA or Optimum Choice is the secondary carrier. Find forms and specific referral processes for some treatments on **UHCprovider.com/plans** > Choose a location > Commercial Plans > Mid-Atlantic Health Plan. The **referral form** is hyperlinked within the protocol titled Referral Protocol for M.D.IPA, M.D.IPA Preferred, Optimum Choice and Optimum Choice Preferred.

Prior authorizations

How to submit

You must submit prior authorization requests electronically; we will not accept them by phone or fax, except where required by law. To avoid duplication, once a prior authorization is submitted and confirmation is received, do not resubmit.

- **Online: UHCprovider.com** > Sign In > Prior Authorizations
- **Information: UHCprovider.com/priorauth** (for information and prior authorization lists)

Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Find the following forms referenced at **UHCprovider.com/priorauth** > Frequently searched > **Advance Notification and Plan Requirement Resources**.

Radiology prior authorization requests and prior authorization list

Prior authorization requests for radiology may be submitted electronically using the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** > Sign In > Prior Authorizations. M.D.IPA and Optimum Choice are not part of the UnitedHealthcare Radiology Prior Authorization Program. Refer to the **UHCprovider.com/priorauth** > **Advance notification** > UnitedHealthcare Mid-Atlantic Plans Prior Authorization Requirements.

Outpatient rehabilitation (physical, occupational and speech therapy) prior authorization request

Prior authorization requests for physical, occupational, speech and other therapy-related service may not be submitted electronically. Fax these prior authorization requests to the Clinical Care Coordination Department at **1-888-831-5080** using the Rehabilitation Services Extension Request Form found at **UHCprovider.com/plans** > Choose a location.

Chiropractic services prior authorization request

Prior authorization requests for chiropractic services may not be submitted electronically. Fax these prior authorization requests to the Clinical Care Coordination Department at **1-888-831-5080** using the Chiropractic Services Extension Form found on **UHCprovider.com**, along with a copy of the current Consultant Treatment Plan (PCP Referral).

Allow 2 business days for extension request decisions. Missing information may result in a delayed response. Decisions are based on the member's plan benefits, progress with the current treatment program and submitted documentation.

Exception requests

All exceptions to our policies and procedures must be preauthorized by submitting a request online at **UHCprovider.com** > Sign In > Practice Management > My Practice Profile. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. The most common exception requests are:

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

Prior authorization is required for elective outpatient services. It is the physician's responsibility to obtain any relevant prior authorization. But the facility should verify prior authorization is obtained before providing the service. If the facility does not get the required prior authorization, we may deny payment. Final coverage and payment decisions are based on member eligibility, benefits and applicable state law.

If you have a question about a preservice appeal, see the section on **Preservice appeals** under **Chapter 7: Medical management**.

Inpatient admission notification

It is the facility's responsibility to notify UnitedHealthcare within 24 hours after weekday admission (or by 5 p.m. ET the next business day if 24-hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5 p.m. ET the next business day.

For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us as soon as they know the information and explain the extenuating circumstances. Facilities

are responsible for providing admission notification for inpatient admissions, even if advance notification was provided by the physician and coverage approval is on file.

Prior authorization is required for all elective inpatient admissions for all M.D.IPA and Optimum Choice members. It is the admitting physician's responsibility to obtain the relevant prior authorization. But the facility should verify that prior authorization is obtained before the admission. Payment may be denied to the facility and attending physician for services provided in the absence of prior authorization. Prior authorization doesn't guarantee coverage or payment. All final coverage and payment decisions are based on member eligibility, benefits and applicable state law.

SNF placements do not require prior authorization. You must verify available benefit and notify us within 1 business day of SNF admission.

Admission Notification Requirements

EDI: Transaction 278N

Online: **UHCprovider.com** > Sign In > Prior Authorizations

Phone: 1-800-962-2174

Once we receive your notification, we begin a case review. If notification isn't provided in a timely manner, we may still review the case and request other medical information. We may retroactively deny 1 or more days based upon the case review. If a member receiving outpatient services needs an inpatient admission, you must notify us as previously noted. Emergency room services resulting in a covered admission are payable as part of the inpatient stay as long as you have notified us of the admission as described.

Delay in service

Facilities that provide inpatient services must maintain appropriate staff resources and equipment to help ensure covered services are provided to members in a timely manner. A delay in service is defined as any delay in medical decision-making, test, procedure, transfer or discharge not caused by the member's clinical condition. Services should be scheduled the same day as the physician's order. However, procedures in the operating room, or another department requiring coordination with another physician, such as anesthesia, may be performed the next day unless emergent treatment was required. A service delay may result in sanctions of the facility and non-reimbursement for the delay days, if permissible under state law.

A clinical delay in service is assessed for any of these reasons:

- Failure to execute a physician order in a timely manner, resulting in a longer length of stay
- Equipment needed to fulfill a physician's order is not available
- Staff needed to fulfill a physician's order is not available
- A facility resource needed to fulfill a physician's order is not available
- Facility doesn't discharge the member on the day the physician's discharge order is written

Concurrent review

Review is conducted by phone for each day of the stay using criteria. Your cooperation is required when we request information, documents or discussions such as clinical information on member status and discharge planning. If criteria aren't met, the case is referred to a medical director for assessment. We deny payment for facility days that don't have a documented need for acute care services. We require physicians' progress notes be charted for each day of the stay. Failure to document will result in denial of payment to the facility and the physician.

Facility post-discharge review

A post-discharge review is conducted when a member has been discharged before notification to UnitedHealthcare occurs or before information is available for certification of all the days. A UnitedHealthcare representative will request the member's records from the Medical Records Department or assess a review by phone and review each non-certified day.

Inpatient days that don't meet acuity criteria are referred to a medical director for determination and may be retrospectively denied. Delays in service or days that don't meet criteria for level of care may be denied for payment.

Facility-to-facility transfers

The facility must notify us of a facility-to-facility transfer request. In general, transfers are approved when:

- There is a service available at the receiving facility that isn't available at the sending facility
- The member would receive a medically appropriate level of care change at the receiving facility
- The receiving facility is a network facility and has appropriate services for the member

If any of the previous conditions aren't met, transfer coverage is denied. Services at the receiving facility will be approved if:

- Medical necessity criteria for admission were met at the receiving facility
- There were no delays in providing services at the receiving facility

Clinical appeals

To appeal an adverse decision (a decision by us to not prior authorize a service or procedure, or a payment denial because the service wasn't medically necessary or appropriate), you must submit a formal letter that includes your intent to appeal, justification for the appeal and supporting documentation. The denial letter will provide you with the filing deadlines and instructions for submitting an appeal.

Urgent appeal submissions:

Medical
Online: **UHCprovider.com** > Sign In > Prior Authorizations
Fax: 1-801-994-1083

Pharmacy
Fax: 1-801-994-1058

Claims process

Refer to **Chapter 10: Our claims process** for detailed information about our claims process. All claims that can be submitted electronically must be submitted to payer ID 87726.

Reconsideration and appeals processes

For claim reconsiderations for M.D.IPA and Optimum Choice, submit your request in the Claims tool in the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > Claims.

Capitation

Capitation payment will be paid to the practice for covered services PMPM. The PCP receives separate capitation payments for members of M.D.IPA and Optimum Choice monthly, on the fifth day of each month.

The PMPM is calculated by multiplying the fixed monthly rates (detailed in the Capitation Rate Schedule contained in your Agreement) by the number of members who have selected or been assigned to a PCP within the practice.

Payment rules

The capitation payment for a given month is calculated based on the 15/30 rule. This rule is used to determine whether a capitation payment is made for the full month or not at all. If the effective date of member change falls between the first and 15th of the month, the change is effective for the current month. If the effective date of the member change falls on or after the 16th of the month, the capitation adjustment is reflected on the first of the following month. As such, retroactive adjustments to capitation payments may be made based on the member's eligibility on the 15th of the month.

15/30 rule	For purposes of capitation payments, members are added on the first day of the month or terminated on the last day of the month, with the exception of newborns, which are added on the date of their birth(s). Capitation is paid for full months, and conversely recouped for full months if appropriate. For example: **Retroactive add** A member added retroactively on the 15th of the month would generate a capitation payment for the entire month. However, a member added on the 16th or later would not generate a capitation payment, even though the member would be considered eligible for services. To help you identify these members, the member's standard services capitation is reported as $0. **Retroactive term** A member retroactively terminated between the first and 14th of the month would generate a capitation recoup entry for the capitation previously paid for the entire month. However, a member retroactively terminated on the 15th or later would not generate a capitation recoup entry for the capitation previously paid for the entire month.

UnitedHealthcare of the Mid-Atlantic region provides capitation reports to PCPs, as described as follows:

Plan name	Report subtype	Format
MDIPA/OCI	Capitation Paid Recap (EC7010)	PDF
MDIPA/OCI	Capitation Adjustment Summary (EC7020)	PDF
MDIPA/OCI	Capitation Analysis Summary (EC7030)	PDF
MDIPA/OCI	Primary Member Changes Capitation Summary (EC7090)	PDF
MDIPA/OCI	Capitation Details (EC7210	PDF
MDIPA/OCI	Member Changes Capitation Details (EC7240)	PDF
MDIPA/OCI	Capitation Adjustment Details (EC7290)	PDF
MDIPA/OCI	Capitation Detail File (EC7810)	CSV
MDIPA/OCI	Capitation Summary File (EC7815) – available early 2025	CSV
MDIPA/OCI	Manual Adjustment Backup	PDF
MDIPA/OCI	Remittance Advice	PDF
MDIPA/OCI	Negative Balance	PDF
MDIPA/OCI	Capitation Check Image	PDF

The PCP practice should reconcile the capitation payment and report upon receipt. Requests for an adjustment or reconciliation of the capitation payment must be made within 60 calendar days of receipt. If the PCP/medical group (practice) does not request reconsideration of the capitation payment within 60 days, the capitation payment

provided is accepted as payment in full (as per contract). You can access the reports and files listed in the chart by logging into the UnitedHealthcare Provider Portal and selecting the Documents & Reporting dropdown under Report Center.

Optum Pay for capitated health care providers

Optum Pay® is available to health care providers who participate under a capitated arrangement. You may enroll in EFT. To enroll go to **optum.com/optumpay**. To sign in after enrollment, go to **optumbank.com** > Sign in. You may access and download a capitation detail file. To learn how to access the report and view instructions for using it, go to **UHCprovider.com/reports**.

Bill above

In addition to the capitation payments, certain covered services are eligible for reimbursement. To obtain a copy of this information, contact your network representative. To locate your network representative, go to **UHCprovider.com/contactus** > State-specific health plan and network support.

Neighborhood Health Partnership supplement

Applicability of this supplement

The Neighborhood Health Partnership (NHP) supplement applies to covered services provided to members enrolled in NHP benefit plans when you fit into these 2 categories:

1. Your Agreement with UnitedHealthcare includes a reference to the NHP protocols or guides, or you have directly contracted with NHP to participate in networks maintained for NHP members
2. You are located in the NHP service area, which is expanding

NHP Flex Benefit Plans – this supplement does not apply to health care providers located outside the NHP service area.

NHP participating health care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For protocols, policies and procedures not referenced in this supplement, refer to appropriate chapter in the main guide.

The term prior authorization referenced in this supplement is also referred to as precertification. We use both terms in this supplement.

How to contact NHP

Resource	Where to go
Provider website	**UHCprovider.com** **Policies: UHCprovider.com/policies** > **For Commercial Plans** **Provider news and updates: UHCprovider.com/news** Note: You must register to access some of the features available to you. Go to **UHCprovider.com/access**.
Advance notifications, prior authorizations, admission notifications	**EDI:** See EDI transactions and code sets on **UHCprovider.com/edi**. We accept EDI 278 submissions directly to UnitedHealthcare or through a clearinghouse. Be sure to include the CPT codes for your request. **Online: UHCprovider.com** > Sign In > Prior Authorizations Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. See ID card for specific service contact information.

Resource	Where to go	
Appeals		
Urgent preservice appeals	Medical **Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Fax:** 1-801-994-1083 Pharmacy **Fax:** 1-801-994-1058	
Standard preservice appeals	Medical **Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Fax:** 1-801-994-1083 Pharmacy **Fax:** 1-801-994-1345	
Post-service appeals	**Online:** UnitedHealthcare Provider Portal: **UHCprovider.com** > Sign In > Claims & Payments **API:** Submit reconsiderations and appeals (with attachments) using API: **UHCprovider.com/api** for more information.	
Breast pumps	Lincare: 1-855-236-8277 Byram Medical: 1-877-902-9726 Edgepark Medical: 1-888-394-5375	lincare.com byramhealthcare.com edgepark.com
Cardiology Request prior authorization of cardiology services as described in the **Outpatient cardiology prior authorization protocol** section of this guide. • Diagnostic catheterization • Electrophysiology implants • Echocardiogram • Stress echocardiogram	**Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** **UHCprovider.com/cardiology** **Phone:** **1-866-889-8054**	
Chiropractic services information	ALIVI 3511 NW 91st Ave. Doral, FL 33172 (Address ID 003138529) **Phone:** 1-786-441-8500 **Fax:** 1-305-675-2353	

Resource	Where to go	
Claims	**EDI: UHCprovider.com/edi** (Payer ID: 87726) The ERA payer ID number is also changing to 87726. If you would like to receive 835 ERA files for NHP, or if you currently receive 835 ERA files for NHP under payer ID 95123 or 96107, contact your vendor to enroll under payer ID 87726. The health plan ID card for members who have transitioned indicates payer ID 87726. **Online: UHCprovider.com** > Sign In > Claims & Payments **Information: UHCprovider.com/claims** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.	
Durable medical equipment/ respiratory and commodity services (oxygen, CPAP, hospital beds, standard wheelchairs)	Apria: 1-855-613-8303 Lincare: 1-855-236-8277 Rotech: 1-877-623-5272	
EDI support	**Online: UHCprovider.com/edi** **Phone: 1-866-509-1593**	
Eligibility verification • Verify primary care physician • Verify eligibility and benefits • Check claim(s) status • Obtain status of referrals • Office visit copay • Inpatient copay • Prescription drug copay (if applicable)	**EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse **Online: UHCprovider.com** > Sign In > Eligibility **Information: UHCprovider.com/priorauth** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.	
Home health services	Lincare: 1-855-236 8277 Byram Medical: 1-877-902-9726 Edgepark Medical: 1-888-394-5375	lincare.com byramhealthcare.com edgepark.com
Home infusion services (including enteral)	Orsini Health: 1-800-240-9572 Express Scripts: 1-855-315-3590 OptionCare Infusion: 1-800-683-5252	orsinihealthcare.com accredo.com optioncarehealth.com
Insulin pumps and supplies national vendors	MiniMed Distribution Group (Medtronic): 1-800-933-3322	minimed.com

Resource	Where to go	
Medical supply providers (disposable supplies, ostomy, urological, incontinence supplies)	Byram Medical: 1-877-902-9726 Edgepark Medical: 1-888-394-5375 Medline: 1-800-633-5463 McKesson: 1-855-404-6727	byramhealthcare.com edgepark.com medline.com mckesson.com
Mental health services prior authorization Optum	**Phone: 1-800-817-4705**	
Outpatient injectable chemotherapy and related cancer therapies	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/oncology** **Phone: 1-888-397-8129**	
Pharmacy (Optum Rx)	**Online: professionals.optumrx.com** > **Prior authorizations** **Prior Authorization: 1-800-711-4555** **Specialty Pharmacy Customer Service: 1-888-739-5820**	
Physical, occupational and speech therapy (Optum Health)	**Phone: 1-800-873-4575** **Fax:** 1-248-733-6070	
Podiatry Foot and Ankle Network (FAN)	ALIVI 3511 NW 91st Ave. Doral, FL 33172 (Address ID 003138529) **Phone:** 1-786-441-8500 **Fax:** 1-305-675-2353	
Prior authorization and advance notification	**EDI:** Transactions 278A and 278N **Online: UHCprovider.com** > Sign In > Prior Authorizations Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. **Information: UHCprovider.com/priorauth**	

Resource	Where to go
Radiology/advanced outpatient imaging procedures Request prior authorization of radiology services as described in the **Outpatient radiology prior authorization protocol** section of this guide: • CT scans • MRIs • MRAs • PET scans • Nuclear medicine studies, including nuclear cardiology	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/radiology** **Phone: 1-866-889-8054**
Radiation therapy	**Online: UHCprovider.com** > Sign In > Prior Authorizations Select the Submission and Status link under the Radiology, Cardiology & Radiation Oncology section Select service type: Radiation Oncology Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. **Information: UHCprovider.com/oncology** > **Radiation Therapy Services**
Substance use disorder services	Optum **Phone: 1-800-817-4705**
Case management	Congenital Heart Disease Kidney Resource Services Ventricular Assist Devices fax: 1-855-282-8929 Transplant Resource Services fax: 1-855-250-8157 Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Discharge of a member from participating provider's care

Refer to the section **Member dismissals initiated by a PCP**, **Chapter 2: Provider responsibilities and standards**, for more information.

Laboratory services

Direct all NHP members to Labcorp, Inc. service centers for outpatient laboratory procedures. If a participating health care provider draws the specimen in the office, send the specimen to Labcorp, Inc.

Home health care agencies are responsible for delivery of drawn specimens to one of the Labcorp, Inc. service centers.

We pay laboratory services according to your Agreement. They must be performed by a participating health care provider that is a facility for:

- Emergency room services
- Chemotherapy
- Ambulatory surgery
- Transfusions
- Hemodialysis

Labcorp, Inc. must process clinical laboratory specimens drawn at a skilled nursing facility.

Use of nonparticipating laboratory services

This applies to all participating health care providers. It also applies to laboratory services, clinical and anatomic, ordered by any practitioner.

You are required to refer laboratory services to participating laboratories, except as otherwise authorized by NHP. To get more information on participating laboratories:

- Go to labcorp.com or call 1-800-833-3984, option 3, to determine how to conveniently access their services
- Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

In the unusual circumstance you require a specific laboratory test for which you find no participating laboratory is available, contact NHP UM. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Labcorp requires this information to make sure accurate testing and billing:

- Member's NHP ID number
- Labcorp requisition forms with all required fields completed
- Specific test orders using test codes
- Diagnosis codes

Referrals

The PCP is responsible for determining when the member needs a referral. Only the PCP may make an initial referral. These must be made to participating health care providers. We deny claims for services rendered without a proper referral. You may not bill the member for those services unless, prior to receiving the service, the member agrees in writing:

1. That the referral is not in place or the service is not a covered service
2. To be financially responsible for the cost of the service

Referrals to a specialist may be necessary:

- When a member fails to respond to current medical treatment
- To confirm or establish a member's diagnosis and/or treatment modality
- To provide diagnostic studies, treatments or procedures that range beyond the scope of the PCP. PCPs may make referrals to a specialist according to the following Specialty Referral Guidelines section.

These specialty services do not require referral:

- Chiropractic (subject to benefit limitations)
- Dermatology

- Gynecology
- Podiatry*
- Substance use disorder treatment*
- Mental health*

Out-of-network referrals

Out-of-network referrals are only approved when the services are not available from a participating health care provider. Request out-of-network referrals by calling NHP. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. Once we receive the referral, the data will be reviewed and, if approved, entered into the system to help ensure payment of the specialist claims.

Specialty referral guidelines

- Once the specialty services have been properly authorized, the member or PCP may schedule an appointment with the specialist
- Submit specialist referrals by visiting **UHCprovider.com** > Sign In > Referrals
- We mail an authorization letter to the specialist for the member's medical record
- We do not pay specialist claims without a referral
- The specialist should re-verify the member's eligibility at the time of visit by calling Provider Services. Refer to the back of the ID card to help ensure the appropriate Provider Services department is contacted. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
- Call **1-800-817-4705** for behavioral health service requests
- All NHP HMO members require a referral before scheduling appointments for specialty services

Obstetrics

A member may self-refer to an NHP obstetrician who is a participating health care provider for routine OB care. If the member is referred to a nonparticipating specialist, the specialist must notify us through **UHCprovider.com** > Sign In > Referrals to make sure accurate claims payment for ante- and postpartum care. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

- Plain film radiography performed by an NHP participating health care provider or in the obstetrician's office during an authorized visit does not require prior authorization
- Routine labs performed in the obstetrician's office, or that are provided by a participating health care provider in support of an authorized visit, do not require prior authorization
- Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician's office that do not require prior authorization may be performed

Utilization management

Submit your utilization management (UM) request electronically using one of the methods outlined in the **How to contact NHP** section. Be sure to include the place of service and CPT codes in your request.

If you do not have electronic access, you may submit prior authorization requests by phone.

Prior authorization requirements

All NHP members require prior authorization for the services listed on the Prior Authorization List located on **UHCprovider.com/priorauth** > Advance notification > **Neighborhood Health Partnership (NHP) Advanced Notification / Prior Authorization Requirements**.

*See the Prior authorization requirements section of this supplement.

Concurrent review

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

- Certify the continued stay
- Allow the review of the member's medical status during an inpatient stay
- Extend the member's stay
- Coordinate the discharge plan
- Determine medical necessity at an appropriate level of care
- Perform quality assurance screening

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

Reimbursement for continued stay that does not meet NHP medical necessity criteria is denied. The member may not be billed for these services unless they have signed a waiver of liability or the services are denied as noncovered services. The member is held harmless in these proceedings.

Claims reconsiderations and appeals

Claim reconsideration

Refer to **Claim reconsideration and appeals process** section located in **Chapter 10: Our claims process** for detailed information about the reconsideration process.

Your documentation should clearly explain the nature of the review request.

If you are unable to use the online reconsideration and appeals process outlined in **Chapter 10: Our claims process**, fax reconsideration or appeal information to 1-801-938-2100.

You have 1 year from the date of occurrence to file an appeal with the NHP. You will receive a decision in writing within 60 calendar days from the date we receive your appeal.

If you have a question about a preservice appeal, see the **Preservice appeals** section in **Chapter 7: Medical management**.

Capitated health care providers

Optum Pay® is available to health care providers who participate under a capitated arrangement. You may enroll in EFT. To enroll go to **optum.com/optumpay**. To sign in after enrollment, go to **optumbank.com** > **Sign in**.

You may access and download a capitation detail file. To learn how to access the report and view instructions for using it, go to **UHCprovider.com/reports**.

New Mexico Employer-sponsored, Individual and Exchange plans: Provider grievance process

In accordance with New Mexico (NM) law NMAC 13.10.16, all providers have the right to file a grievance for the following concerns:

- Credentialing deadlines
- Claim payment amount or timing
- Network adequacy, including participation determinations based on network composition
- Network composition including provider qualifications
- Utilization management practices
- Surprise billing reimbursement amount, rate or timing
- Discrimination

As part of their grievance related to the concerns identified above, nonparticipating providers must assert and explain that our act or practice directly impacted them or one of their patients.

Participating providers may also file a grievance for the following concerns:

- Claim submission requirements or compliance
- Provider contract construction or compliance
- Patient care standards or access to care
- Termination
- Operation of the plan, including compliance with any law enforceable by the superintendent, or of any directive of the superintendent

Note: No person shall be subject to retaliatory action for submitting or supporting a grievance or appeal.

How the grievance process works

- **Timeline to file:** A provider has at least 90 days from the incident, which is the subject of the grievance, to file a grievance
- **Filing procedures and response:** A provider should submit a written grievance electronically or manually. We will send written acknowledgment of the grievance to the provider within 5 days of its receipt using the provider's preferred communication method.
- **Request for supplemental information:** We may need supplemental information pertinent to the resolution of a grievance. We will request the information within 10 days of receipt of the grievance. We will require the provider to submit the information within 10 days.
- **Review panel:** A review panel comprised of multiple individuals, at least one of whom is in a position of authority over the operations that are the subject of the grievance, will review and decide upon the provider's grievance
  - An NM-licensed medical professional will be included on a review panel considering quality-of-care concerns. Such medical professional will be one who practices in the general area of concern.
  - An NM-licensed physician will be included on a review panel considering complex quality-of-care concerns
  - No person with a conflict of interest will participate in a decision to resolve a grievance. Employment with the carrier, standing alone, does not present a conflict of interest.
- **Response:** We will provide a written response to a grievance using the provider's preferred method of communication within 45 days of receipt of the grievance, receipt of supplemental information requested to resolve the grievance or the due date for submission of any requested supplemental information. The response will include:

  - The name(s), title(s) and qualification(s) of each person who participated in the grievance decision
  - A statement of issue(s) decided and of the ultimate decision(s)
  - A clear and complete explanation of the rationale for the decision and a summary of the evidence relied upon to support the decision
  - A summary of any proposed remedial action
  - Information on the provider's appeal rights
- **Extension of deadlines:** We and the provider may agree, in a documented communication, to extend any deadline imposed by this grievance plan
- **Presentation of evidence:** A provider may present oral or documentary evidence to the assigned grievance panel
- **Bundled or group grievances:** A provider may submit multiple related grievances simultaneously, provided the grievances are not unduly duplicative or repetitive. A group of providers may assert a single grievance on behalf of multiple providers.

Terminations other than for cause

If a termination is not for cause, we will give the provider written notice at least 60 days before the effective date of termination. The notice will:

- Be communicated in writing via the format preferred by the provider
- Contain an explanation of the termination

Terminations for cause

For terminations based on cause, we will provide a fair hearing process that provides these minimum rights and protections:

- The right of the provider to appear in person at a hearing before the deciding panel
- The right of the provider to present testimonial or documentary evidence at the hearing
- The right of the provider to call witnesses and cross-examine any witness
- The right of the provider to be represented by an attorney or by any other person of the provider's choice
- The right to an expedited hearing within 14 days of the termination in those instances when we have not provided advance written notice of termination and the termination could result in imminent and significant harm to a covered person
- A written decision within 20 days after the hearing, contemporaneously delivered via the provider's preferred method of communication
- If a group of providers is terminated for cause, each provider in the group has an individual right to a hearing. However, if any one of the providers in the group submits a grievance relating to the termination, we will provide each similarly situated provider in the group with a notice of hearing, and each provider who receives such notice will be bound by our determination subject to any appeal rights.

Where to direct your concerns

If you have not received a notification with specific contact information, please direct your concerns to:

Operational grievances, including:

- Claim payment amount or timing
- Claim submission requirements or compliance
- Utilization management practices
- Patient care standards or access to care
- Surprise billing reimbursement amount, rate or timing
- Discrimination

- Operation of the plan, including compliance with any law enforceable by the superintendent or of any directive of the superintendent

Employer-sponsored plans

Mail to: UnitedHealthcare
Attn: PAO Appeals
P.O. Box 30559
Salt Lake City, UT 84130

Individual and Exchange plans

Mail to: UnitedHealthcare
Attn: Provider Dispute
P.O. Box 6111
Cypress, CA 90630

Network grievances, including:

- Network adequacy, including participation determinations based on network composition
- Network composition including provider qualifications
- Provider contract construction or compliance
- Credentialing deadlines
- Terminations

Mail to: UnitedHealthcare
Attn: Provider Contract Appeals
P.O. Box 31376
Salt Lake City, UT 84131-0376

Appeals

If a provider is not satisfied with the results of our internal grievance procedure for a grievance that pertains to an issue listed below, they may file a request for an external review with the superintendent in accordance with the requirements set forth in New Mexico Administrative Code, Section 13.10.16.10.

The appeal must be filed no later than 30 days after receipt of our written decision or the deadline for our decision, whichever is earlier.

1. **Types of grievances subject to appeal:** The superintendent will only review a grievance that pertains to any of the following:
   - An alleged violation of a law enforceable by the superintendent;
   - Alleged noncompliance with an order of the superintendent; or
   - A termination based on a provider's alleged failure to comply with a law or order enforceable by the superintendent
2. **Disposition:** In the disposition of an appeal, the superintendent may only impose a remedy, penalty or corrective action authorized by the insurance code
3. **Exhaustion of internal remedies required:** The superintendent shall not review a provider grievance appeal unless the provider has exhausted the carrier's internal grievance process
4. **Timeline for filing appeal:** A provider appeal of a grievance shall be filed no later than 30 days after the provider receives a response to the grievance, or the deadline for the response, whichever is earlier
5. **Appeal content:** The superintendent shall not review a provider grievance appeal that does not contain the following information:
   - The provider's name, license number, address, daytime telephone number, email address and any relevant claim numbers
   - The name and phone number of the carrier
   - Certification that the grievance did not pertain to Medicaid or Medicare coverage, excluding Medicare supplement
   - A copy of the carrier's written disposition of the grievance, or certification by the provider that the carrier did not issue a written disposition within the time allowed by law

- The date the provider received the carrier's written disposition of the grievance or the date by which the carrier was required to provide a written disposition if not disposition was received
- A clear and concise statement of the issue on appeal and the remedy requested on appeal

6. **Additional documentation:** Within 45 days of receipt of a provider grievance appeal, the superintendent shall determine whether the appeal is authorized by this section and otherwise reviewable. The superintendent may request supplemental information from the provider or carrier to so determine. The time between any such request and the delivery of the requested information by the superintendent shall be excluded from the 45-day deadline imposed by this section.
   - If the superintendent determines that an appeal is not authorized or reviewable, the superintendent shall issue an order dismissing the appeal and stating the reason for dismissal
   - If the superintendent determines that an appeal is authorized and reviewable, the superintendent shall schedule either a formal or an informal hearing pursuant to the superintendent's rules, as appropriate to the issues, facts and circumstances presented in the appeal. The order setting the hearing shall authorize a designated hearing officer to take or authorize any action authorized by law to resolve the appeal.
7. **Settlement:** The superintendent may order the parties to an appeal to participate in formal or informal settlement discussions focused on resolving the issue on appeal. If all parties to an appeal consent, the assigned hearing officer may facilitate the settlement discussions without being disqualified from issuing a recommended decision on appeal.
8. **Waiver:** Upon an express finding of good cause, the superintendent may waive any deadline, format or process requirement imposed by this section

Note: No person shall be subject to retaliatory action for submitting or supporting a grievance or appeal.

Providers may file an appeal with the New Mexico Office of Superintendent of Insurance.

Questions?

Contact your network management representative by visiting **UHCprovider.com/contactus** > State-specific health plan and network support. Or you may contact the following:

Provider Relations Advocate Team

Phone: 1-877-842-3210

Email: newmexico_pr_team@uhc.com

OneNet PPO/Workers' compensation supplement

Applicability of this supplement

This supplement lists operational procedures and information applicable to services received by a OneNet customer that are covered under a Property or Casualty Benefit Plan sponsored, issued or administered by a OneNet payer. (Terms defined in the following section.) Such services are subject to both the main guide and this supplement. This supplement controls in the event of any conflict with the main guide. For protocols, policies and procedures not referenced in this supplement, refer to the appropriate chapter in the main guide. OneNet PPO, LLC (OneNet) is a wholly owned subsidiary of UnitedHealthcare Insurance Company, a part of UnitedHealth Group, Inc. Because OneNet is a network only and not a payer, certain provisions of the main guide will apply to OneNet with some variation. This supplement identifies these principal variations.

Terms used in the supplement

Adjuster: An adjuster works for an insurance company, third-party administrator (TPA) or directly for a self-insured employer. This person coordinates with all parties on a workers compensation case or auto liability claim. They are responsible for, among other things, the wage replacement and return-to-work coordination as well as all management of the funding for medical services.

Clean bill/claim: Bill refers to the submitted UB or CMS1500 form. Claim represents the entire workers compensation or auto accident, including all submitted bills.

Bill/Claim pricing or repricing: The process of applying the OneNet contracted rates to bills, including the application of clinical edits, reimbursement policies and standard coding practices. It may include the application of state or federal workers compensation fee schedule rates, usual and customary or reasonable rate (UCR) or prevailing rate as defined by the state, or other government-authorized pricing methodology or schedule. The terms claim/bill pricing and repricing are used interchangeably. The process of applying contracted rates to bills from network care providers includes the application of the lesser of the billed charges, contracted rate, state/federal schedule, UCR or other authorized fee schedule.

OneNet Client: An entity that has contractual authority to access the OneNet network of health care providers. OneNet Clients may include, without limitation, insurance carriers, workers compensation insurance carriers, auto liability insurers, risk management entities, claims management entities, TPAs and employers. A OneNet client can access the OneNet network for itself, on behalf of another entity that is a OneNet Payer or both. A OneNet Client may or may not be the OneNet Payer for a particular OneNet Customer. A OneNet Client accessing the OneNet Network on behalf a OneNet Payer may perform some or all of the OneNet Payer's administrative services (e.g., eligibility verification, claims adjudication and bill payment).

OneNet Customer: A person whose coverage under a Property or Casualty Benefit Plan enables them to receive treatment from OneNet participating health care providers. The term OneNet Customer means the same as customer, member, participant, primary participant, injured worker, subscriber, employee, insured and claimant as used this guide.

OneNet Payer: An entity that is obligated to reimburse services covered under a Property or Casualty Benefit Plan and that has contractual authority to access the OneNet network of health care providers. References to Participating Entity, Payer or Alternate Payer in the health care provider Agreement and in this guide also apply to OneNet Payers. OneNet, Procura and UnitedHealthcare and its affiliates are not OneNet Payers. OneNet Payers may include, without limitation, insurance carriers, workers compensation insurance carriers, auto liability insurers, risk management entities and employers. A OneNet Payer's access to the OneNet Network may be through its own contractual access to the OneNet network or through a OneNet Client's contractual access to the OneNet network. Some or all of a OneNet Payer's administrative services (eligibility verification, claims adjudication and bill payment) may be performed by a OneNet Client or other entity.

Property or Casualty Benefit Plan: A benefit plan sponsored, issued or administered by a OneNet Payer that is not a medical benefit plan but that includes coverage for medical services and supplies. Property and Casualty Benefit Plans include, without limitation, workers compensation programs and auto liability insurance.

Utilization review: Utilization management or utilization review is the use of managed care techniques such as prior authorization that allows payers to address clinical appropriateness using evidenced-based criteria or guidelines as defined by each state. Procura may or may not provide utilization management services for their clients.

UCR/Prevailing rate: The UCR rate (also known as prevailing rate) determined by the state or other governmental entity or a database referenced by a state or governmental agency such as FAIR Health. The database is created using rates typically charged by care providers in a geographic area.

OneNet PPO product overview

OneNet is a network of physicians, health care practitioners, hospitals and ancillary facilities whose Agreements with UnitedHealthcare provide for participation in Property and Casualty Benefit Plans, including workers compensation programs and auto liability insurance. Entities that are obligated to reimburse medical services under Property and Casualty Benefit Plans contract directly or indirectly with Procura Management, Inc. (a UnitedHealthcare affiliate) to access OneNet providers at negotiated rates.

OneNet may include health care providers within the OneNet service area, as well as those in other areas (e.g., states adjacent to the service area or future expansion areas). Currently, the OneNet service area includes Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Pennsylvania, Tennessee (except for auto liability insurance), Virginia, Washington D.C., and West Virginia.

Advantages that providers who participate in the OneNet Property and Casualty network may see include the following:

- Increased patient volume by referrals generated through published directories, workplace postings and online provider look-up tools
- Efficient and consistent payment and adjudication of bills defined by your contract terms
- Hands-on Provider Relations staff

Who to contact

Resource	Where to go
OneNet/Procura clients and payers Responsible for the administration and payment of Property and Casualty programs (including workers compensation and auto liability) accessing the OneNet PPO Network. Responsibilities include: • Determining bill eligibility • Processing bills • Providing EOB statements or remittance advices • May also include case management and utilization review services	For questions related to these services, contact the payer identified on the EOR or the payer provided by the patient. Procura and OneNet names will appear on the EOR/EOB/remittance advice when the OneNet Network is being accessed.

Resource	Where to go
Procura	For OneNet PPO in-network referrals, OneNet contracted rate pricing inquiries/ appeals, or how to contact our clients. **Phone: 1-877-461-3750** **Email: optumwc.proppo@optum.com**
Contract questions	Contact your UnitedHealthcare Network Management representative. If you require assistance determining who your representative is, or how to reach them, visit **UHCprovider.com** > **Contact us** > State-specific health plan and network support.
Appeals	If you are disputing state pricing or services deemed not part of the workers compensation/auto illness or injury, contact the client at the number identified on the EOR. For all network-related concerns, contact Procura: **Phone: 1-877-461-3750** **Email: optumwc.proppo@optum.com** Some states have formal dispute resolution or appeals processes. Follow the appeal time frames and dispute resolution procedures outlined in your contract and this guide. Contact Procura if you have questions about this requirement.
To request a copy of the Decision Point Review (DPR) plan	Contact the payer identified on the EOR. DPR plan provides specific requirements for submitting an appeal for medical reconsideration of an auto liability claim, but they are not required in all states.
Website	OneNet pricing sheets are available in the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > Claims & Payments > OneNet PPO Pricing. Final payment determination is the responsibility of our clients.
News, information and updates	For information on policies, protocols, products, new initiatives, website enhancements and online solutions, visit **UHCprovider.com/news**. Sign up for email updates at **UHCprovider.com/subscribe**.

Patient eligibility

Contact the claimant or injured worker's employer, workers compensation carrier, auto liability insurer or administrator to verify acceptance of an injury for purposes of coverage. ID cards are not usually issued or used for workers compensation and auto liability programs. Injured workers and claimants accessing you through the OneNet PPO Network will not present an ID card. Insurers, administrators and employers are instructed to advise you of network access, if known, when you call to verify the injury and coverage. You may ask if the employer, carrier or administrator is contracted with Procura to access OneNet's workers compensation and auto liability networks.

Bill process

Bill submission

All bills should be sent directly to the applicable employer, worker's compensation carrier, auto liability insurer or third-party administrator (TPA). Do not submit bills directly to OneNet or Procura, except for pricing appeals.

When submitting a bill, it is important to submit complete bills and to accurately code all diagnoses and services in accordance with national coding guidelines.

Additional information may be required for particular types of services, or based on particular circumstances or state requirements.

Clean bills must be submitted within the time frame identified in your contract, or within 12 months of the date services are provided, and in accordance with any applicable laws. Failure to submit bills correctly will result in the rejection and return of bills. You will receive a notice from the applicable claimant or injured worker's employer, workers compensation carrier, auto liability insurer or TPA in the event your bills are being withheld from bill pricing and payment while compensability is being determined.

If you have questions about submitting claims to us, call the claimant or injured workers' employer, workers compensation carrier, auto liability insurer or TPA for instructions on how to submit a bill.

Complete bill requirements

Your bills may not be processed if you omit:

- Items identified under the **Claims and encounter data submissions** section of the UnitedHealthcare Guide

Additional requirements:

- Items identified under the Additional information needed for a complete UB-04/CMS-1450 Form section of the UnitedHealthcare Guide
- When billing late charges, indicate bill type 115 or 117 (inpatient), or 135 or 137 (outpatient), in form locator 4 of the CMS-1450/UB-04
- Bill all outpatient surgeries with the appropriate revenue and CPT codes if reimbursed according to ambulatory surgery groupings

Submit all bills for professional services or facility services on a CMS 1500 or UB-04 claim form or their electronic equivalents and include all standard code sets that apply.

Bill review procedures

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

Tips to expedite bill processing:

- Submit bills on a red CMS 1500 or a UB-04 form, using 11 or 12 point font size and black laser jet ink
- Do not use a highlighter on the claim form or any attachments
- Line up forms to print in the appropriate boxes
- Submit bills on original forms, not photocopies
- Complete all required fields on standard forms
- Make sure attachments are complete and legible
- Make sure information such as the health care provider's name, telephone number, taxonomy code, NPI and other information is accurate
- Remember to sign and date all necessary forms; an electronic signature is acceptable

Pricing of bills

OneNet pricing includes bill completeness, accuracy review and pricing, per your contracted rate.

Payment for covered services related to a workers compensation injury is the least of the following:

- The Property & Casualty Benefit Plan payment rate per your Agreement
- Your eligible billed charges
- The state's workers compensation fee schedule
- The federal workers compensation fee schedule
- UCR or prevailing rate as determined by the state
- Other state, federal or government authorized fee schedule

Application of this reimbursement comparison is generally at the claim line (service code) level, unless state or federal regulations applicable to the job-related injury specify comparisons must be done at claim-level aggregate values.

Payment for covered services of an auto liability bill is the least of the following:

- The Property & Casualty Benefit Plan Auto Liability payment rate per your agreement
- Your eligible billed charges
- UCR or prevailing rate as determined by the state
- Any state, federal or mandated rates applicable to auto

Bills subject to bill edits

For bills subject to code edits or line bundling and unbundling, the bill pricing resulting from these edits is allocated to the original submitted bill lines and codes (refer to the OneNet pricing sheet). Priced bills do not display the lines or codes added or deleted by these bill edits. This is intended to assist physicians and OneNet's clients and payers in bill reconciliation by having priced bills match the originally submitted bills.

Allocation of global pricing to the bill line level

Certain bills are subject to global pricing, including case rates, flat rates and per diems. In these cases, a fixed percentage of the overall global rate may be allocated to the applicable lines of the bill.

Example of global pricing distributed across lines

A health care provider has billed lines totaling $100 that are subject to a state fee maximum of $90 and a contracted global rate of $80. A portion of the global rate is allocated to each line as a percentage of the state fee charges.

	Billed charges	State fee	Allowed amount
Line 1	$50	$45	$40
Line 2	$30	$27	$24
Line 3	$20	$18	$16
Total	$100	$90	$80

These allocations occur because individual lines where global pricing has been distributed may not be processed separately. This means if the payer finds a service line to be non-compensable, and a portion of a global rate has been allocated to that line, that portion must still be considered when determining payment. Remark codes on the pricing sheet show when we cannot process individual lines of a bill-level rate separately.

Bill inquiries

OneNet can verify our receipt, the OneNet contracted pricing and the date returned to our client. We cannot verify payment status or questions related to anything outside of the network contract.

Bill inquires related to the status of payments and non-OneNet related pricing should be directed to the applicable claimant or injured worker's employer, workers compensation carrier, auto liability insurer or TPA.

The fastest way to locate a OneNet PPO pricing sheet is to visit **UHCprovider.com** > Sign In > Claims & Payments > OneNet PPO Pricing. Pricing sheets show the allowed amount of your bills after the application of OneNet bill pricing. They do not show the final bill adjudication by the payer, which could include pricing for charges that the payer identifies as non-payable, ineligible or the patient's responsibility. The EOB or remit created by the applicable claimant or injured worker's employer, workers compensation carrier, auto liability insurer or TPA will identify charges deemed not payable for workers compensation or auto liability.

If you do not have internet access, or if you cannot find the information for the Procura client you need on our website, call **1-877-461-3750**.

Bill payment

OneNet and Procura do not pay bills and do not have an obligation to pay for services rendered to an injured worker or claimant authorized to access a OneNet PPO network provider. We send the priced bill to the appropriate client or payer for adjudication and payment determination. You are required to accept the OneNet contracted amount as payment in full for covered services. For compensable workers compensation-related services, the injured worker may not be billed. There are no copayments, deductibles or coinsurances. Balance billing is prohibited for all services covered by a workers compensation benefit plan.

A health care provider may not bill participants for non-professional services, including charges for overhead, administration fees, malpractice surcharges, membership fees, fees for referrals or fees for completing bill forms or submitting additional information. If OneNet rejects or denies a bill because a health care provider failed to follow policies and procedures, the patient may not be billed.

For compensable auto claims, the claimant may have deductibles according to their policy. The claimant is responsible for those deductibles. An auto liability policy may also contain limited benefits. Once those benefits are exhausted, the claimant is responsible for all remaining charges or the services can be billed through their health insurance carrier if there are additional benefits for the claimant to use.

OneNet payers are required to adjudicate and pay clean bills within 30 days of bill pricing, or within applicable state or federal guidelines. If the OneNet payer fails to adjudicate and pay a bill within this time period, the health care provider may, at their discretion, request the least of the full charges. In the case of workers compensation, the applicable state or federal maximums will still apply. In these instances, the OneNet payer will pay the bill as it was priced by OneNet. After receiving payment, the health care provider must notify the OneNet payer that payment of full charges or applicable state or federal maximums are requested due to late bill payment. A health care provider cannot request full billed charges for failing to offer timely payment if OneNet, Procura or the client or payer notifies the health care provider after receipt of the bill but before the expiration of the bill payment's time limit that the bill is denied, is missing required information, is deficient in some way or is being held to determine auto or workers compensation compensability.

The claimant or injured worker's employer, workers compensation carrier, auto liability insurer or TPA must send you an EOB or remittance advice indicating that the OneNet PPO Network was accessed and the reimbursement amount for those services. The EOB shows:

- The billed charges for services
- The OneNet contracted amount
- The reimbursement amount
- The amount adjusted based on the Property or Casualty Benefit Plan contract/benefit plan
- Services found to be non-payable

Submit bills with services not payable under the Property or Casualty Benefit Plan to the injured worker or claimant's health plan. Do not assume that UnitedHealthcare is the claimant or worker's health insurer. You can get this information by calling their employer or from the claimant or injured worker directly.

Noncovered services and other participant protocols

Follow the UnitedHealthcare protocols on compensation for care provided to OneNet participants with the following exceptions:

- Workers compensation and auto liability lines of business – When you perform a service that may not be covered under the workers compensation/auto claim or the patient's health insurance, you may balance bill the injured worker or claimant only if the following conditions are met:
  - You notified the injured worker or claimant at the time of service that the charge may not be compensable under their workers compensation/auto injury or illness
  - The injured worker or claimant agrees at the time of service to be responsible for the charge
  - You obtained written consent from the patient to perform the service
  - You have submitted the bill to both the workers compensation/auto employer, carrier, insurer or TPA and the claimant or injured worker's health insurance, and the service is not compensable under either the workers compensation/auto coverage or the injured worker or claimant's health insurance
- The claimant or injured workers' employer, workers compensation carrier, auto liability insurer or TPA determines compensability
- You cannot submit OneNet bills for real-time processing on the UnitedHealthcare Provider Portal

For hospital audit services, OneNet and OneNet clients or payers may conduct their own audits of hospital bills. They may follow their own procedures, subject to mutual agreement of the OneNet client or payer and the audited facility. These procedures vary from those of our Hospital Audit Service Department. OneNet or Procura may request copies of medical records to comply with audits required by external accreditation agencies, the state, OneNet clients or payers or for cause. OneNet clients and payers may conduct independent hospital or facility bill audits and request copies of medical records to help ensure quality care. You must provide medical records when requested by OneNet or OneNet clients or payers at no cost to OneNet, the OneNet client or payer, or the participant. Our hospital bill audit protocol does not apply to such audits or requests for medical records.

Bill appeals (post-service)

Email direct pricing appeals for Procura bills to **optumwc.proppo@optum.com**, or call **1-877-461-3750**. Questions about a state rate allowance should be directed to the claimant or injured worker's employer, workers compensation carrier, auto liability insurer or TPA identified on the EOR.

Any bill pricing appeals must be submitted within 12 months of the bill process date, or within the time frame prescribed by applicable law or your Agreement.

Use the following procedure for payment appeals related to OneNet PPO:

- Email your payment appeals to Procura at **optumwc.proppo@optum.com**
- When resubmitting information, attach all applicable documentation, including any additional information requested
- Include the UB/HCFA bill and EOB

If you have any concerns about the appeal process or specific concerns about a Procura/OneNet client or payer, contact Procura at **optumwc.proppo@optum.com** or call **1-877-461-3750**.

Overpayments

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

If you find a bill where you were overpaid or if we inform you of an overpaid bill that you do not dispute, you must send the overpayment within 30 calendar days (or as required by law or your Agreement) from the date of your identification or our request.

Attach appropriate documentation that outlines the overpayment, including the patient's name, ID number, date of service and amount paid. If possible, include a copy of the EOB that corresponds with the payment.

If you disagree with a request for an overpayment refund, notify the payer in writing as to why you do not believe overpayment occurred and why you dispute the refund.

If the payer still believes a refund should be provided, the payer forwards the information to Procura and OneNet for further review. Procura and OneNet will work with you and the payer to resolve the issue.

Bill pricing adjustments of $5 or less

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

Bill pricing resulting in either an overpayment or underpayment of $5 or less is not adjusted.

Appeals, grievances or complaints

OneNet injured workers and claimants direct appeals or grievances to their employer, workers compensation carrier, auto liability insurer or TPA. They do not use the Appeals and Grievance Form used by UnitedHealthcare members. You are required to support the payer's appeals process by providing records as requested and complying with final determinations. In the case of complaints or grievances related to a participating health care provider, the employer, workers compensation carrier, auto liability insurer or TPA refers the information to UnitedHealthcare and OneNet. If you are disputing the state or services deemed not part of the workers compensation/auto illness or injury, contact the employer, workers compensation carrier, auto liability insurer or TPA at the number identified on the EOR. For all network-related concerns, call Procura at **1-877-461-3750**.

Some states have formal dispute resolution or appeals processes. You must submit your appeal to Procura before using these appeals processes for both workers compensation and auto bills.

Online services

Health care professionals can view pricing sheets in the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > Claims & Payments > OneNet PPO Pricing. Pricing sheets show the allowed amount of your bill after the application of OneNet pricing. Pricing sheets do not show the final bill adjudication by the payer. It may include billed charges and pricing for charges that are not payable as identified on the EOB or remittance advice.

Because workers compensation and auto liability information is not stored on any UnitedHealthcare member system, many of the online solutions on **UHCprovider.com** are unavailable for OneNet claims.

Some unavailable tools include the following:

- Eligibility or benefits
- View patient personal health records
- Submit advance notifications
- View your OneNet fee schedule
- Claim estimator
- Claim submission
- Reprint EOBs
- Optum Pay
- Authorizations and referral information, submission and status

Similar limitations exist for other UnitedHealthcare systems designed to use or verify benefits and eligibility information, such as the United Voice Portal.

Referrals

The UnitedHealthcare requirements for health care provider referrals do not apply to the OneNet PPO Network. Do not use the referral submission system online. However, in some states the injured worker or claimant may be required to use certain health care providers to receive benefits. Contact the injured worker or claimant's adjuster for guidance. Try to recommend another participating health care provider, if requested. For assistance identifying participating health care providers, call Procura at **1-877-461-3750**.

Air ambulance, fixed-wing nonemergency transport

The UnitedHealthcare requirement to refer nonemergency fixed-wing air ambulance to a participating health care provider does not apply. The injured worker or claimant may not receive benefits, depending on the state, unless an authorized health care provider is used. If an in-network provider is not available, contact the adjuster to determine where to refer the injured worker or claimant for authorized care.

Laboratory services

The UnitedHealthcare requirement that participating laboratory providers must be used does not apply. The injured worker or claimant may not receive benefits unless an authorized laboratory is used. Contact the adjuster for guidance. Try to refer to a laboratory, based on the information provided by the adjuster. The OneNet PPO Network includes national, regional and local health care providers of laboratory services. The self-referral and anti-kickback provisions of the UnitedHealthcare laboratory services protocols apply to OneNet health care providers.

Pharmacy services

The OneNet PPO workers compensation and auto liability networks do not include a pharmacy network. Contact the adjuster to determine where to refer the patient for care.

Specialty pharmacy and home infusion

The UnitedHealthcare requirements on Designated Specialty Pharmacy or Home Infusion Providers for Specialty Medications, and Specialty Pharmacy Requirements for Certain Specialty Medications do not apply to, and are not supported by, the OneNet PPO Network. Contact the adjuster for the name of a specialty pharmacy provider, as the injured worker or claimant may be required to use certain health care providers to receive benefits.

Provider responsibilities and workflows

OneNet health care providers follow **Chapter 2: Provider responsibilities and standards** with these noted exceptions:

- As part of transitions under continuity of customer care, participating health care providers should notify current patients accessing them through the OneNet network of an effective date of termination of their Agreement at least 30 calendar days prior, or as required under applicable laws. OneNet does not maintain participant names and addresses and may not notify participants on your behalf.
- Additional exceptions related to benefits, eligibility, online tools and health plan ID cards are in other parts of this supplement

Behavioral health services

Contact the adjuster if you believe an injured worker or claimant would benefit from mental health/substance use disorder services due to their job-related injury or auto accident. The OneNet network includes behavioral health care providers. Follow Official Disability Guidelines (ODG) and requirements or other evidence-based requirements as defined by each state.

Case management

Payers may use their own internal case management services for injured workers or claimants. You are required to comply with the case management programs used by Procura and its clients and payers. They will follow state-driven requirements or other evidence-based guidelines. OneNet health care providers must work with case managers and follow all applicable state laws, regulations and rules.

Medical records standards and requirements

Standards and requirements described in **Chapter 12: Medical records standards and requirements** apply to OneNet health care providers. Adhere to any state requirements that exceed the requirements as outlined.

Quality management and health management programs

The following exceptions apply to the Health and Disease Management procedures in how they apply to OneNet and OneNet participants:

- UnitedHealthcare Case Management, Behavioral Health and Disease Management programs do not apply to OneNet workers compensation or auto liability
- Do not report OneNet participant information to the UnitedHealthcare Cancer Registry
- OneNet encourages the use of the Clinical and Preventive Health Guidelines when treating OneNet participants. A complete list of clinical guidelines located on **UHCprovider.com/policies** > Additional Resources > **Clinical Guidelines**.
- While OneNet encourages the use of resources available on **UHCprovider.com** related to mental health/substance use disorder, the processes described for behavioral health consults do not apply to the OneNet PPO Workers compensation or Auto Liability. Contact the case manager or adjuster for guidance if you believe a participant would benefit from mental health/substance use disorder services due to their job-related injury or auto accident. You must follow ODG guidelines and requirements or other evidence-based requirements as defined by each state.

Participant rights and responsibilities

Get a copy of OneNet Participant Rights and Responsibilities, which vary from the UnitedHealthcare Member Rights and Responsibilities, by calling Procura at **1-877-461-3750**.

Advance directives

Follow the advance directive requirements provided in the UnitedHealthcare guide for the OneNet Network, if applicable. OneNet does not produce benefit materials for injured workers or auto liability plans. We cannot inform OneNet participants of state laws on advance directives. This is the responsibility of the employer, workers compensation carrier or other entities as defined by the employer.

Oxford commercial supplement

Oxford commercial product overview

Our Oxford commercial products are gated, non-gated and level funded. For information specific to level funded plans in New Jersey and Connecticut, see the **Oxford Level Funded plans** section of this supplement. Oxford Level Funded is also offered in New York.

Applicability of this supplement

This supplement applies to all covered services you provide to your patients who are Oxford members (insured by or receiving administrative services from Oxford). Oxford commercial products are offered under the names of Freedom, Liberty and Metro, as follows:

- Freedom products are offered in Connecticut, New Jersey and New York
- Liberty products are offered in Connecticut, New Jersey and New York
- Metro products are offered in New York and New Jersey

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

Benefit plans not subject to the requirements in this protocol
• UnitedHealthcare Medicare Advantage plans offered under the AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic and UnitedHealthcare Medicare Advantage brands on the Oxford health plan platform • Benefit plans offered through the Individual Exchanges administered pursuant to the federal Patient Protection and Affordable Care Act and utilizing the Oxford Metro network of providers. Please refer to **Chapter 4: Individual Exchange plans** for more information. • Oxford individual benefit plans underwritten by Oxford Health Insurance, Inc.

How to contact Oxford commercial

Resource	Where to go
Appeals, administrative (claims)	**Online:** **UHCprovider.com** > Sign In > Claims & Payments **API:** Submit reconsiderations and appeals (with attachments) using API. Go to **UHCprovider.com/api** for more information.

Resource	Where to go
Appeals, clinical and medical necessity	**Preservice** **Online:** UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > Prior Authorizations **Fax:** 1-801-994-1416 **Phone: 1-800-666-1353** **Post-service** **Online:** UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In **API:** Submit reconsiderations and appeals (with attachments) using API. Go to **UHCprovider.com/api** for more information. **Behavioral Health Appeals** **Mail:** Oxford Behavioral Health Appeals P.O. Box 30512 Salt Lake City, UT 84130-0512 **Phone: 1-866-566-8166** **Fax:** 1-855-312-1470
Appeals (members) Second-level member appeals	**Online: UHCprovider.com** > Sign In > Claims & Payments Provider acting on member's behalf should submit electronically. **Mail:** Oxford Grievance Review Board P.O. Box 31387 Salt Lake City, UT 84131
Internal appeals: claims payment disputes	**Online: UHCprovider.com** > Sign In > Claims & Payments
Appeals: pharmacy (urgent)	**Fax:** 1-801-994-1058
Behavioral health department	**Phone: 1-800-201-6991**
Cardiology Cardiac catheterization Echocardiogram Stress echocardiogram	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need **Policies: UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies** **Phone (EviCore):** 1-877-PREAUTH (1-877-773-2884) Monday–Friday, 7 a.m.–7 p.m. ET
Chiropractic services: Optum	Provider Services/Claims **Online: myoptumhealthphysicalhealth.com** **Phone: 1-800-985-3293**
Claim submission	**EDI:** Commercial Claims Payer ID: 06111 More information about EDI: **optumpay.com/optumpay** You may also visit pntdata.com to learn about a free submission tool that doesn't require practice management software. **Online: UHCprovider.com** > Sign In > Claims & Payments **Information: UHCprovider.com/claims**

Resource	Where to go
Claim corrections and reconsiderations	**EDI:** Submit facility claim corrections electronically. **Online:** **UHCprovider.com** > Sign In > Claims & Payments **Information:** **UHCprovider.com/claims**
Claim status	**EDI:** 276/277 Claim Status Inquiry and Response transactions are available through your vendor or clearinghouse. **Online:** **UHCprovider.com** > Sign In > Claims & Payments **Information:** **UHCprovider.com/claims** **Phone: 1-800-666-1353** and say claims when prompted. You may also speak with a representative Monday–Friday, 7 a.m.–7 p.m. CT.
Clinical and administrative policies	**Online:** **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies**
Clinical services department	**Phone: 1-800-666-1353** (Monday–Friday, 7 a.m.–7 p.m. CT)
Credentialing and recredentialing Member of the Council for Affordable Quality Healthcare (CAQH)	**Online:** **UHCprovider.com** > Resources > Resource library > **Join the UnitedHealthcare Network** Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. **New Jersey only** **Online:** State of New Jersey Department of Health: nj.gov/health or caqh.org **Phone:** Provider Services at **1-800-666-1353** or CAQH Support at 1-888-599-1771
Electronic Data Interchange (EDI) Check status of referrals, precertifications and claims; member eligibility and benefits	**Payer ID:** 06111 **Online:** • **UHCprovider.com/edi** • **UHCprovider.com** > **Eligibility and Referrals** **Phone: 1-800-842-1109**, Monday–Friday, 8:30 a.m.–5 p.m. ET
Eligibility and benefits	**EDI:** 270/271 Eligibility and Benefits Inquiry and Response transactions are available through your vendor or clearinghouse. For more information, go to **UHCprovider.com/edi270**. **Online:** **UHCprovider.com** > Sign In > Eligibility **Voice Portal and Provider Services:** **1-800-666-1353** and say benefits and eligibility when prompted. You may also speak with a representative Monday–Friday, 7 a.m.–7 p.m. CT.
Forms	**Oxford commercial supplement forms**
Fraud hotline	**Phone: 1-866-242-7727**
Genetic and molecular testing	**Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need.

Resource	Where to go
HIPAA compliance and security	**Online: uhc.com/privacy** For additional information on granting remote access to your EMR system: **emrcdsa@uhc.com**.
Infertility services: Optum	**Phone: 1-877-512-9340** **Fax:** 1-855-536-0491
Inpatient admission	**EDI:** Use your clearinghouse. **Online: UHCprovider.com** > Sign In > Prior Authorizations **Phone: 1-800-666-1353**
Inpatient and outpatient: clinical services	**Phone: 1-800-666-1353**
Laboratory services	Locate participating laboratories: **Online: UHCprovider.com/findprovider** > **Preferred Lab Network**
Optum Pay Information and enrollment	**Online:** • **optum.com/optumpay** • **optumbank.com** > **Sign in** **Helpdesk: 1-877-620-6194**
Outpatient injectable chemotherapy and related cancer therapies	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Phone: 1-888-397-8129**
Pharmacy customer service	**Phone: 1-800-788-4863** Benefit information: Call the number on the back of the member ID card. **TTY/TDD:** 1-800-498-5428 Available 24 hours per day
Pharmacy prior authorization	**Phone: 1-800-711-4555** Available 24 hours per day
Physical and occupational therapy claims submission and inquiry	**Authorizations: 1-877-369-7564** **Claims: 1-800-666-1353** **Online: myoptumhealthphysicalhealth.com** For claims submitted electronically: Payer ID 06111 **Phone: 1-800-873-4575** **Mail (paper claims):** UnitedHealthcare Attn: Oxford Claims Department P.O. Box 31386 Salt Lake City, UT 84131
Prescription mail order	Optum Rx P.O. Box 2975 Mission, KS 66201

Resource	Where to go
Prior authorization submission	**EDI:** Use your vendor or clearinghouse. **Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** **UHCprovider.com/priorauth** **Phone (only where telephonic submission is permitted):** Provider Services **1-800-666-1353** (Monday–Friday, 7 a.m.–7 p.m. CT)
Prior authorization verification	**EDI:** Use your vendor or clearinghouse. **Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** **UHCprovider.com/priorauth** **Phone (only where telephonic submission is permitted):** Provider Services **1-800-666-1353** and say precertification when prompted. You may also speak with a representative Monday–Friday, 7 a.m.–7 p.m. CT.
Radiation therapy	**Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Fax:** 1-844-284-8068 **Mail:** UnitedHealthcare Attn: Oxford Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265 **Phone (only where telephonic submission is permitted): 1-888-397-8129** (Monday–Friday, 7 a.m.–9 p.m. CT)
Radiology	**Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Policies:** **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies** **Phone (EviCore): 1-877-PREAUTH (1-877-773-2884)** Monday–Friday, 7 a.m.–7 p.m. CT
Referral submission or verification	**EDI:** Use your clearinghouse or vendor. **Online:** **UHCprovider.com** > Sign In > Referrals **Information:** **UHCprovider.com/referrals** **Phone:** Provider Services **1-800-666-1353** and say referral when prompted. You may also speak to a representative Monday–Friday, 7 a.m.–7 p.m. CT.
Search for participating health care providers, other health care professionals and facilities	**Online:** **UHCprovider.com/findprovider** **Phone: 1-800-666-1353** (Monday–Friday, 7 a.m.–7 p.m. CT)

Resource	Where to go
Termination requests	**Phone: 1-800-666-1353** (Monday–Friday, 8 a.m.–6 p.m. ET) **Mail:** Physicians and other health care professionals send by certified mail, return receipt requested to: UnitedHealthcare Oxford Network Contract Support Mail Route: TX023-1000 1311 W President George Bush Highway, Suite 100 Richardson, TX 75080-9870 Termination requests can be submitted through **UHCprovider.com** > Sign In > Practice Management > My Practice Profile. **Behavioral health providers only** **Phone: 1-877-614-0484**

Health care provider responsibilities and standards

Compliance with quality assurance and utilization review

Physicians and other health care professionals agree to fully comply with and abide by the rules, policies and procedures that we have or will establish. We provide written notice of any changes 30 days in advance, including, but not limited to:

- Quality assurance, such as on-site case management of members, incentive programs and notification compliance measures
- Utilization management, including prior authorization procedures, referral processes or protocols and reporting of clinical accounting data
- Member, physician and other health care professional grievances
- Timely provision of medical records when we or our contracted business associates request them
- Cooperation with quality of care investigations, including timely response to queries and/or completion of improvement action plans
- Health care provider credentialing
- Any similar programs developed by us

Advising members of their rights

Our members have the right to obtain complete, current information concerning diagnosis, treatment and prognosis in terms they may understand. When it is not advisable to give such information to the member, make the information available to an appropriate person acting on the member's behalf.

Our members also have the right to receive information as necessary to give informed consent before the start of any procedure or treatment. They may refuse treatment to the extent permitted by law. You must inform them of the medical consequences of that action.

Office and access standards

Your office must adhere to policies regarding:

- Confidentiality of member medical records and related member information
- Patient-centered education

- Informed consent, including telling a member before initiating services when a particular service is not covered and disclosing to them the amount they must pay for the service
- Maintenance of advance directives
- Handling of medical emergencies
- Compliance with all federal, state and local requirements
- Minimum standards for appointment and after-hours accessibility
- Safety of the office environment
- Use of physician extenders, such as physician assistants, nurse practitioners and other allied health professionals, together with the relevant collaborative agreements

As a participating health care provider, you agree to certain access standards. You agree to arrange coverage for medical services, 24 hours a day, 7 days a week, including:

1. **Telephone coverage after hours** – you must have either a constantly operating answering service or a telephone recording directing members to call a special number to reach a covering medical professional. Your message must tell the caller to go to the emergency room or call 911 if there is an emergency. The message should be in English and any other relevant languages if your panel consists of members with special language needs.
2. **Covering health care providers** – you must provide coverage of your practice 24 hours a day, 7 days a week. Your covering health care provider must be a participating health care provider unless there isn't one in your area. We must certify any nonparticipating health care professionals you use to provide coverage for your practice.

Americans with Disabilities Act (ADA) guidelines

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

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

We may request from a health care provider's office

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

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

Care for members who are hearing-impaired

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

We will bear the reasonable cost of providing an interpreter. You must not bill the member for interpreter fees.* The health care provider/facility pays the interpreters for their services, then bills us for these services by submitting a claim form with Current Procedural Terminology (CPT) code 99199 with a description of the interpreter service.

If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing, so they receive them prior to the Virtual Visit.

*28 CFR Sect. 36.301(c) and 36.303(b)(1)-36.303(c).

Confirming eligibility and benefits

Checking the member's eligibility and benefits before rendering services helps ensure you submit the claim to the correct payer, collect correct copayments, determine if a referral is required and reduce denials for noncoverage. To check eligibility and benefits, use any of the following methods:

- **EDI:** 270/271 Eligibility and Benefit Inquiry and Response transactions are available through your vendor or clearinghouse.
- **Online:** **UHCprovider.com** > Sign In > Eligibility
- **Information:** **UHCprovider.com/eligibility**
- **Phone: 1-800-666-1353** and say benefits and eligibility when prompted. You can also speak with a representative Monday–Friday, 7 a.m.–7 p.m. CT.

For additional help with the website, Oxford Voice Portal and EDI solutions, go to **UHCprovider.com** > Our network > Contact us > **Technical support for providers and staff**. You will find quick reference guides and instructions to assist you.

Member health plan identification (ID) cards

You can view current member ID cards when you verify eligibility and benefits by going to **UHCprovider.com** > Sign In > Eligibility.

You may download and keep a copy of both sides of the ID cards for your records.

For more detailed information and to see a sample ID card, refer to the **Commercial health care ID card legend** in **Chapter 2: Provider responsibilities and standards**. You may see a sample ID card image specific to the member when you verify eligibility and benefits in the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** > Sign In > Eligibility.

Participating hospitals, ancillary providers and health care providers agree to:

- Verify a member's status. We will not pay for services rendered to persons who are not our members.
- Obtain prior authorization from us or a delegated vendor for all hospital services requiring prior authorization before rendering services. Generally, all hospital services require our prior authorization.
- Notify us of all emergency/urgent admissions of members upon admission or on the day of admission. If the facility is unable to determine on the day of admission that the patient is our member, the facility must notify us as soon as possible after discovering that the patient has coverage with us.
- Notify us of an ambulatory surgery performed due to an ER or urgent care visit within 24–48 hours.
- Admit and treat our members the same way you treat all other facility patients (i.e., according to the severity of the medical need and the availability of covered services).
- Render services to members in a timely manner. The services provided must be consistent with the treatment protocols and practices used for any other facility patient.
- Work with the responsible PCP to help ensure continuity of care for our members.
- Maintain appropriate standards for your facility.
- Cooperate with our utilization review program and audit activities.
- Receive compensation only from us and adhere to our balance billing policies.
- Complete appeals process in a timely manner before proceeding to arbitration.

Standards of practice

Services you perform for members must be consistent with the proper practice of medicine and be performed following the customary rules of ethics and conduct of the American Medical Association and other bodies, formal or informal, governmental or otherwise, from which you seek advice and guidance or to which they are subject to licensing and control.

PCP selection

All HMO products require members to select a PCP to provide primary care services and coordinate their overall care. Female members may also select an obstetrician/gynecologist (OB/GYN), which they may see without a referral from their PCP. Members may only select a PCP within their network (i.e., a Liberty Plan member must select a Liberty Network participating PCP).

Role of the PCP

As a PCP, you must deliver medically necessary primary care services. You are the coordinator of our members' total health care needs. Your role is to provide all routine and preventive medical services and coordinate all other covered services, specialist care and care at our participating facilities or at any other participating medical facility where our members might seek care (e.g., emergency care). You are responsible for seeing all members on your panel who need care, even if the member has never been in for an office visit. You may not discriminate on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, place of residence, health status or source of payment.

Some PCPs are also qualified to perform services ordinarily handled by a specialist. We will only pay claims submitted for specialist services by such a PCP if they are listed as a participating specialist in the particular specialty.

HIV confidentiality

Per New York regulations, all health care providers must develop and implement policies and procedures to maintain the confidentiality of HIV-related information. You must have the following procedures in place to comply with regulations specific to the confidentiality, maintenance and appropriate disclosure of HIV patient information.

Office staff will:

1. Receive initial and annual in-service education regarding the legal prohibition of unauthorized disclosure
2. Maintain a list containing job titles and specified functions for employees authorized to access such information
3. Maintain and secure records, including records which are stored electronically, and ensure records are used for the purpose intended
4. Maintain procedures for handling requests by other parties for confidential HIV-related information
5. Maintain protocols prohibiting employees, agents and contractors from discriminating against persons having or suspected of having HIV infection
6. Perform an annual review of the following policies and procedures:
   - Perform HIV testing on all newborns
   - Prenatal health care providers should counsel expectant mothers regarding the required testing of newborns and the importance of the mother getting tested
   - Advise expectant mothers of the counseling and services offered when results are positive. This includes psychosocial support and case management for medical, social and addictive services.

Only employees contractors and medical nursing or health-related students who have received such education on HIV confidentiality shall have access to confidential HIV-related information while performing the authorized functions.

Specialists

As a participating specialist, you agree to:

- Provide referrals for specialty services
- Provide results of medical evaluations, tests and treatments to the member's PCP
- Precertify inpatient admission
- Receive compensation only from us and adhere to our balance billing policies

- Provide access to your records relating to services rendered to our members. If you believe consent is required from the specific member, you must obtain their consent.
- Follow our authorization guidelines for those services requiring prior authorization

We only reimburse you for services if:

- We have a referral on file, or the member has a non-gatekeeper benefit plan and the service is covered and medically necessary
- A referral is not on file, and the member has an out-of-network benefit (e.g., a POS benefit plan), and if the service is covered and medically necessary, you are entitled to the contracted rate. However, the member is required to pay any deductible and/or coinsurance based on their out-of-network benefits.
- If the member is enrolled in a benefit plan without an out-of-network benefit (e.g., an HMO benefit plan), we are not responsible for payment (except in cases of emergency), nor may the member be balance billed

Specialists as PCPs

We allow a member who has a life-threatening condition or a degenerative and disabling condition (i.e., complex medical condition) or disease, either of which requires specialized medical care over a prolonged period of time, to elect a network specialist as their PCP. We may grant a standing referral, and the specialist PCP becomes responsible for providing and coordinating all of the member's primary care and specialty care. The PCP, specialist and our established Oxford treatment plan must all be aligned.

We may authorize a standing referral (see **Standing referrals and specialty care centers**) when the health care provider is requesting more than 30 visits within a 6-month period or covered services beyond a 6-month period but within 12 months. Under a standing referral, a member may seek treatment with a designated specialist or facility without a separate PCP referral for each service.

If such an election appears to be appropriate, our Clinical Services department faxes the specialist a form to complete and return.

We cover such services without a referral only after you complete the form and we accept it. Otherwise, a referral is required for members with a gatekeeper benefit plan.

Transitional care

Continuity and coordination of care helps ensure ongoing communication, monitoring and overview by the PCP across each member's health care continuum. Documentation of services provided by specialists such as podiatrists, ophthalmologists and mental health practitioners, as well as ancillary health care providers including home care and rehabilitation facilities, help the PCP maintain a medical record supporting whole person care.

The state departments in the tristate area (New York, New Jersey and Connecticut) require elements of the chart to indicate continuity and coordination of care among health care providers. We monitor the continuity and coordination of care that members receive through the following mechanisms:

- Medical record reviews
- Adverse outcomes that may develop as the result of disruptions in continuity or coordination of care
- Health care provider termination

Newly enrolled members who need transitional care or continuity of care

When a new member enrolls with us, they may qualify for coverage of transitional care services rendered by their nonparticipating health care providers.

For more information about transitional care, members may call us at the phone number on their health plan ID card or at **1-800-444-6222**.

Reassignment of members who are in an ongoing course of care or who are being treated for pregnancy

We adhere to the following guidelines when notifying members affected by a health care provider termination:

- We notify all members who are patients of any terminated PCP's panel – internal medicine, family practice, pediatrics, OB/GYN – about our policy and what steps to follow should the member require transitional care. We follow the same policy for members who regularly see a specialist who is terminated from our network or who is not (or no longer) in our network.
- We instruct members of a terminated PCP's panel to call Member Services if they choose to select a new PCP or to request transitional care from their current health care provider. We encourage them to request our Roster of Participating Physicians and Other Health Care Professionals to make their new selection.
- We instruct members of a specialist terminated from our network to call Member Services if they need to request transitional care from their current specialist. We also direct members to call their current PCP for an alternate specialist referral.

Transitional care when a health care provider leaves our network

We use the following rules when notifying members affected by a health care provider terminated from our network:

- Oxford members in New York qualify for transitional services on a network basis for a certain time period to be determined based upon their clinical presentation.
- We tell all members who are patients of any terminated PCP, such as internal medicine, family practice, pediatrics and OB/GYN, about our policy and what steps to follow should they need transitional care. We follow the same policy for members being seen regularly by a specialist who is terminated from our network.
- We instruct members with PCPs who are not or no longer in our network to call Member Services whether they choose to select a new PCP or to ask for transitional care from their current health care provider. We encourage them to visit **myuhc.com** to make their new selection.
- We tell our members who are patients of a terminated specialist to call Member Services if they need to request transitional care from their current specialist. Additionally, we tell them to call their current PCP to ask for a referral to a different network specialist.

If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period includes the provision of postpartum care directly related to the delivery. Our medical director must find the treatment by the nonparticipating health care provider medically necessary. Transitional care is available only if the health care provider agrees to:

- Accept as payment our negotiated fees for such services before transitional care
- Adhere to our quality management procedures and provide medical information related to the member's care
- Adhere to our policies and procedures regarding the delivery of covered services, including referrals and preauthorization policies, and a treatment plan approved by us

Referrals

Submitting and verifying referrals

A PCP or OB/GYN may issue a referral to participating health care providers using any of the methods outlined in the **How to contact Oxford commercial** section.

Once you enter the referral, the referring health care provider may receive a reference number by fax. Provide the referral reference number to the member. The member may bring this reference number to the specialist who can directly confirm a referral by visiting **UHCprovider.com** > Sign In > Referrals or by calling **1-800-666-1353**.

Referral policies and guidelines

Our physician contracts require referrals be issued to participating physicians, hospitals, ancillaries and other health care professionals within the applicable network of health care providers available to our members enrolled in gated health benefit plans. The only exceptions to this are:

1. Emergency cases
2. There are no participating health care providers who can treat the member's condition

If you would like to direct a member to nonparticipating health care providers, you must request a network exception from our Clinical Services department and receive approval before the member receives service. If the member requests to see a specialist and is unable to reach their PCP or OB/GYN (after-hours, weekends or holidays), the PCP may issue a referral up to 72 hours after the member received services.

Prior authorization guidelines still apply to those covered services requiring prior authorization.

We must review and approve all referrals. A referral does not guarantee coverage of the services provided by the participating specialist. Covered services are subject to:

- Medical necessity, as determined by Oxford clinical policies
- Member eligibility on the date(s) of service
- Member's benefits as defined in the conditions, terms and limitations of their summary of benefits/certificates/contract

Participating specialists may only issue referrals within the applicable network of health care providers available to the members enrolled in gated health benefit plans for certain covered services as outlined in the referrals policy. You may not refer a member to a nonparticipating specialist. For more information, refer to the section on **Using nonparticipating health care providers or facilities**.

Member self-referrals

We have programs to improve outcomes for members and help us better manage the use of medical services. You may refer members to these programs, or members may self-refer, to network specialists for the following services:

1. OB/GYN care, to include prenatal care, 2 routine visits per year and any follow-up care, or for care related to an acute gynecological condition
2. 1 mental health visit and 1 substance use disorder visit with a participating health care provider per year for evaluation
3. Vision services from a participating health care provider
4. Diagnosis and treatment of tuberculosis by public health agency facilities
5. Family planning and reproductive health from participating or Medicaid health care providers

Outpatient radiology self-referral procedures

We designed the Outpatient Imaging Self-Referral Policy to promote appropriate use of diagnostic imaging by network PCPs, specialty physicians and other health care professionals in the office and outpatient setting.

This policy does not apply to radiology services performed during an inpatient stay, ambulatory surgery, ER visit or pre-operative/pre-admission testing. See the **How to contact Oxford commercial** section for contact information.

The outpatient imaging self-referral list is applicable to commercial benefit plans. You may find more information in the Oxford Outpatient Imaging Self-Referral Clinical Policy at **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies**.

Standing referrals and specialty care centers

You may request a standing referral to a participating specialist, ancillary provider or specialty care center if a member requires ongoing specialist treatment, has a life-threatening condition or disease or a degenerative and disabling condition or disease. This referral is available only if the condition or disease requires specialized medical care over a prolonged period. The participating specialist or ancillary provider must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the medically necessary care required for the treatment of the condition or disease. We cover the services provided only to the extent outlined in the member's Certificate of Coverage.

Utilization management

Prior authorization (precertification)

We refer to the terms prior authorization and precertification in the supplement. You will notice both terms used throughout this supplement.

You may submit prior authorization requests using any of the methods outlined in the **How to contact Oxford commercial** section.

We urge you, facilities, ancillaries and other health care professionals to perform a prior authorization status check first to determine if there is already a prior authorization on file.

Submit prior authorization as far in advance of the planned service as possible to allow for review. We require prior authorization at least 14 business days before the planned service date.

- Submit authorization requests for obstetrical admissions for normal delivery as early as possible in the course of prenatal care, based on the expected date of delivery
- Participating health care providers and facilities are responsible for contacting us for:
  - Procedures requiring prior authorization. However, an active referral must also be on file for services to be covered as network benefits, depending on the member's health benefit plan referral requirements.
  - Any change of treating health care provider, location, CPT codes or dates of service for the authorized service
  - Member emergency admissions upon admission or on the day of admission. If the health care provider/facility is unable to determine on the day of admission that the patient is our member, the health care provider/facility must notify us as soon as possible after discovering that the patient has coverage with us.
- We notify participating health care providers of all determinations involving New York members by phone and in writing. All participating health care providers are responsible for calling the member the same day the health care provider receives notification of our determination.
- Neither prior authorization nor referral is required for members to access a participating women's health specialist (i.e., gynecologists and/or certified nurse midwives) for routine and preventive health care services. Routine and preventive health care services include screening breast exams, mammograms and pap tests.
- Members are responsible for notifying us of emergency facility admissions to a nonparticipating facility
- We may require a member see a health care provider, selected by us, for a second opinion. We reserve the right to seek a second opinion for any surgical procedure. There is no formal list of procedures requiring second opinions. Members may also seek a second opinion when appropriate.

Status of a submitted authorization request

Verify the status of an authorization request by the following methods:

- **Voice Portal** – available 24 hours a day
- **Online** – available 24 hours a day
- **Provider Services** – speak to a service representative during business hours

Medically necessary services

Medically necessary services are services or supplies provided by a hospital, skilled nursing facility (SNF) or health care provider that are required to identify or treat a member's illness or injury, as determined by our medical director. These services or supplies must be:

- Consistent with the symptoms or diagnosis and treatment of a member's condition
- Appropriate regarding standards of good medical practice
- Not solely for the member's convenience or that of any health care provider

- The most appropriate supply or level of service that may safely be provided
- For inpatient services, it also means the member's condition may not safely be diagnosed or treated on an outpatient basis

Prior authorization list

1. Go to **UHCprovider.com/priorauth** > Advance notification > **Commercial Advanced Notification/Prior Authorization Requirements**
2. You may request a copy of the most current list by mail:
   Oxford Policy Requests and Information
   4 Research Drive
   Shelton, CT 06484

Changes to the policies related to services appearing on this list are announced in the Oxford Policy Update Bulletin available at **UHCprovider.com/policies** > For Commercial Plans > UnitedHealthcare® Oxford Clinical and Administrative Policies > **Policy Update Bulletins**.

- A member's benefit plan may not cover certain services, regardless of whether we require advance notification.
- If there is conflict or inconsistency between applicable regulations and the supplement notification requirements, we follow applicable regulations.
- Prior authorization requirements may differ by individual health care providers, ancillary providers and facilities. If additional prior authorization requirements apply, we notify you before applying prior authorization rules

EviCore healthcare prior authorizations online

EviCore healthcare (EviCore) provides a secure, interactive web-based program where prior authorization requests may be initiated and determined in real time. If the program finds the request is medically necessary, it issues an authorization number immediately. If the program cannot verify medical necessity through the online process, you may submit more information at the session conclusion and print a procedure request summary page.

If an online request for authorization doesn't meet medical necessity criteria, EviCore forwards it for clinical review. They may request more information for medical necessity review with a medical director. If the criteria have not been met, your office and the member are notified in writing of the denial.

Go to **UHCprovider.com** > Sign In > Prior Authorizations to submit information. This eliminates the need to call EviCore and lets you enter multiple clinical certification requests at your convenience. Learn more at **UHCprovider.com/priorauth**.

Prescription medications requiring prior authorization

Based on the member's benefit plan design, some high-risk or high-cost medications require advance notification to be eligible for coverage. This process is also known as prior authorization and requires you to submit a formal request and receive advanced approval for coverage of certain prescription medications.

Learn more at **UHCprovider.com/priorauth** > **Clinical and specialty pharmacy**.

Prior authorization and referral guidelines when coordinating benefits

When we are the secondary or tertiary carrier, we modify normal requirements for prior authorization and referrals as follows:

- We defer to the requirements of the primary carrier and waive our referral and prior authorization guidelines. We do not waive other requirements (e.g., itemized bills, student verification, consent for exchange of mental health or substance use disorder information).

- Exception: Referral and prior authorization guidelines apply:
  - If the primary carrier does not cover a service or applies an authorization penalty
  - When a motor vehicle accident occurs or workers' compensation is involved

Using nonparticipating health care providers or facilities

As a participating health care provider, you must use participating health care providers and facilities within the member's benefit plan network (e.g., Liberty Network). We have a compliance program to identify participating health care providers who regularly use nonparticipating health care providers and facilities. We take appropriate measures to enforce compliance.

If a member asks you for a recommendation to a nonparticipating health care provider, you must tell the member you may not refer to a nonparticipating health care provider. The member must contact us to obtain the required prior authorization by calling us at the phone number on their health plan ID card or **1-800-444-6222**.

If you contact us for authorization to perform a nonemergency procedure at a nonparticipating facility for a member who has out-of-network benefits, we may authorize the procedure as out-of-network.

This means the reimbursement to the nonparticipating facility is subject to the member's out-of-network deductible and coinsurance obligations. The nonparticipating facility's charges are only eligible for coverage up to the reimbursement levels available under the member's benefit plan, using either a usual, customary and reasonable (UCR) fee schedule or a Medicare reimbursement system called the Out-of-Network Reimbursement Amount for our New York members.

Members are responsible for paying their out-of-pocket cost and the difference between the UCR fee or other out-of-network reimbursement and the nonparticipating facility's billed charges. Remind the member their expenses may be significantly higher when using a nonparticipating health care provider.

If you contact us for authorization to perform a nonemergency procedure at a nonparticipating facility on a member who does not have out-of-network benefits (HMO and EPO benefit plan members), we may deny the services based on the benefit plan.

If you ask for an exception, we may consider it only when our medical director determines in advance that:

1. Our network does not have an appropriate participating network provider who can deliver the necessary care
2. Medically necessary services are not available through our network providers

In such cases, we will approve the requested authorization. It must include a treatment plan approved by our medical director, the PCP and the nonparticipating health care provider.

Exception process for the use of nonparticipating health care providers (New York and Connecticut)

For participating health care providers, the use of participating health care providers is required unless:

1. We approved an in-network exception.
2. The member explicitly agrees prior to the service (no more than 90 days before the scheduled date of the procedure) to receive services from a nonparticipating health care provider by signing the applicable consent form and understands that the use of this health care provider is:
   - **Out-of-network:** For members with out-of-network benefits, we pay non-care provider claims at the out-of-network benefit level. Out-of-network cost-shares and deductibles apply.
   - **Denied:** For members without out-of-network benefits, we deny nonparticipating health care provider claims as not covered because the member has no coverage for services provided by nonparticipating health care providers. Members are therefore responsible for the entire cost of the service.

For more information, go to **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies**.

Hospital services, admissions and inpatient and outpatient procedures

Facilities are responsible for providing admission notification for all the following types of inpatient admissions, even if advance notification was provided by the physician and coverage approval is on file:

- Planned/elective admissions for acute care
- Unplanned admissions for acute care (admission notification only)
- SNF admissions
- Admissions following outpatient surgery and observation
- Newborns admitted to Neonatal Intensive Care Unit (NICU) and who remain hospitalized after the mother is discharged
- The facility must confirm a preservice approval is on file for services requiring prior authorization

Health care providers and ancillary providers are responsible for obtaining prior authorization for outpatient surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility.

Concurrent review: Clinical information

Upon admission, Clinical Services will accept concurrent review information provided by the admitting health care provider or other health care professional and/or the hospital's Utilization Review department. The hospital must also provide us with the discharge plan on or before the discharge date. If a member requires an extended length of stay or more consultations, call our Clinical Services department at **1-800-666-1353** for prior authorization instructions.

- For mental health/substance use disorder, direct calls related to inpatient prior authorization to **1-800-201-6991**.
- You must cooperate with all requests for information, documents or discussions for purposes of concurrent review and discharge. When available, provide clinical information using electronic medical records (EMR).
- You must cooperate with all requests from the interdisciplinary care coordination team and/or medical director to engage our members directly face-to-face or by phone
- You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if you receive our request before 1 p.m. ET. You must make best efforts to provide requested information within the same business day if you receive the request after 1 p.m. ET (but no later than 12 p.m. ET the next business day).
- We use InterQual Care Guidelines with our Oxford members, which are nationally recognized clinical guidelines, to help clinicians make informed decisions in many health care settings

Inpatient maternity stay and subsequent home nursing

We follow federal mandates regarding the length of an inpatient maternity stay and the coverage of subsequent home nursing visits. Home nursing visit regulations vary by state as outlined in the following.

Inpatient maternity length of stay

We will cover the Oxford member's inpatient maternity stays for both mother and newborn as follows:

- 48 hours following a vaginal delivery
- 96 hours following a cesarean delivery

Post-discharge home nursing visits

- **Connecticut Oxford Plans:** We will approve 2 home nursing visits if both mother and newborn are discharged before the mandated length of stay described previously
- **New Jersey and New York Oxford plans:** We will approve 1 home nursing visit if both mother and newborn are discharged before the mandated length of stay described previously

Newborn coverage varies by benefit plan and state. For more details, refer to **UHCprovider.com/eligibility**.

Neonatal Intensive Care Unit (NICU) level of care

We base NICU bed levels on the intensity of services and identifiable interventions received by the neonate. NICU bed levels are linked to revenue codes defined by the National Uniform Billing Committee. Based on our medical necessity review, we assign a bed day level for those facilities contracted with more than one level of NICU. Claims are reimbursed based on what has been authorized per a medical necessity review of the NICU bed day per the facility contract.

Hospital responsibilities

The hospital is required to notify us of:

- Newborns admitted to NICU and who remain hospitalized after the mother is discharged
- Concurrent inpatient stays (notification before discharge)
- Any member who changes level of care. The member must be enrolled and effective with us on the date the services are rendered. But, if CMS or an employer or group retroactively disenrolls the member up to 90 days following the dates of service, we may deny or reverse the claim.

The hospital must also:

- Provide daily inpatient census log by 10 a.m. ET, including all admits and discharges through midnight the day prior
- Provide notification of all admissions of our members at the time of, or before, admission. The hospital must notify us of all emergencies (upon admission or on the day of admission), and of rollovers (i.e., any member who is admitted immediately upon receiving a preauthorized outpatient service).
- Provide notification for any transfer admissions of members before the transfer unless the transfer is due to life-threatening medical emergency
- Communicate necessary clinical information daily, or as requested by our case manager

If the hospital does not provide the necessary clinical information, we may deny the day for medical necessity. We give reconsideration only if we receive clinical information within 48 hours (72 hours for New Jersey facilities).

If we conduct on-site utilization review, the hospital will provide our on-site utilization management personnel reasonable workspace and access to the hospital, including access to members and their medical records. All health care providers must deliver letters of noncoverage to the member before discharge. This includes hospitals, acute rehabilitation, SNFs and home care.

We consider appeals if the hospital can show that the necessary clinical information was provided within 48 hours, but we failed to respond in a timely manner.

Retrospective review of inpatient stays (notification of admission after discharge)

If we request it, the hospital will provide the necessary clinical information to perform a medical necessity review within 45 days of discharge. If the hospital does not provide the necessary clinical information, we may deny the day for medical necessity. We give reconsideration only if clinical information is received within 48 hours (72 hours for New Jersey members).

Our responsibilities for inpatient notifications

- We will maintain a system for verifying member eligibility/status and use reasonable efforts to transmit a decision regarding an emergency/urgent admission to the hospital
- We will request any necessary clinical information. If we do not ask for such information, the day's services will be our liability.
- We agree to provide concurrent and prospective reviews for all services
- We will assign a first day of review (FDOR) for all elective inpatient services, and we will certify all days up to and including the FDOR
- We will notify the hospital and attending health care provider or other health care professional verbally and in writing of all denied days

- We will perform clinical review of days that fall on the weekends and holidays for which we or the facility is closed, and days upon which there are unforeseen interruptions in business on the following business day. Such reviews will be considered concurrent.
- We will not deny services retrospectively or reduce the level of payment for services that have been preauthorized or received concurrent review approval unless:
  - The member is retroactively disenrolled
  - The certification or concurrent review approval was based on materially erroneous information
  - The services are not provided in accordance with the proposed plan of care
  - Hospital delays in providing an approved service to prolong the length of stay beyond what was approved

Mental health, substance use disorder and detoxification treatment

Inpatient care

All inpatient mental health/substance use disorder treatment requires prior authorization.

Partial hospitalization

Partial hospitalization always requires certification through the behavioral health department. If clinical criteria are met, the case manager facilitates certification and management at a contracted facility with a partial hospitalization program. The case manager continues to follow the member's treatment while they are in the program.

Prior authorization outpatient mental health services (New York)

Covered services are those received on an outpatient basis from duly licensed psychiatrists or practicing psychologists, certified social workers, or a facility-issued operating certificate by the commissioner of mental health, a facility operated by the Office of Mental Health, a professional corporation or university faculty practice corporation. This includes:

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

We provide coverage to the maximum number of visits shown on the member's Summary of Benefits.

Inpatient mental health services (New York)

Members receive covered services on an inpatient or partial hospitalization basis in a facility as defined by subdivision 10 of section 1.03 of the Mental Hygiene Law, as well as by any other network provider we deem appropriate to provide the medically necessary care.

We cover a required inpatient stay as a semi-private room. If we authorize partial hospitalization, 2 partial hospitalization visits may be substituted for 1 inpatient day. We provide coverage for active treatment to the maximum number of days shown on the member's Summary of Benefits.

Visits for biologically based services will apply to this limit. Active treatment means treatment furnished together with inpatient confinement for mental, nervous or emotional disorders, or ailments that meet standards prescribed within the regulations of the commissioner of mental health.

Laboratory policies and procedures

Ancillary services

Our network of laboratory service providers consists of an extensive selection of walk-in patient service centers; many local, regional and national laboratories.

Participating vs. nonparticipating laboratory provider referrals

Refer our members to participating service centers and laboratories to help them avoid unnecessary costs. Referrals are not required. Only a health care provider's prescription or lab order form is required.

We review laboratory ordering information periodically. If our data shows a pattern of out-of-network utilization for your practice, we contact you to share this information and engage you to use the contracted network.

Participating provider laboratory and pathology protocol (New York)

You must follow specific guidelines when you are recommending the use of, making a referral to, or involving a nonparticipating laboratory or pathologist in a member's care.

For additional details and/or to get a copy of the Laboratory & Pathology Services Consent Form, refer to administrative policy titled **Participating Providers Using Nonparticipating Providers Protocol** on **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies**.

In-office laboratory testing and procedures list

The in-office laboratory testing and procedure list outlines the laboratory procedural/testing codes we reimburse to network providers when performed in the office setting. For the most up-to-date list, refer to the In-Office Laboratory Testing and Procedures List at **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies**. One of our network laboratories must perform laboratory procedures/tests not appearing on this list. See the **How to contact Oxford commercial** section for contact information.

Specimen handling and venipuncture

Your prescription or lab order form is required when using participating laboratories to process specimen. If you bill specimen handling and venipuncture codes along with a lab code on the In-Office Laboratory Testing and Procedures List, we only reimburse the lab and venipuncture codes.

If you bill specimen handling and venipuncture codes without a lab code on our In-Office Laboratory Testing and Procedures List or with other non-laboratory services, we reimburse the specimen handling and venipuncture codes per our fee schedule.

Radiology and cardiology procedures

We have engaged EviCore to perform initial reviews of prior authorization requests on behalf of our Oxford members. EviCore has established an infrastructure to support the review, development and implementation of comprehensive outpatient imaging criteria. The radiology and cardiology evidence-based guidelines and management criteria are available on the EviCore website.

EviCore handles all prior authorization requests. To request prior authorization for radiology or cardiology, call EviCore or use the Prior Authorization and Notification tool in the UnitedHealthcare Provider Portal:

- **Online: UHCprovider.com** > Sign In > Prior Authorizations
- **Information: UHCprovider.com/priorauth**
- **Phone: 1-877-PREAUTH (1-877-773-288)**

Accreditation requirements

We require health care provider accreditation and certification requirements for various radiology and cardiology imaging studies performed on our Oxford members.

Find more detailed information in the following policies found at **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies**:

- **Accreditation Requirements for Radiology Services**
- **Credentialing Guidelines: Participation in the eviCore healthcare Network**

- **Oxford's Outpatient Imaging Self-Referral Policy**
- **Radiology Procedures for EviCore healthcare Arrangement**
- **Obstetrical Ultrasonography**
- **Cardiology Procedures for eviCore healthcare Arrangement**

Imaging requiring prior authorization

The referring health care provider is responsible for contacting EviCore to request prior authorization and to provide sufficient history to verify the appropriateness of the requested services. Our policy does not permit prior authorization requests from persons or entities other than referring health care providers.

Urgent requests during regular business hours

As the attending health care provider, you may make an urgent request for a prior authorization number if you determine the service is medically urgent. Make urgent requests by calling 1-877-PRE-AUTH (1-877-773-2884). You must state the case is clinically urgent and explain the clinical urgency. EviCore will respond to urgent requests within 24 hours of receiving all required information.

Retrospective review process for urgent requests outside of regular business hours

If you determine an Advanced Outpatient Imaging Procedure is medically urgent, and you cannot request a prior authorization number because it is outside of EviCore's normal business hours, you must make a retrospective prior authorization request within 2 business days after the date of service. Request the retrospective review by calling 1-877-PRE-AUTH (1-877-773-2884) according to the following process:

1. Documentation must explain why the procedure had to be done on an urgent basis and why you could not request an authorization number during EviCore's normal business hours
2. Once EviCore receives retrospective notification of an Advanced Outpatient Imaging Procedure, and if the member's benefit plan requires services to be medically necessary to be covered, EviCore will conduct a clinical coverage review to determine whether the service was medically necessary
3. If EviCore determines the service was not medically necessary, they will issue a denial and will not issue an authorization number. The member and health care provider will receive a denial notice outlining the appeal process.

Cardiology procedures

We engage EviCore to perform initial reviews of requests for prior authorization of echocardiogram, stress echocardiogram, cardiac nuclear medicine studies, cardiac CT, PET and MRI and cardiac catheterizations procedures for our Oxford members. Evidence-based criteria is used to determine medical necessity of cardiology services. The cardiology evidence-based criteria and management criteria are available on the EviCore website at EviCore.com. We continue to be responsible for decisions to limit or deny coverage and for appeals.

The utilization review process involves matching the member's clinical history and diagnostic information with the approved criteria for each imaging procedure requested. Qualified health care providers make utilization review decisions for diagnostic procedures. EviCore may assign data collection for clinical certification of imaging services to non-medical personnel working under the direction of qualified health care providers. You receive communication of review determinations for non-urgent care by fax/telephone within 2 business days of receiving all the necessary information.

Urgent requests during regular business hours

As the attending health care provider, you may make an urgent request for a prior authorization number if you determine the service is medically urgent. Make urgent requests by calling 1-877-PRE-AUTH (1-877-773-2884). You must state the case is clinically urgent and explain the clinical urgency. EviCore will respond to urgent requests within 24 hours of receiving all required information.

Retrospective review process for urgent requests outside of regular business hours

If you determine that a cardiac procedure is medically urgent, and you cannot request a prior authorization number because it is outside of EviCore's normal business hours, you must make a retrospective authorization request using the following guidelines:

- Within 2 business days of the date of service for:
  - Echocardiograms
  - Stress echocardiograms
- Within 15 calendar days of the date of service for:
  - Diagnostic catheterizations

Request the retrospective review by calling 1-877-PRE-AUTH (1-877-773-2884), according to the following process:

1. Documentation must explain why the procedure had to be done on an urgent basis and why you could not request an authorization number during EviCore's normal business hours
2. Once EviCore receives retrospective notification of a cardiac procedure, and if the member's benefit plan requires services to be medically necessary to be covered, EviCore will conduct a clinical coverage review to determine whether the service was medically necessary
3. If EviCore determines the service was not medically necessary, they will issue a denial and will not issue an authorization number. The member and health care provider will receive a denial notice outlining the appeal process.

Claims processing

You may not balance bill the member if a claim is denied because medical necessity was not demonstrated. We will offer all appropriate appeal rights for any service that is not approved for payment.

Prior authorization is not required when radiology or cardiology procedures are provided in the ER, observation unit, urgent care facility or during an inpatient stay.

Prior authorization is required for services listed on the Advance Notification/Prior Authorization list located at **UHCprovider.com/priorauth**.

The clinical criteria consistent with existing Oxford policies are available on EviCore.com.

You can verify prior authorization requirements by calling the number on the back of the member's ID card to check eligibility or by visiting **UHCprovider.com** > Sign In > Prior Authorizations.

Infertility utilization review process

Optum, a UnitedHealth Group company, is delegated to perform reviews for infertility services under the Managed Infertility Program (MIP) for all Oxford commercial members with an infertility benefit. Optum uses MIP to promote both quality of care and continuity of service by supporting members through every aspect of the infertility process. Optum infertility nurse case managers provide support and help members make informed decisions about infertility treatment and care through treatment education, considerations in choosing where to obtain care and assistance navigating the health care system.

For Oxford products, the rendering health care provider is required to request prior authorization and/or notification of services. Make this request using the Managed Infertility Program Treatment form. Provide sufficient information to determine the medical necessity of the requested services.

Optum has been diligent in its research to help ensure the clinical policies and guidelines it uses are consistent with best practices and state mandates.

Get the Managed Infertility Program Prior Authorization template by:

- Logging on to **myoptumhealthcomplexmedical.com**
- Calling Optum at **1-877-512-9340**
- Sending an email to **mip@optum.com**

Musculoskeletal services

OrthoNet, a musculoskeletal disease management company, is our network manager for most musculoskeletal services.

OrthoNet's orthopedic division performs utilization management review of requested services to help ensure it meets approved clinical guidelines for medical necessity.

OrthoNet conducts the review by determining medical necessity and medical appropriateness, and initiates discharge planning, as appropriate. OrthoNet will base the results on clinical information and some or all of the following criteria/tools:

- Member benefits
- Oxford medical and reimbursement policies
- InterQual Care Guidelines

Physical and occupational therapy

We have delegated certain administrative services related to outpatient physical and occupational therapy services for Oxford members to OptumHealth Care Solutions, LLC (Optum). Hospital outpatient treatment facilities and outpatient facilities at or affiliated with rehabilitation hospitals are considered outpatient settings for physical and occupational therapy. Optum may request records for medical necessity review. If Optum does not receive the requested information within the given time frame, it may deny the claim.

Chiropractic services

OptumHealth Care Solutions, LLC (Optum) manages our chiropractic benefit. To receive standard chiropractic benefit coverage, members must obtain an electronic referral from their PCP. PCPs perform the customary initial comprehensive differential diagnosis with the necessary and appropriate workup.

You may request a chiropractic referral for a maximum of 1 visit within 180 days (6 months). Participating chiropractors must complete and submit Patient Summary Forms to Optum for services performed.

They may submit the Patient Summary Forms through the Optum website at **myoptumhealthphysicalhealth.com**. They must submit the form within 3 business days and no later than 10 business days following the member's initial visit or recovery milestone. We must receive the patient summary form within 10 days from the initial date of service indicated on the form. Optum adjusts the initial payable date when it receives the forms outside of the 10-day submission requirement.

Once it receives the forms, Optum reviews the services requested for medical necessity and makes denial determinations.

If a member's care requires more visits or time than was approved, you must submit a new Patient Summary Form with updated clinical information after the initially approved visits have occurred.

According to your contract with Optum, the member may not be balance billed for any covered service not reimbursed if you do not submit the Patient Summary Form, or for those services which do not meet medical necessity or coverage criteria. However, you may file an appeal.

Acupuncture services

Only members who have the alternative medicine rider have coverage for acupuncture. If a member does not have the alternative medicine rider, we deny requests to cover acupuncture, even if a letter of medical necessity has been submitted. Acupuncture services must be rendered in-network and performed by one of the following health care provider types:

- Participating licensed acupuncturist
- Participating licensed naturopaths
- Participating health care provider (MD or DO) who is a credentialed physician acupuncturist

Pharmacy management programs

The pharmacy benefit plan includes a dynamic medication list, referred to as the PDL, and various clinical drug utilization management programs. We base these programs on FDA-approved indications and medical literature or guidelines.

The PDL contains medications in 3 tiers. Tier 1 is the lowest cost option, and Tier 3 is the highest cost option. Some groups have a 4-tier benefit design.

To help make medications more affordable, consider whether a Tier 1 or Tier 2 alternative is appropriate if the member is currently taking a Tier 3 medication. We perform ongoing reviews of the PDL and make updates up to 3 times per year. Medications requiring notification or prior authorization are noted with a PA, medications that require step therapy are noted with ST and supply limits with SL.

PDL Management Committee and the Pharmacy and Therapeutics Committee

Our PDL Management Committee, a group of senior health care providers and business leaders, makes tier decisions and changes to the PDL based on a review of clinical, economic and pharmacoeconomic evidence.

Our National Pharmacy and Therapeutics (P&T) Committee is responsible for evaluating and providing clinical evidence to the PDL Management Committee to help assign medications to tiers on the PDL. The information provided by the P&T Committee includes evaluation of a medication's role in therapy, its relative safety and its relative efficacy.

The P&T Committee reviews and approves clinical criteria for prior authorization and step therapy programs and supply limits. In addition to medications covered under the pharmacy benefit, the P&T Committee is responsible for evaluating clinical evidence for medications, which require administration or supervision by a qualified, licensed health care professional.

The P&T Committee is comprised of internal and external physicians representing various specialties and pharmacists.

For more information regarding the Oxford pharmacy management program, go to **UHCprovider.com/pharmacy**.

Quality Management and Patient Safety Programs Drug Utilization Review (DUR)

We receive the majority of prescription claims electronically for payment. Within seconds, our systems record the member's claim and review past prescription history for potential medication-related problems. DUR helps review for potentially harmful medication interactions, inappropriate utilization and other adverse medication events to maximize therapy effectiveness within the appropriate medication usage parameters. There are 2 types of DUR programs: concurrent and retrospective.

Concurrent Drug Utilization Review (C-DUR)

The C-DUR program performs online, real-time DUR analysis at the point of prescription dispensing. This program screens every prescription before dispensing for a broad range of safety and utilization considerations. C-DUR uses a clinical database to compare the current prescription to the member's inferred diagnosis, demographic data and past prescription history. The C-DUR program uses criteria to identify potential inappropriate medication consumption, medical conflicts or dangerous interactions that may result if the prescription is dispensed.

If the C-DUR identifies a potential problem, it notifies the dispensing pharmacist by sending either a soft alert (warning message) or a hard alert (a warning message also requiring the pharmacist to enter an override). The dispensing pharmacist uses professional judgment to determine appropriate interventions, such as contacting the prescribing health care provider or other health care professional, discussing concerns with the member and dispensing the medication.

Retrospective Drug Utilization Review (R-DUR)

The R-DUR program involves a daily review of prescription claims data to identify patterns in prescribing or medication utilization suggesting inappropriate or unnecessary medication use. The program uses a clinical

database to review member profiles for potential over- or under-dosing as well as duration of therapy, potential drug interactions, drug-age considerations and therapy duplications.

You and other prescribers receive a member-specific report outlining opportunities for intervention and asking them to respond to specific issues and concerns.

Clinical programs

Prescription medications requiring prior authorization (subject to plan design)

Based on the member's benefit plan design, selecting high-risk or high-cost medications may require advance notification to be eligible for coverage. We may ask you to provide information explaining medical necessity and/or past therapeutic failures. A representative will collect pertinent clinical data for the service requested. If we do not approve the prior authorization, a pharmacist or medical director, in keeping with state regulations, makes the final coverage determination. We notify you and the member of the decision.

Step therapy (subject to plan design)

Certain medications may be subject to step therapy, also referred to as First Start for members with a New Jersey plan. The step therapy program requires a trial of a lower-cost, Step 1 medication before a higher-cost, Step 2 medication is eligible for coverage. When a member presents a Step 2 medication at the pharmacy, our systems may automatically check the claims history to see if a Step 1 medication is in the claims history. The medication may automatically process. If not, you may request a coverage review. If we do not approve the medication, a pharmacist or medical director, in keeping with state regulations, makes the final coverage determination. We notify you and the member of the decision.

Supply limits (subject to plan design)

Some medications are subject to supply limits. We base supply limits on FDA-approved dosing guidelines as defined in the product package insert and the medical literature or guidelines and data supporting the use of higher or lower dosages than the FDA-recommended dosage. This program focuses on select medications or categories of medications that are high cost and/or are frequently used outside of generally accepted clinical standards.

When a pharmacist submits an online prescription claim, the online claims processing system compares the quantity entered with the allowable limits.

If the prescription exceeds the established quantity limits, we reject the claim and the pharmacist receives a message. The current supply limit for the medication is displayed in the message. For New York and New Jersey fully insured business, a subset of medications has coverage criteria available to obtain quantities beyond the established limit, if medically necessary.

Emergencies and urgent care

Urgent care

Urgent care is medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not a medical emergency. It does not otherwise fall under the definition of emergency care.

Definition of a medical emergency

Connecticut: An emergency condition is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in placing the health of such person or others in serious jeopardy or serious impairment to bodily functions; or serious dysfunction of a bodily organ or part; or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

New Jersey: An emergency condition is defined as a medical condition, manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance use disorder, and the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer of the woman or unborn child to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child.

New York: Emergency condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Emergency room visits

We cover ER services for medical emergencies. The member is responsible for paying their copayment. Follow-up care in the ER within our service areas are not covered. Follow-up care, if appropriate, is coordinated through the member's PCP and is subject to the standard referral process. If the member requests to be seen, you must inform the member that services are not covered. You must obtain the member's written consent in advance of services, otherwise you cannot bill the member.

- ER visits during which a member is treated and released without admission do not require notice to us
- If an ambulatory surgery occurs because of an ER or urgent care visit, you must notify us within 24–48 hours of when the surgery is performed. Coordinate all follow-up needs related to such emergency services through the member's PCP. They are subject to the standard referral process.
- When a member is unstable and not capable of providing coverage information, the facility should submit the concurrent authorization as soon as they know the information and communicate the extenuating circumstances

In-area emergency services

You do not need to provide notification or obtain authorization for in-area ER treatment and subsequent release. However, all emergency inpatient admissions and emergency outpatient admissions (e.g., for emergent ambulatory surgery) require notification upon admission or on the day of admission (no later than 48 hours from the date of admission, or as soon as reasonably possible).

Out-of-area emergency services

Out-of-area coverage for ER services are limited to care for accidental injury, unanticipated emergency illness or other emergency conditions when circumstances prevent a member from using ER services within our service area.

Emergency admission review

If the member is admitted to a hospital due to an emergency (as previously defined), we review the hospital admission for medical necessity and determine appropriate length of stay based on our approved criteria for concurrent review. Review begins when we become aware of the admission. You must notify us of all emergency inpatient admissions no later than 48 hours from the date of admission, or as soon as reasonably possible.
If the member is admitted to a contracted hospital, we use reasonable efforts to transmit a decision about the admission to the hospital (to the fax number and contact person designated by the hospital) within 24 hours of making the decision.

Nonemergency hospitalization

Any hospitalization service that does not meet the criteria for an emergency or for urgent care requires prior authorization and is subject to medical necessity review.

Coverage outside of the United States

We provide limited coverage for Oxford members outside of the United States, Mexico, Canada or the U.S. Territories.

New York (NY) and Connecticut (CT) products

The following applies to out-of-country health care providers:

- Claims received for services performed outside of the United States do not require an authorization if the services are emergent in nature
- We will not cover elective procedures outside of the United States, Mexico, Canada or the U.S. Territories for members who reside in the United States unless an authorization exists specifically indicating that out-of-country services were authorized. This includes prenatal care and delivery.
- All claims from out-of-country health care providers must be translated and the amount billed and calculated in American dollars using the conversion rate as of the processing date

New Jersey (NJ) products

The following applies to out-of-country health care providers:

- Claims received for services performed outside of the United States do not require an authorization if the services are emergent or urgent in nature
- Claims will not be covered for elective procedures outside of the United States, Mexico, Canada or the U.S. Territories for members who reside in the United States unless an authorization exists specifically indicating that out-of-country services were authorized. This includes prenatal care and delivery.
- All claims from out-of-country health care providers must be translated and the amount billed and calculated in American dollars using the conversion rate as of the processing date

Out-of-country resident members

NJ Small Group/PPO FP and Liberty

Services provided outside of the United States are excluded unless the covered member is outside of the United States for one of the following reasons:

- Travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, is for a period of 6 months or less
- Business assignment, provided the covered member is temporarily outside of the United States for a period of 6 months or less
- Eligibility for full-time student status (subject to preapproval), provided the covered member is either enrolled and attending an accredited school in a foreign country or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States grants academic credit

Note: We deny charges in connection with full-time student status in a foreign country that we have not preapproved as noncovered charges.

Utilization reviews

Our utilization management (UM) represents a combination of different disciplines, including utilization review with benefit and eligibility requirements, effective and appropriate delivery of medically necessary services, quality of care across the continuum, discharge planning and case management.

Our Clinical Services department monitors services provided to members to identify potential areas of over- and underutilization. UM decision-making is based only on appropriateness of care and service and the existence of coverage. We do not specifically reward or offer incentives to practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

Criteria and clinical guidelines

We use the InterQual Care Guidelines and criteria for inpatient and ambulatory care where no specific Oxford policy exists. We also develop specific policies related to covered services. Each policy describes the service and its appropriate utilization.

We employ several means to review the consistency and quality of clinical decision-making as directed through policies and adopted guidelines. The following processes are in addition to those required by regulatory agencies and NCQA:

- Inter-rater reliability tests developed in conjunction with an external consultant
- Monthly medical director consistency meetings and case discussions
- Monthly blind reviews done by all medical directors on a common set of clinical factors

We employ a process for adopting and updating clinical practice guidelines for use by network providers and other health care professionals. Clinical practice guidelines help practitioners and members make decisions about health care in specific clinical situations. We develop guidelines for preventive screening, acute and chronic care, and appropriate drug usage based on:

- Availability of accepted national guidelines
- Ability to monitor compliance
- Projected ability to make a significant impact upon important aspects of care

Clinical practice guidelines are available on **UHCprovider.com/policies** > **Clinical Guidelines**.

Clinical review

We may perform clinical reviews for various reasons, including but not limited to, medical necessity determinations, member eligibility and to validate accuracy of coding for services or procedures requested or rendered by participating or nonparticipating health care providers and other qualified health care professionals. We consider medically necessary services for reimbursement when rendered to eligible members, as reflected in the clinical information, provided the services are not fraudulent or abusive.

We may review clinical information on an entire population of, or a subset of, health care providers, procedures or members, at our discretion. We may review this information prospectively, concurrently and/or retrospectively. We define clinical information as the member's clinical condition, which may include symptoms, treatments, dosage and duration of drugs, and dates for other therapies. Dates of prior imaging studies performed and other information the ordering health care provider believes is useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports, should be provided.

Clinical information reviewed prospectively may be reviewed again concurrently or retrospectively to confirm the accuracy of the information available at the time of previous review. We will retrospectively deny an approval only in circumstances indicated in the approval or in circumstances involving fraud, abuse or material misrepresentation.

The procedure and information required for review will depend on the circumstances of interest, as determined by us.

The process of selecting services for review, requests for clinical information concerning such services, review of clinical information and action based on clinical information complies with all relevant federal and state regulations, laws and provisions in your Oxford contract. We provide information on appeal rights for adverse determinations as required by law and regulation.

Utilization review of services provided to New York members

All adverse utilization review (UR) determinations (whether initial or on appeal) are made by a clinical peer reviewer. Appeals of adverse UR determinations will be reviewed by a different clinical peer reviewer than the clinical peer reviewer who rendered the initial adverse determination.

Initial UR determination time periods

We make UR decisions by the following methods and in the following time frames:

Prior authorization – we make UR decisions and provide notice to you and the member, by phone and in writing, within 3 business days of receipt of necessary information.

Concurrent review – for standard concurrent reviews, we make UR decisions and provide notice to the member or their designee by phone and writing within 1 business day of receipt of necessary information. For urgent concurrent reviews, we make our decision and provide notice within 24 hours of receipt of necessary information.

Retrospective – we will make UR decisions within 30 days of receipt of necessary information. We may reverse a preauthorized treatment, service or procedure on retrospective review when all the following circumstances occur:

1. Relevant medical information presented to us or the UR agent during retrospective review is materially different from the information presented during the preauthorization review
2. The information existed at the time of the preauthorization review but was withheld or not made available
3. We, or our UR agent, were not aware of the existence of the information at the time of the preauthorization review
4. If we had been aware of the information, we would not have authorized the treatment, service or procedure requested
5. If an initial adverse UR determination is rendered without attempting to discuss such matter with the member's health care provider or other health care professional who specifically recommended the health care service, procedure or treatment under review, such health care providers and other health care professionals have the opportunity to request reconsideration of the adverse determination. Except in cases of retrospective reviews, the medical director or other health care professional conducts the review as the clinical peer reviewer and make the determination within 1 business day of receipt of the request.

Failure to make an initial UR determination within the time periods described is deemed to be an adverse determination eligible for appeal.

Components of an initial adverse determination

If the review results in an adverse determination, the initial adverse determination letter includes the following:

1. Reasons for the determination, including clinical rationale
2. Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals
3. Clinical review criteria relied upon to make our decision is provided upon request from the member or the member's designee
4. Any other necessary information that must be provided to, or obtained by us, to render a decision on an appeal of our determination

Appeal requirements for initial adverse utilization review determinations (New York member appeals)

Member appeals must be submitted to us or our delegate within 180 days from the receipt of the initial adverse UR determination. Standard (non-expedited) UR appeals may be filed online or by telephone by the member or their designee. Member appeals may be initiated in writing or by calling our Member Services department at the number on the member's ID card or at **1-800-444-6222**. However, we strongly recommend the appeal be filed in writing. Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis. In the event that only a portion of such necessary information is received, we request the missing information, in writing, within 5 business days of receipt of partial information. If a determination is not made within 15 days of

the filing of the appeal, we provide written acknowledgment to the appealing party within 15 days of the filing of a standard appeal.

Expedited UR appeals

An expedited UR appeal may be filed for denials of:

- Continued or extended health care services, procedures or treatment
- Additional services for member undergoing a course of continued treatment
- Health care services for which the health care provider or other health care professional believes an immediate appeal is warranted

We make a decision on expedited UR appeals within 2 business days of receipt of the information necessary to conduct such appeal. If we require more information to conduct an expedited appeal, we immediately notify the member and their health care provider by phone or fax to identify and request the necessary information. We follow up with a written notification. The appealing party may re-appeal an expedited appeal using the standard appeal process or through the external appeal process.

We allow you to submit an expedited member appeal without a member's written consent. All other appeals require the member's explicit written consent to appeal after our initial UR decision is made. A general assignment will not be accepted.

If we do not make a determination within 60 calendar days of receipt of the necessary information for a standard appeal or within 2 business days of receipt of necessary information for an expedited appeal, we consider the initial adverse UR determination to be reversed.

The law allows the member and us to jointly agree to waive the internal UR appeal process. Typically, we do not agree to this.

In those rare situations where we are willing to waive the internal UR appeal, we inform the appeal requester and/or member verbally and/or in writing. If the member agrees to waive the internal UR appeal process, we provide them with a letter within 24 hours of the Agreement with information on filing an external appeal.

Internal utilization management appeals process

Retrospective review appeals (New York provider appeals)

A retrospective adverse determination is one where the initial medical necessity review is requested or initiated after the services have been rendered. This process does not apply to services where precertification or concurrent review is required. You may request an external appeal on your own behalf, by phone or in writing, when we have made a retrospective final adverse determination on the basis that the service or treatment is not medically necessary or is considered experimental or investigational (or is an approved clinical trial) to treat the member's life-threatening or disabling condition (as defined by the New York State Social Security law).

All requests for such internal retrospective appeals must be made within 60 days of receipt of the initial retrospective medical necessity or experimental/investigational determination. If we require more information to conduct a standard internal appeal, we notify the member and their health care provider, in writing, within 15 days of receipt of the appeal, to identify and request necessary information.

Once we make a decision about the retrospective review appeal, we notify the member and their health care provider in writing within 2 business days from the date we make the decision.

If the decision is adverse, and you continue to dispute our decision, you may be eligible for an external appeal through the New York external appeal process. Hospitals and other facilities may have alternate dispute mechanisms in place for review of these issues instead of external appeal. Check your contract for more information.

Internal retrospective appeals submitted after the 60-day time frame is not handled through this process. If your appeal is still submitted within the contractual deadlines for an appeal, we automatically handle it through the contractual appeal process discussed in the following section.

Medical necessity internal appeals process for health care providers under your contract

If we make a decision that a requested service is not medically necessary, you may dispute our determination. Mail a written request, with supporting clinical documentation showing why we should reverse the denial of services, to:

Oxford Clinical Appeals Department
P.O. Box 816
Salt Lake City, UT 84131

Appeals, clinical and medical necessity preservice
Online: UnitedHealthcare Provider Portal at UHCprovider.com > Sign In > Prior Authorizations
Fax: 1-801-994-1416
Phone: 1-800-666-1353

The Clinical Appeals department makes a reasonable effort to render a decision within 60 calendar days of receiving the appeal and supporting documentation. If the contractual appeal decision is adverse, and you continue to dispute the decision, the dispute may be eligible for arbitration under your contract.

Note: There is a separate appeal process for internal member appeals and retrospective provider appeals under New York law. These processes do not apply to contractual appeals.

Appeals not submitted within the contractual time frames are denied.

Connecticut members

Utilization review appeals

UR occurs whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. The UR appeals process should be used after you receive an initial adverse UR determination and you do not agree with our decision. All appeals are subject to a review by us to evaluate the medical necessity of the services. You may use this process to appeal adverse determinations relating to all UR determinations, regardless of whether the services requested by you or your authorized representative have not yet been rendered (preservice), are currently being rendered (concurrent) or have already been rendered (post-service).

Note: This UR appeals process should not be used for appeals relating to benefit, network or administrative issues.

UR appeals must be initiated within 180 days from receipt of an adverse determination (i.e., receipt of the determination notice). A decision may be rendered within the standard time frames or may be expedited as described in this section.

While a UR appeal may be filed by telephone or in writing, we strongly recommend you file your appeal in writing. The written request will give us a clear understanding of the issues being appealed. In addition to your request for an appeal, you or your authorized representative must send documentation/information already requested by us (if not previously submitted) and additional written comments and documentation/information you would like to submit in support of the appeal. At the time of our review, we will review all available comments, documentation and information.

Unless we already issued a written determination, we use our best efforts to provide written acknowledgment of the receipt of your appeal within 5 business days but not later than 15 calendar days. Our decision to either uphold or reverse the adverse determination is made and communicated to you as follows:

- **Request for service (preservice)** – within 30 calendar days of our receipt of the appeal. However, if additional information is requested, a determination is made within 3 business days of our receipt of the information, or the expiration of the period allowed to provide the information (45 days).
- **Concurrent services for a member in an ongoing course of treatment (concurrent)** – within 30 calendar days of our receipt of the appeal. In this instance, treatment is continued without liability while your appeal is being reviewed. However, if additional information is requested, a determination is made within 1 business day of our receipt of the information, or the expiration of the period allowed to provide the information (45 days).
- **Coverage for services rendered (post-service)** – within 60 calendar days of our receipt of the appeal. However, if

additional information is requested, a determination is made within 15 days of our receipt of the information, or the expiration of the period allowed to provide the information (45 days).

If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process. You may then file a request for an external review (see the following section), regardless of whether we can assert substantial compliance or de minimis error.

This will be our final adverse determination. If you are not satisfied with our decision, you have the option of filing an External Appeal. Refer to the following External Appeals section.

Expedited/urgent UR appeals

You can expedite your UR appeal when:

- You receive an adverse determination involving continued or extended health care services, procedures or treatments or additional services while you are undergoing a course of continued treatment (concurrent) prescribed by a health care provider
- The time frames of the non-expedited UR appeal process would seriously jeopardize your life, health or ability to regain maximum function
- In the opinion of a health care provider with knowledge of the health condition, the time frames of the non-expedited UR appeal process would cause you severe pain that cannot be managed without care or treatment requested
- Your health care provider believes an immediate appeal is necessary because the time frames of the non-expedited UR appeal process would significantly increase the risk to your health
- For a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting

You have 2 available options for expedited reviews. These options are not available for health care services that have already been rendered (post-service).

1. **Internal expedited UR appeal** – this process includes procedures to facilitate a timely resolution of the appeal including, but not limited to, the sharing of information between your health care provider and us by telephone or fax. We provide reasonable access to our clinical peer reviewer within 1 business day of receiving notice of an expedited UR appeal.

   A decision is rendered and communicated for an internal expedited UR appeal within the following time frames:

   - 24 hours from our receipt of the appeal when the service being appealed is for substance use disorder or co-occurring mental disorder, and inpatient services, partial hospitalization, residential treatment or those intensive outpatient services needed to keep the member from requiring an inpatient setting in connection with a mental disorder
   - 72 hours from our receipt of the appeal for all other types of services
   - If you are not satisfied with the outcome of the expedited UR appeal, you may further appeal through the external appeal process. If we do not make a determination within 72 hours of receipt of the necessary information, the adverse determination is reversed.
   - The notice of an appeal determination includes reasons for the determination. If the adverse determination is upheld on appeal, the notice will include the specific reason(s) and clinical rationale used to render the determination, a reference to the specific health benefit plan provisions on which the decision is based, a statement you may receive from us (upon request and free of charge) and reasonable access to and copies of all relevant documents. We also include a notice of your right to initiate an external appeal. A description of each process and associated time frames is included.

   If we do not follow the process outlined in this section, you will have been deemed to have exhausted the internal appeals process. You may then file a request for an external review (see the following option), regardless of whether we can assert substantial compliance or de minimis error.

2. **External expedited appeal** – you have the option to seek review by an independent review organization in emergency or life-threatening circumstances. You may make a request to the Commissioner of Insurance for an expedited external appeal without first completing the internal appeals if:
   - The time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life-threatening situation; or
   - For a substance use disorder, a co-occurring mental disorder or a mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting; and
   - The member or you, acting on their behalf with their consent, filed a request for expedited internal review. If you choose this option, you must submit the appeal by contacting:

     Connecticut Insurance Department
     P.O. Box 816
     Hartford, CT 06142-0816

     Phone: 1-860-297-3910

For more information on how to file an expedited external appeal, refer to the External UR Appeals section.

Final Adverse Determination (FAD) notice

The contents of an FAD vary based on the state in which the member's certificate of coverage was issued. Each notice of FAD is in writing, dated and includes the following:

Connecticut:

1. Information sufficient to identify the benefit request or claim involved, including the date of service, the health care professional and the claim amount, if known
2. The specific reason(s) for the adverse determination, including, upon request, a listing of relevant clinical review criteria including professional criteria and medical or scientific evidence used to reach the denial and a description of the Oxford standard, internal rule, guideline, protocol or other criterion, if applicable, used in reaching the denial
3. Reference to the specific health benefit plan provisions we used to reach the denial
4. A description of other material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim
5. A description of the Oxford internal appeals process, which includes:
6. Oxford expedited review procedures
7. Limits applicable to such process or procedures
8. Contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and a statement the member or their authorized representative is entitled, following requirements of the Oxford internal grievance process, to receive from us, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the request.

If the adverse determination is based on:

1. An internal rule, guideline, protocol or other similar criteria:
   - The specific rule, guideline, protocol or other similar criteria; or
   - A statement that:
     - A specific rule, guideline, protocol or other similar criteria was relied upon to make the adverse determination and a copy of such rule, guideline, protocol or other similar criteria will be provided to the covered person free of charge upon request;
     - Provides instructions for requesting a copy; and
     - Provides links to such rule, guideline, protocol or other similar criteria on the Oxford website
2. Medical necessity or an experimental/investigational treatment:

- A written statement of the scientific or clinical rationale used to render the decision that applies the terms of the benefit plan to the member's medical circumstance
- Notification of the member's right to receive, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence not previously provided regarding the adverse determination under review

3. A statement explaining the right of the member to contact the Office of the Healthcare Advocate at any time for assistance, or upon completion of the Oxford internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include:
   - The contact information for said offices
   - A statement if the member or their authorized representative chose to file a grievance that:
     - Appeals are sometimes successful
     - The member may benefit from free assistance from the Office of the Healthcare Advocate, which may assist them with filing a grievance pursuant to 42 USC 300gg–93, as amended from time to time
     - The member is entitled and encouraged to submit supporting documentation for our consideration during the review of an adverse determination, including narratives from the member or from their authorized representative and letters and treatment notes from the member's health care professional
     - The member has the right to ask their health care professional for such letters or treatment notes
4. A health carrier may offer a member's health care professional the opportunity to confer with a clinical peer as long as a grievance has not already been filed prior to the conference. This conference between the physician and the health care professional peer will not be considered a grievance of the initial adverse determination.

New Jersey:

1. Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. Any request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to as soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal.
2. The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by us in the denial
3. Any new or additional rationale, which was relied upon, considered or used, or generated by us, in connection with the adverse benefit determination
4. Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24-8.7(b)

New York:

1. The specific reason for denial, reduction or termination of services
2. The specific health service that was denied, including the name of the facility/health care provider and developer/manufacturer of service, as available
3. A statement that the member may be eligible for an appeal, and a description of appeal procedures including a description of the urgent appeal process if the claim involves urgent care
4. A clear statement, in bold, that the member has 45 days from the FAD to request an external appeal, and that choosing the second level internal appeal may exhaust the time limits required for filing an external appeal
5. A description of the external appeals process

If we fail to adhere to these requirements for rendering decisions, the following rules apply to members enrolled in Connecticut and New Jersey Oxford products.

Connecticut: The member is deemed to have exhausted the Oxford internal appeals process and may file an external review, even if we could prove substantial compliance or minor (de minimis) error.

New Jersey: Members are not obligated to complete the internal review process and may proceed directly to the external review process under the following circumstances:

- We fail to comply with any deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance
- We, for any reason, expressly waive our rights to an internal review of any appeal
- The member and/or their health care provider applied for expedited external review at the same time as applying for an expedited internal review

In such a case where we assert good cause for not meeting the deadlines of the Oxford appeals process, members or their designee and/or their health care provider may request a written explanation of the violation. We must provide the explanation within 10 days of the request and must include a specific description of the basis for which we determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with us and rejects the request for immediate review, the member has the opportunity to resubmit their appeal.

Members' rights to external appeal

The member has a right to an external appeal of a FAD.

A FAD is a first-level appeal denial of an otherwise covered service where the basis for the decision is either a lack of medical necessity, appropriateness, health care setting, level of care or effectiveness or the experimental/investigational exclusion.

The health care provider's certification must include a statement of the evidence relied upon by the health care provider in certifying their recommendation, and an external appeal must be submitted within 45 days upon receipt of the FAD, whether a second-level appeal is requested or not. If a member chooses to request a second-level internal appeal, the time may expire for the member to request an external appeal.

An external appeal may also be filed:

1. When the member had coverage of a health care service denied on the basis that such service is experimental or investigational
2. The denial has been upheld on appeal, or both we and the member have jointly agreed to waive any internal appeal
3. The member's attending health care provider certified that the member has a life-threatening or disabling condition or disease:
   - For which standard health services or procedures have been ineffective or would be medically inappropriate
   - For which there does not exist a more beneficial standard health service or procedure covered by their health care plan
   - For which there exists a clinical trial
4. The member's attending health care provider, who must be a licensed, board-certified or board-eligible health care provider qualified to practice in the area of practice appropriate to treat the member's life-threatening, or disabling condition or disease, must have recommended either:
   - A health service or procedure (including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B)), that based on 2 documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure.
   - A clinical trial for which the member is eligible. Any health care provider certification provided under this section shall include a statement of the evidence relied upon by the health care provider in certifying their recommendation.
5. The specific health service or procedure recommended by the attending health care provider that would otherwise be covered under the policy except for our determination that the health service or procedure is experimental

or investigational. The member is not required to exhaust the second level of internal appeal to be eligible for an external appeal.

External appeal process

If the Clinical Appeals department upholds all or part of such an adverse determination, the member or their designee has the right to request an external appeal. An external appeal may be filed when:

1. The member had coverage of a health care service denied on appeal, in whole or in part, on grounds that such health care service is not medically necessary but otherwise would have been a covered benefit
2. We made a final adverse determination regarding the requested service
3. We and the member both agreed to waive any internal appeal

All external appeal requests may be sent to the following:

New York State Insurance Department
P.O. Box 7209
Albany, NY 12224-0209
Phone: 1-800-400-8882
Fax: 1-800-332-2729

Claims process

Time frame for claims submission

To be considered timely, health care providers, other health care professionals and facilities are required to submit claims within the specified period from the date of service:

- **Connecticut** – 90 days
- **New Jersey** – 90 or 180 days if submitted by a New Jersey participating health care provider for a New Jersey line of business member
- **New York** – 120 days

The claims filing deadline is based on the date of service on the claim. It is not based on the date the claim was sent or received. Claims submitted after the applicable filing deadline will not be reimbursed; the stated reason will be filing deadline has passed or services submitted past the filing date unless one of the following exceptions applies.

Exceptions:

- If you have an Oxford agreement containing specific filing deadlines, the agreement will govern
- If COB caused a delay, you have 90 days from the date of the primary carrier explanation of benefits to submit the claim to us
- If the member has a health benefit plan with a specific time frame regarding the submission of claims, the time frame in the member's certificate of coverage will govern. If a claim is submitted past the filing deadline due to an unusual occurrence (e.g., health care provider illness, health care provider's computer breakdown, fire, flood) and the health care provider has a historic pattern of timely submissions of claims, the health care provider may request reconsideration of the claim.

Clean and unclean claims, required information for all claim submissions

For complete details and required fields for claims processing, refer back to **Chapter 10: Our claims process**.

Time frame for processing claims

The state-mandated time frames for processing claims for our fully insured members are as follows. The time frames are applied based upon the site state of the member's product:

- **Connecticut** – 45 days (paper and electronic)

- **New Jersey** – 40 days (paper), 30 days (electronic)
- **New York** – 45 days (paper), 30 days (electronic)

We strive to process all complete claims within 30 days of receipt. If you have not received an EOB/remittance advice within 45 days, and have not received a notice from us about your claim, verify that we received your claim.

Hospitals and ancillary facilities

A member must be enrolled and effective with us on the date the hospital and ancillary service(s) are rendered. Once the facility verifies a member's eligibility with us (we maintain a system for verifying member status), that determination will be final and binding on us, unless the member or group made a material misrepresentation to us or otherwise committed fraud in connection with the eligibility or enrollment.

If an employer or group retroactively disenrolls the member up to 90 days following the date of service, we may deny or reverse the claim. If there is a retroactive disenrollment for these reasons, the facility may bill and collect payment for those services from the member or another payer. A member must be referred by a participating health care provider to a participating facility within their benefit plan's network. Network services require an electronic referral or prior authorization consistent with the member's benefits.

Requirements for claim submission with COB

Under COB, the primary benefit plan pays its normal plan benefits without regard to the existence of any other coverage. The secondary benefit plan pays the difference between the allowable expense and the amount paid by the primary plan, if the difference does not exceed the normal plan benefits that would have been payable had no other coverage existed.

If Oxford coverage is secondary to that of a commercial payer, bill the primary insurance company first. When you receive the primary carrier's EOB/remittance advice, submit it to us along with the claim information.

We participate in Medicare Crossover for all our members who have Medicare as their primary benefit plan. This means Medicare will automatically pass the remittance advice to us electronically after the claim has been processed. We may process these claims as secondary without a claim form or remittance advice from your office.

Note: If Medicare is the secondary payer, you must continue to submit the claim to Medicare. We cannot crossover in reverse.

Determining the primary payer among commercial plans

When a member has more than 1 commercial health insurance policy, primary coverage is determined based upon model regulations established by the National Association of Insurance Commissioners.

1. **COB provision rule** – the benefit plan without a COB provision is primary.
2. **Dependent/non-dependent rule** – the benefit plan covering the individual as an employee, member or subscriber or retiree is primary over the benefit plan covering the individual as a dependent.
3. **Birthday rule** – the birthday rule applies to dependent children covered by parents who are not separated or divorced. The coverage of the parent whose birthday falls first in the calendar year is the primary carrier for the dependent(s).
4. **Custody/divorce decree rule** – if the parents are divorced or separated, the terms of a court decree determines which benefit plan is primary.
5. **Active or inactive coverage rule** – the benefit plan covering an individual as an employee (not laid off or retired), or as that employee's dependent, is primary over the benefit plan covering that same individual as a laid off or retired employee or as that employee's dependent.
6. **Longer/shorter length of coverage rule** – if the preceding rules do not determine the order of benefits, the benefit plan that has covered the person for the longer period of time is primary.

Coordinating with Medicare benefit plans

We coordinate benefits for members who are Medicare beneficiaries according to federal Medicare program guidelines.

We have primary responsibility if any of the following apply to the member:

- 65 years or older, actively working and their coverage is sponsored by an employer with 20 or more employees
- Disabled, actively working and their coverage is sponsored by an employer with 100 or more employees
- Eligible for Medicare due to end-stage renal disease (ESRD) and services are within 30 months of the first date of dialysis

Reimbursement claim components

Additional copies of EOBs/remittance advice: Should you misplace a remittance advice, you may obtain a copy by visiting **UHCprovider.com** > Sign In > Documents & Reporting > Document Library.

Ancillary facility reimbursement: We reimburse ancillary health care providers for services provided to members at rates established in the fee schedule or in attachment or schedule of the ancillary contract.

Fee schedules: Although our entire fee schedule is proprietary and may not be distributed, upon request, we provide our current fees for the top codes you bill. Provider Services may provide this information to answer questions regarding claims payment.

Global surgical package (GSP): A global period for surgical procedures GSP may be found in the Global Days policy at **UHCprovider.com/policies** > For Commercial Plans > **Reimbursement Policies for UnitedHealthcare Commercial Plans**.

Hospital reimbursement: We reimburse hospitals for services provided to members at rates established in the attachment of the hospital contract.

Modifiers: Modified procedures are subject to review for appropriateness consistent with the guidelines outlined in our policies. For complete details regarding the reimbursement of recognized modifiers, refer to the Modifier Reference policy at **UHCprovider.com/policies** > For Commercial Plans > **Reimbursement Policies for UnitedHealthcare Commercial Plans**.

PCP/specialist reimbursement: All PCPs and specialists agree to accept our fee schedule and payment and processing policies associated with administration of these fee schedules.

Release of information: Under the terms of HIPAA, we have the right to release to, or obtain information from, another organization to perform certain transaction sets.

Request for additional information: There are times when we request additional information to process a claim. Submit the requested information promptly as outlined in the request. If you don't submit it within 45 days, you must submit an appeal with the information.

Reimbursement address, phone or TIN changes: An accurate billing address is necessary for all claims logging, payment and mailings. Notify us of any changes. For instructions and forms on how to do so, go to **UHCprovider.com** > Our network > **Demographics and profiles**.

New York Health Care Reform Act of 1996 (HCRA)

The enactment of the HCRA, in part, created an indigent care (bad debt and charity care) pool to support uncompensated care for individuals with no insurance or who lack the ability to pay. Therefore, the New York Bad Debt and Charity (NYBDC) surcharge is applied on a claim-by-claim basis. The NYBDC surcharge applies to most services of general facilities and most services of diagnostic and treatment centers in New York. Your obligation is to:

- Understand your eligibility as it relates to HCRA
- Know which services have a surcharge and bill those services accordingly

For additional information on HCRA, reference the New York Department of Health's website: health.ny.gov > Laws & Regulations (on the bottom of the page under General Information) > Health Care Reform Act.

Member billing

Balance billing policy

Health care providers in our Oxford network are contracted with us to provide specific services to Oxford members. Health care providers participating with the Oxford network must follow the Oxford referral, precertification and privileging policies and procedures. You may not bill members for unpaid charges related to covered services except for applicable copays, coinsurance or permitted deductibles. This includes balance billing a member for a covered service denied by us because there was no referral or authorization on file with us when one was required.

Exceptions: The instances in which you are authorized to balance bill a member, after first getting the member's written consent, are as follows. You are still required to follow the Oxford privileging, referral and/or precertification requirements. In these instances, you may balance bill the member billed charges. To the extent that the terms and conditions of your contract conflict with these guidelines, the terms and conditions of your contract prevail. You may balance bill a member when any of the following apply:

- A service or item is not a covered benefit (i.e., the service is excluded in the Exclusions and Limitations section of the member's certificate of coverage)
- A benefit limit is exceeded/exhausted
- We denied a request for precertification, before the service was rendered, and the member proceeded to receive the service anyway
- We denied a concurrent certification request (i.e., the member is currently receiving the service)
- If you do not participate in a member's Oxford network, and a member self-refers to you (i.e., Oxford Liberty Network member self-refers to you, and you do not participate in the 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 health care provider, the member has the right to file a complaint or grievance, verbally or in writing, regarding the balance billing. Participating health care providers who repeatedly violate these restrictions will be subject to discipline up to and including termination of their provider Agreement. If you inappropriately balance bill a member, we will hold the member harmless and pursue the matter directly with you.

Member out-of-pocket costs

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

Claims recovery, appeals, disputes and grievances

See **Claim reconsideration and appeals process** found in **Chapter 10: Our claims process** for general appeal requirements.

Claims submission and contact

To submit a claim, or verify the status of a claim, use any method outlined in the **How to contact Oxford commercial** section in this chapter.

Claims recovery

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

We periodically ask our participating health 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 coverage was not the primary coverage)
- Behavioral issues: Upcoding, misrepresentation of service provided, services not rendered at all, frequent waiver of member financial responsibility

We may pursue such claim overpayments as permitted by law and following the applicable statute of limitations (usually 6 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 health care provider is given notice, we initiate discussions and take action during the following 1-year period.

We do not pursue collection of overpayments from individual participating health care providers when overpayments are identified as isolated mistakes or where the health care provider is not at fault if the overpayments were more than 1 year before the date of notice of the overpayment or use extrapolation. Examples include overpayments related to duplicate claims, fee schedule issues, isolated situations of incorrect billing/unbundling and claims paid when Oxford coverage was not the primary coverage.

Exception: We will pursue collection of overpayments beyond 1 year and use statistical methods and extrapolation in situations where:

1. We have 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 health care provider rendering the services or licensure of such health care provider, and similar issues
2. A health care provider affirmatively requests additional payment on claims or issues older than 1 year
3. CMS makes a retroactive change to enrollment or to primary versus secondary coverage of a Medicare benefit plan member

Participating health care provider claims reconsiderations and appeals

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

Claim reconsideration

See **Claim reconsideration and appeals process** found in **Chapter 10: Our claims process** for general reconsideration requirements and submission steps. Continue for Oxford-specific requirements.

1. **Pre-appeal claim review**
   Before requesting an appeal determination, contact us, verbally or in writing, and request a review of the claim's payment. We make every effort to clarify or explain our actions. If we determine that additional payment is justified, we reprocess the claim and remit the additional payment.
2. **Who may submit a reconsideration or appeal**
   - Participating health care providers appealing a decision on their own behalf, according to the terms of their Agreement with us

- Any health 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.

3. **Time frame for submitting a reconsideration or appeal**

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

  The 2-step process described here allows for a total of 12 months for timely filing — not 12 months for step 1 and 12 months for step 2. If an appeal is submitted after the time frame has expired, we uphold the denial.

  Exceptions: There are separate processes for New Jersey Participating Providers and Unilateral Coding Adjustments for New York Hospitals. Refer to the **New Jersey participating provider appeal process** and **Unilateral coding adjustments for New York hospitals** sections for additional information.

  - **Step 1 – Reconsideration level:** Submit the reconsideration using the UnitedHealthcare Provider Portal: **UHCprovider.com** > Sign In > Claims & Payments. If after reconsideration we do not overturn our decision, the EOB or response letter includes next-level rights and how to submit a request for further review.
  - **Step 2 – Appeal level:** Participating health care provider and practitioner appeals must be submitted in writing within the same 12-month time frame. The appeal must include all relevant documentation, including a letter requesting a formal appeal and a **Single Claim Reconsideration Form**. If the appeal does not result in an overturned decision, the health care provider must review their contract for further dispute resolution steps.

- **New Jersey participating provider appeal process**
  New Jersey (NJ) participating health care providers are subject to the NJ state-regulated appeal process. If a NJ participating health care provider has a dispute relating to payment of a claim involving a NJ commercial member, the dispute is eligible for an individual 2-step process.

  - **First level:** The first-level appeal is made through the Oxford internal appeals 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 our initial determination notice to:

    UnitedHealthcare
    Attn: Oxford Provider Appeals
    P.O. Box 31387
    Salt Lake City, UT 84131

    We conduct the review and communicate the results to the health care provider in a written decision within 30 calendar days of receipt of all material necessary for such appeal.

  - **Second level:** The second-level appeal must be made through the external dispute resolution process. If a NJ participating health care provider completed the internal appeal process and is not satisfied with the results of that internal appeal, the health care provider had the right under their Oxford contract to arbitrate the dispute with us. Health 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 1-585-425-5296. (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 health care provider and us, unless the arbitrator determines otherwise. The

decision in such arbitration depends on the participating health care provider and us, pursuant to the terms of the Agreement. To commence arbitration, the health care provider must file a statement of claim with the AAA.

- **Unilateral coding adjustments for New York hospitals**
  New York hospital receives an Oxford remittance advice/payment indicating that we have 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. We must review the medical records within the normal review time frames (45 days). If our 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, we must provide the additional reimbursement within the 45-day review time frame

  If we fail to provide the additional reimbursement within the 45-day review time frame, we 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 nor the subsequent processing of the claim by us may be considered an adverse determination if it is based solely on coding determination.

4. There are separate processes for the following appeal types:

- Internal and external claims payment appeals for NJ participating health care providers who treat NJ commercial members
- The appeal of unilateral coding adjustments made to New York hospital claims

5. Appeal decision and resolution

Full documentation of the substance of the appeal and the actions taken will be maintained in an appeal file (paper or electronic). Written notification to the health care provider is issued by means of a letter or updated Remittance Advice (RA) statement at the time of determination of the appeal. This decision constitutes our final internal decision. If the health care provider is not satisfied with our decision, they may arbitrate the issue as set forth in their Oxford contract.

6. Arbitration

If the health care provider wants to file for arbitration after the first-level appeal has been completed, the health care provider must follow the terms of their participation agreement and file a statement of claim with the American Arbitration Association (AAA) at the following address:

American Arbitration Association
Northeast Case Management Center
950 Warren Avenue 4th Floor
East Providence, RI 02914
Phone: 1-800-293-4053

Health care providers located outside of New York, New Jersey and Connecticut should refer to the AAA website at adr.org for submission guidelines.

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

New York state-regulated process for external review

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

This appeals process does not apply to the self-funded line of business. Health care providers may use this process to appeal concurrent and retrospective utilization review decisions. Other external appeals require written consent from the member.

In connection with retrospective decisions, if the health care provider's Agreement includes arbitration language or alternate dispute language, the health care provider must follow that process. The external review process is no longer an option for dispute resolution.

Medical necessity appeals

Standard medical necessity appeals process

If members or their designees would like to file an appeal, they must mail a written request within 180 days of receiving the initial denial determination notice to:

Oxford Clinical Appeals Department
P.O. Box 31388
Salt Lake City, UT 84131

Expedited medical necessity appeals process for members

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

Benefit appeals

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

Administrative appeals (grievances)

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

Second-level member appeals

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

External appeal process for members

New York, New Jersey and Connecticut members have the right to appeal* a medical necessity determination to an external review agent. They may file a consumer complaint with one of the following applicable regulatory bodies.

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

The applicable regulatory body is determined by the state in which the member's certificate of coverage was issued, not where the member resides.

Connecticut	State of Connecticut Insurance Department 153 Market Street P.O. Box 816 Hartford, CT 06142-0816 1-860-297-3800
New Jersey	Division of Insurance Enforcement and Consumer Protection 20 West State Street P.O. Box 329 Trenton, NJ 08625-0329
	Consumer Protection Services Dept. of Banking and Insurance P.O. Box 329 Trenton, NJ 08625-0329 1-800-446-7467 (in NJ) 1-609-292-7272 Fax: 1-609-545-8468
New York	Consumer Services Bureau State of New York Insurance Department 25 Beaver Street New York, NY 10004-2349 1-212-480-6400
	Office of Managed Care Certification and Surveillance New York Department of Health Corning Tower, Room 1911 Empire State Plaza Albany, NY 12237 1-518-474-2121

New York notice of health care provider contract termination and appeal rights

We immediately remove all health care providers from the Oxford network who are unable to provide health care services due to a final disciplinary action.

We may not prohibit, terminate or refuse to renew a contract with a health care provider solely for the following:

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

We grant health 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 health care provider's contract with us, may be heard before disciplinary action is implemented. A health 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 health care provider or health care professional's ability to provide health care services to our members for reasons relating to the professional competence or conduct that adversely affects or could adversely affect the member's health or welfare.

A notice is provided within 30 calendar days after the adverse action is taken. It includes the following:

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

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

The hearing panel will be composed of at least 3 persons appointed by UnitedHealthcare. At least 1 person on the panel will have the same discipline or same specialty as the health care provider under review. The panel may consist of more than 3 members, provided the number of clinical peers constitutes one-third or more of the total panel membership.

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

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

Quality assurance

Medical records requirements

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

Standards for medical records

A comprehensive, detailed medical record is vital to promoting high-quality medical care and improving patient safety. Our 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 6 years after date of service rendered and for a minor, 3 years after majority or 6 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 7 days to help ensure continuity of care. To safeguard the privacy of the member's records, mark them as Confidential. Be sure no part of the record is visible during transmission.

Electronic medical records

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

Oxford credentialing and recredentialing notifications

We follow New York and New Jersey requirements regarding notification of when we receive a credentialing application and when credentialing has been completed. For more information, refer to our Credentialing Plan and the State and Federal Addendum at **UHCprovider.com/join**.

Health care provider performance evaluations

We are required to provide health care professionals with any information and profiling data used to evaluate your performance. Periodically, and at your request, we provide the information, profiling data and analysis used to evaluate your performance. You are given the opportunity to discuss the unique nature of your patient population, which may have bearing on your profile, and we work with you to improve your performance as needed.

HEDIS set measures

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

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

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

Case management and disease management programs

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

For more information, connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. You can also visit **myuhc.com**.

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.

Clinical process definitions

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

Acute Hospital Day (AHD)

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

Alternative Level of Care (ALC)*

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

- An acute clinical situation has stabilized
- The intensity of services required may be provided at less than an acute level of care
- An identified skilled nursing and/or skilled rehabilitative service is medically indicated
- ALC is prescribed by the member's health 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
  - Such services must be provided directly by or under the general supervision of those skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and achieve the medically desired result

New technology

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

Potentially avoidable days (PADs)

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

There are several types of PADs:

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

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

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

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

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

In any of these situations, the hospital may not bill the member for any portion of the covered services not paid for by us.

Diagnosis-Related Group (DRG) hospitals

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

When admission information is received through our website, we consider this to be notification only. First-day approval is granted to hospitals with a DRG contract. When we receive notification of an admission to a hospital with a DRG contract, our case manager reviews the admission for appropriateness. If the case manager cannot make a determination based on the admitting diagnosis, the case manager requests an initial review to determine whether the admission is medically necessary. The hospital is required to provide admission notification.

Prepayment DRG validation program

We may request a DRG hospital to send the inpatient medical record before claim payment so we may validate the submitted codes. After review of all available medical information, the claim is paid based on substantiated codes following review of the medical record. See the **Claims recovery, appeals, disputes and grievances** section of this supplement for Appeal Rights.

We may request hospital records 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, we only pay the claim 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. It helps eliminate certain areas of contention among participating parties and allows processing of claims. Specific instances where a disposition determination may apply:

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

Late and no notification

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

Mental health and substance use disorder services

The behavioral health department specializes in the administration of mental health and substance use disorder 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 PCPs as the best way to achieve effective and appropriate treatment. For this purpose, we developed a Release of Information Form to help facilitate member consent and share information with the PCP in the presence of their behavioral health clinician. See the **How to contact Oxford commercial** section for telephone numbers.

Clinical definitions and guidelines

The behavioral health department uses the Optum Clinical Criteria when determining the medical necessity of inpatient psychiatric, partial hospitalization substance use disorder treatment and rehabilitation, and outpatient mental health treatment. For a complete list of programs and detailed information on clinical criteria, 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 4 or more hours per day

Residential treatment

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

Outpatient mental health

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

Inpatient detoxification

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

Outpatient substance use disorder rehabilitation

Outpatient substance use disorder rehabilitation is the treatment of a substance use disorder including dependence at an accredited, licensed substance use disorder treatment facility.

Member rights and responsibilities

For the entire list of member rights and responsibilities, go to **uhc.com** > Legal > **Annual Member Notices** > Select Your Code.

Medical/clinical and administrative policy updates

We amend the contents of this supplement annually to reflect changes in policies or as required by regulation. A complete library of the Oxford Clinical and Administrative Policies is available for your reference at **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® Oxford Clinical and Administrative Policies**.

You may also request a paper copy of a clinical or administrative policy by writing to:

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

Policy update bulletin

We publish monthly editions of the Oxford Policy Update Bulletin. This online resource provides notice to our network providers of changes to our Clinical and Administrative Policies. The bulletin is posted on the first calendar day of every month on **UHCprovider.com/policies** > For Commercial Plans > UnitedHealthcare Oxford Clinical and Administrative Policies > **Policy Update Bulletins**. A supplemental link to the policy updates announced in the Oxford Policy Update Bulletin is posted monthly at **UHCprovider.com/news**.

Oxford Level Funded plans (CT, NJ and NY) supplement

Applicability of this supplement

This supplement applies to all covered services you provide to your patients who have a Connecticut, New Jersey or New York Oxford Level Funded plan.

Oxford Level Funded product contacts

Resource	Where to go	Requirements/notes
Cardiology Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/cardiology** **Phone: 1-877-773-2884** (Monday–Friday, 7 a.m.–7 p.m. ET)	Request prior authorization for services as described in the **Outpatient cardiology prior authorization protocol** section of **Chapter 7: Medical management**.
Claims submission	**Payer ID:** 06111	
Genetic and molecular testing	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need.	
Outpatient injectable chemotherapy and related cancer therapies	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** and select the specialty you need. **Phone: 1-888-397-8129**	Policies and instructions
Pharmacy services	**Prior Authorization: 1-800-711-4555** **Benefit Information:** Call the number on the back of the member's ID card	For information on the Prescription Drug List, visit **UHCprovider.com**
Prior authorization and notification	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** Go to **UHCprovider.com/priorauth** **Phone (only where telephonic submission is permitted): 1-800-666-1353**	Prior authorization and admission notification is required as described in **Chapter 7: Medical management**. EDI 278A transactions are not available.

Resource	Where to go	Requirements/notes
Radiology/advanced outpatient imaging procedures CT scans, MRIs, MRAs, PET scans and nuclear medicine studies including nuclear cardiology	**Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** UHCprovider.com/radiology **Phone (only where telephonic submission is permitted):** **1-877-773-2884** (Monday–Friday, 7 a.m.–7 p.m. ET)	Request prior authorization for services as described in the **Outpatient radiology prior authorization protocol** section of **Chapter 7: Medical management**.

Our claims process

Follow these steps for fast payment:

1. Notify Oxford Level Funded claims
2. Prepare a complete and accurate claim form
3. For Oxford Level Funded plan participants, submit electronic claims using payer ID number 06111

Claim reimbursement (adjustments)

If you think your claim was processed incorrectly, call the number on the plan participant's health plan ID card. If you find a claim where you were overpaid, send us the overpayment within 30 calendar days. If we find a claim was overpaid, payment is due within 30 calendar days. If you disagree with our decision regarding a claim adjustment, you may appeal.

Claim reconsideration, appeals and disputes

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

There is a 2-step process available for review of your concern. Step 1 is a claim reconsideration. If you disagree with the outcome of the claim reconsideration, you may request a claim appeal (step 2).

How to submit your reconsideration or appeal

Claims payment issues or outcome of a reconsideration review

If you disagree with claim payment issues or the outcome of your reconsideration review, submit your request using our electronic tools:

Online: UHCprovider.com > Sign In > Claims & Payments

API: Submit reconsiderations and appeals (with attachments) using API. Go to **UHCprovider.com/api** for more information.

Overpayment recoveries, pharmacy, medical management disputes or contractual issues

If you disagree with overpayment recoveries, pharmacy, medical management disputes or contractual issues, send a letter requesting a review to:

Grievance Administrator
P.O. Box 31393
Salt Lake City, UT 84131-0371

Fax: 1-801-994-1416

Time frame

You must submit your claim reconsideration and/or appeal to us within 12 months (or as required by law or your Agreement), from the date of the original EOB or denial. The 2-step process allows for a total of 12 months for timely submission, not 12 months for step 1 and 12 months for step 2.

What to submit

As the health care provider of service, you submit the dispute with the following information:

- Plan participant's name and health plan ID number
- Claim number
- Specific item in dispute
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved. If you disagree with the outcome of the claim appeal, you may file for an arbitration proceeding. A description of this process is in your Agreement.

Refer to **Claim reconsideration and appeals process** section in **Chapter 10: Our claims process**, for more information.

Peoples Health supplement

Applicability of this supplement

Peoples Health participating health care providers are subject to both the main guide and this supplement (Provider Reference Guide). This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures, you will be directed to the relevant website.

If you are looking for information applicable to dates of service prior to 2024, visit **peopleshealth.com/providerportal**.

Additional contact information for Peoples Health

Resource	Where to go	Requirements/notes
Behavioral health services	**1-877-566-7913**	Provided by Optum Behavioral Health
Inpatient or outpatient facility authorizations	**1-877-346-5707**	To request authorizations
Outpatient services authorizations	**1-877-346-5708**	To request authorizations
Louisiana Medicaid Recipient Eligibility Verification System	**1-800-776-6323**	Access Medicaid eligibility information

Peoples Health care coordination model

Our care coordination model is a member-centric health care delivery system, designed to provide more personalized, coordinated care for the higher-risk population of our membership. We manage the health of our members through a proactive approach by surrounding them with a comprehensive care team of network physicians and clinical support staff. We work closely with our network providers and offer resources and clinical support through care coordinators to enhance member care and help ensure the best possible health outcomes.
All components of our health care delivery system play a role in ensuring high-quality care focused on the member.

Care coordinators (registered nurses and social workers)

Our medical professionals work to support our providers in managing the health of their Peoples Health patients. Our care coordinators engage members with complex and multiple chronic conditions by utilizing disease-specific assessments and creating care plans that assist in self-management goals. Additionally, care coordinators provide educational and community resources as needed. To ensure members' needs are met, targeted outreach is done to address gaps in care and transition-of-care activities are conducted to perform medication reconciliations, educate on signs and symptoms, and ensure ordered post-discharge services have begun.

Peoples Health Medicare Center

The Peoples Health Medicare Center, at 3017 Veterans Memorial Blvd. in Metairie, LA, offers an easily accessible location for members and the community to meet in-person with Peoples Health representatives. Educational programs about Medicare, preventive health and Peoples Health benefits are available, along with wellness activities. Representatives are available at the center Monday–Friday, from 8 a.m.–5 p.m. CT.

Regional service centers

We have service centers in many of our regions. At the centers, your Peoples Health patients can receive select preventive care and a Peoples Health comprehensive wellness assessment, which includes a physical examination and medical history review performed by a Peoples Health nurse practitioner. The assessment may also include a referral for a consultation with a Peoples Health care coordinator social worker to discuss other health needs and concerns.

For more information about the Peoples Health care coordination model, contact your Peoples Health representative.

Dual-special needs plans (D-SNPs)

Peoples Health D-SNPs provide specialized care for plan members, called dual-eligibles, who have both Medicare and Medicaid. These members, who qualify for Medicaid based on income or disability, have more complex medical and social needs, often referred to as special needs. Dual-eligibles also tend to have fragmented care experiences, leading to higher use of health services. We have created a D-SNP model of care that addresses their special needs via access to and utilization of affordable care, health education, assistance with management of complex health care needs, and care coordination.

Additionally, our D-SNP model of care addresses the specially tailored services we provide to our most vulnerable subpopulation. The most vulnerable D-SNP members are those who are frail, disabled, have multiple comorbidities, have chronic illnesses or are near the end of life. The plan targets these subsets because they are most at risk among the dual-eligible population.

Our D-SNPs are structured according to the regulations of the CMS Managed Care Manual. Your participation in our D-SNP care planning and care coordination processes will help us meet regulatory and quality performance requirements, as well as ensure the best health outcomes for your Peoples Health D-SNP patients.

To facilitate the relationship between patients new to a Peoples Health D-SNP and their Peoples Health PCP and to ensure the patients have their medical and psychosocial needs addressed early on, we encourage an initial PCP visit within the first 90 days of enrollment into the plan.

Enhanced access to medical and psychosocial services

We conduct health risk assessments (HRAs) to evaluate the patient's needs and develop and update the patient's individualized care plan (ICP). The HRA collects information about the patient's medical, functional, cognitive, psychosocial and mental health needs. The Peoples Health D-SNP Interdisciplinary Care Team, which providers are a part of, evaluates the patient's responses to the HRA, along with available medical records, to create the ICP. We may occasionally request information from your medical records or copies of your Peoples Health patient records to assist us in developing the ICP. The ICP consists of health goals and interventions (actions the patient may take to manage their care) for each condition identified in the HRA.

ICPs are reviewed with patients and are available on the UnitedHealthcare Provider Portal to review. These care plans are completed within the first 3 months of enrollment and updated at least annually, as well as whenever the patient experiences a change in health status. ICPs enable Peoples Health to better assist you and your Peoples Health patients in managing their health.

Using health risk assessment information

Information gathered through the HRA and other Peoples Health assessments and records helps identify conditions that may affect D-SNP patients, including ability to access care and the presence of complex health care needs. The HRA also helps determine whether the patient needs information about life-planning resources, advance directives or hospice services. In addition, the HRA is vital to providing needed information on population demographics, such as socioeconomic status or cultural beliefs, that can be used in care planning.

Lower out-of-pocket costs

In addition to an ICP, most D-SNP patients also benefit from lower out-of-pocket costs for most covered health care services and prescription drugs. They are eligible for benefits and waiver services through Louisiana Medicaid and have lower out-of-pocket costs for many plan benefits compared with other Peoples Health plan members, depending on their level of Medicaid coverage.

Post-discharge reconciliation of medications

All patients, including D-SNP patients, discharged from an inpatient facility must have a reconciliation of medications performed by their PCP within 30 days of discharge. Peoples Health will communicate with PCPs regarding patient admission. The care provider has 30 days following discharge to reconcile the patient's discharge medications and current prescriptions. The provider must date and initial all medication reconciliation documentation in the patient's health records. By completing post-discharge medication reconciliation documentation for your Peoples Health patients, you can help ensure their safety by preventing potentially harmful drug interactions or overdoses and decrease the potential for unnecessary readmission due to medication errors.

Medicaid eligibility

If you believe that any of the Peoples Health patients you are treating may be eligible for Medicaid, please refer them to our customer service department, and a representative will help confirm Medicaid eligibility and provide information about our D-SNPs.

When a dual-eligible beneficiary joins a Peoples Health D-SNP, the beneficiary retains membership in Louisiana Medicaid. This means that both Louisiana Medicaid and Peoples Health may provide coverage for services the beneficiary receives. For your reference, a comparison chart of benefits covered by Peoples Health D-SNPs and Louisiana Medicaid is available at **peopleshealth.com**.

Peoples Health dual-special needs plans model of care

The Peoples Health model of care (MOC) is the framework for care management processes and systems that enable coordinated care for Peoples Health D-SNP members. The Peoples Health MOC includes descriptions of the following:

- D-SNP population (including health conditions)
- Care coordination
- Provider network
- Quality measurement
- Performance improvement

The Peoples Health MOC helps ensure the unique needs of Peoples Health D-SNP members are identified and addressed through care management practices. We evaluate MOC goals on an annual basis to determine effectiveness.

CMS requires annual SNP MOC training for all health care providers who treat SNP members. The training is reviewed and updated annually to reflect current practices related to care coordination. This includes communication of the individualized care plan (ICP) for each member. The Annual Peoples Health D-SNP MOC Provider Training is available at **UHCprovider.com**; choose the Louisiana (Peoples Health) tab.

Primary care and the Peoples Health care coordination model

We work closely with network PCPs to ensure Peoples Health patients receive quality care that meets regulatory guidelines and that aligns with our care coordination model. Our care coordinators support network PCPs in coordinating patient services and assisting in meeting quality and performance benchmarks.

PCPs are encouraged to see their Peoples Health patients on a regular schedule to help them manage conditions and avoid emergency visits and hospital admissions. We encourage PCPs to proactively conduct checkups on their highest risk patients to properly manage chronic conditions and improve health outcomes.

PCP performance goals

Peoples Health encourages PCPs to meet the following goals:

- Coordinate care with specialists and ancillary providers as appropriate for patients' needs
- Examine all patients at least once within a 6-month period
- Conduct follow-up visits within 7 days of discharge for recently hospitalized patients
- Conduct preventive screenings in accordance with CMS quality measures
- Monitor patients' medication use and adherence
- Refer patients for Peoples Health care management services as appropriate
- Participate in CMS quality improvement and Peoples Health administrative initiatives
- Periodically review utilization metrics with Peoples Health clinical staff as requested

PCP performance standards

Our initiatives, as well as CMS and NCQA initiatives, require the cooperation of network providers to actively work toward common goals.

The following are a supplement to your Peoples Health provider agreement:

- Administration and coordination of covered services
  - Coordinate patient care with specialists and ancillary providers as appropriate
  - Coordinate and manage the care of patients confined to the home or a custodial care setting
- Patient access
  - Schedule follow-up visits within 7 days of a patient's discharge from an inpatient setting
  - Schedule checkups for patients at least twice during a 12-month period
  - Reserve slots for same-day appointments as appropriate
- Medicare annual wellness visits and Peoples Health comprehensive wellness assessments
  - Schedule and perform patient Medicare annual wellness visits, develop a plan of care and perform medication reconciliation
  - Encourage patients to schedule comprehensive wellness assessments, including with a contracted vendor that performs house calls when available in a patient's area
  - Appropriately document and code quality indicators, such as HCC (hierarchical condition category) and HEDIS (Healthcare Effectiveness Data and Information Set) indicators
  - Schedule a follow-up visit within 30 days of a comprehensive wellness assessment as appropriate and share information with Peoples Health medical management staff as appropriate
  - Allow Peoples Health to perform or arrange Peoples Health comprehensive wellness assessments as needed
- Plan of care
  - Provide all information that Peoples Health needs to create a patient's plan of care and support such efforts as appropriate
- Quality measures
  - Schedule and perform HEDIS screenings and tests, or sign standing orders for the administration of screenings and tests
- Provide timely documentation of compliance with HEDIS screenings
- Schedule appointments to complete necessary screenings and tests for patients who are not in compliance with HEDIS requirements
  - Comply with quality initiatives including but not limited to those related to:

- Completing appropriate screenings in a timely manner
- Improving quality scores and patient health outcomes, including meeting all Medicare Advantage program requirements related to CMS quality measures for health care processes, outcomes, patient perceptions and organizational structure associated with the ability to provide high-quality health care
- Documenting advance directives and body mass index; coding all prior diseases and surgical history relevant to current monitoring and treatment, using CPT II codes to capture in-office test and assessment results and documenting compliance and completion of screenings and tests
- Documenting complete and accurate diagnoses in the medical record to substantiate the severity of illness for which the patient is being treated
- Documenting complete and accurate treatment plans for known conditions

Authorization requests

We encourage you to submit authorization requests online through the UnitedHealthcare Provider Portal. You can also fax your authorization request with supporting clinical information to the medical management department at 1-866-464-5709 or standard, direct admission, level-of-care change, discharge orders and updates.

A request is only considered expedited if, per CMS, the physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

Hospital admissions

All contracted hospitals must notify Peoples Health by 6 p.m. on the next business day (defined as Monday–Friday, including holidays) should any Peoples Health patient be admitted through the emergency department as an unscheduled admission. Clinical information to support medical necessity determination for the admission should also be communicated to us when the notification call is made, but no later than 24 hours after the notification call.

Hospital staff should notify Peoples Health of admissions via the UnitedHealthcare Provider Portal, by calling **1-877-346-5707** or by faxing 1-866-464-5709. Additionally, please submit an authorization request and supporting clinical information to the Peoples Health medical management department. Please note: If you submit your authorization request and supporting clinical information through the UnitedHealthcare Provider Portal, this online submission will serve as your notification.

If a facility fails to notify us by 6 p.m. on the next business day of the patient being admitted, or if an authorization request and adequate clinical information are not submitted within 24 hours of the initial notification, we will issue an administrative denial for the admission, resulting in nonpayment of all hospital claims for the admission.

Level of care changes

- If the patient's level of care is changing (i.e., transitioning from inpatient services to observation services or vice versa, or transitioning from an outpatient procedure to an inpatient or observation stay), the hospital must call us at **1-877-346-5707** by 6 p.m. on the next business day. Additionally, the hospital must submit supporting clinical information and a prior authorization request in advance to the Peoples Health medical management department to obtain authorization for the new level of services.
- Please note: If you submit your authorization request and supporting clinical information through the UnitedHealthcare Provider Portal, this online submission will serve as your notification
- Failure to obtain authorization may result in claim denial

For unplanned inpatient admissions, observation and outpatient authorizations, the hospital or treating facility must obtain authorization from Peoples Health for the services. The treating provider should notify Peoples Health of any unscheduled admission by 6 p.m. on the next business day. Additionally, adequate clinical information to support medical necessity of the requested services must be received within 24 hours of notification.

Additional information for facility authorization requests

To support timely processing of your authorization requests, include the key clinical information listed below for commonly requested services, including acute inpatient and unplanned admissions, observation stay; plus alternate levels of care (ALOC), including acute inpatient rehabilitation, long-term acute care and skilled nursing facilities, and observation, acute inpatient and unplanned admission requests:

- ER records
- Physician orders
- Applicable diagnostic studies, including labs, X-rays, CT scans, MRIs, ultrasounds, catheterization labs, etc.
- Medication administration record (MAR), if applicable
- Input and Output (I&O) record
- Vital signs (include neurological checks if applicable)
- PT/OT notes, if applicable (example: stroke and transient ischemic attack [TIA] patients)

Note: Peoples Health does not limit observations stays to 24 hours.

ALOC requests:

- PT, OT and ST evaluation and subsequent notes (must be no older than 48 hours)
- MAR, if applicable
- Vital signs (include neurological checks, if applicable)
- Applicable diagnostic studies, including labs, X-rays, CT scans, MRIs, ultrasounds, catheterization labs, etc.
- Physician orders
- Physician progress notes
- Wound care documentation, if applicable
- Case management and social worker notes, if applicable

In most cases, a final determination may not be made until the patient has been accepted at the ALOC, the patient is stable, and a discharge order is written.

Inpatient rehabilitation facility (IRF) and SNF requests:

- IRF: Patients must be able to fully participate in an intensive rehabilitation therapy program prior to transfer from the referring hospital (patient must be able to tolerate 3 hours of therapy per day and show no signs of dementia); patient must also have medical complexity requiring a multidisciplinary team, including a physician to evaluate the plan of care at least 3 times per week
- SNF: SNF care may be requested if the patient cannot participate in an intensive rehabilitation program; patients must have completed their course of treatment for the acute stay and be able to tolerate 1.5 hours of therapy per day
- Preadmission screening
- Physician orders

If clinical information was previously submitted with a request for an acute admission, observation stay or concurrent review, and a request is sent for an ALOC, Peoples Health only requires new updated clinical information.

You may request to speak with a Peoples Health medical director, either concurrent to ordering services or requesting a level-of-care change, or after a denial has been issued. Please be aware the post-denial peer-to-peer discussion is only for reviewing the rationale used in making the denial. It does not qualify as a request to change our decision.

Maintaining status as a contracted provider

To obtain and maintain status as a Peoples Health contracted provider, you must meet qualifications including but not limited to the following:

- Have a current, valid, unrestricted state medical or professional license or registration certificate(s) (there must not be any restrictions on the provider's license to practice medicine)
- Have a current, valid, unrestricted Drug Enforcement Agency certificate or current, valid, unrestricted Controlled Dangerous Substance certificate, if applicable
- Meet accreditation standards
- Provide requested information, including but not limited to the following, for review by the Peoples Health credentialing department:
  - Peer reference
  - Work history
  - Malpractice claims history
  - Proof of liability insurance coverage
- Maintain status as a Medicare provider and not be on the Medicare Preclusion List
- Adhere to Quality Improvement and Medical Management program requirements

Join the Peoples Health network

Providers interested in contracting with Peoples Health should complete the form at **peopleshealth.com/providers/contract-with-peoples-health**. We will direct your inquiry to the appropriate representative, who will contact you regarding your request.

Medical management programs

Peoples Health utilizes an integrated Medical Management Program to coordinate care for plan members throughout the health care continuum, and ensures appropriate treatment and coordination of inpatient and outpatient health care services. The program identifies and incorporates methods and tools for coordinating, managing and monitoring all levels of service; proactively manages the utilization of resources; and supports continuity of care to provide medically necessary services and promote optimal treatment outcomes.

The program is not a vehicle for Peoples Health to engage in the practice of medicine or influence the decision-making processes of health care providers. It does not use financial incentives to make or drive medical management or utilization management decisions.

Continued participation in the Peoples Health provider network is dependent upon adherence to Quality Improvement and Medical Management Program requirements. Violation of these requirements could include sanctions up to and including termination from the provider network. For more information about the Quality Improvement and Medical Management Program requirements, contact your Peoples Health representative.

Medical management medical necessity review

Medical management conducts medical necessity reviews as needed to determine the medical necessity of services provided to plan members. These reviews include:

- Prospective review prior to services, including a second opinion, being rendered
- Concurrent review, including reviews of urgent and emergent admissions, observation admission monitoring, continued stay review and discharge planning
- Post-stabilization review

Important steps for care providers

- Become familiar with all services that require prior authorization
- Submit accurate and fully completed authorization requests
- Cooperate with discharge planning activities for members in inpatient settings

Care management and social services

Peoples Health members are periodically stratified utilizing the predictive risk severity within the clinical documentation system. Some of the goals for care management of the higher-risk population with complex and multiple health conditions requiring assessment and coordination of resources include:

- Activities to prevent complications of chronic illness through member education
- Improved access to care
- Improved self-management and independence
- Reduction of acute events

Coordination by social workers identified through referral allows interventions to empower a member's or caregiver's ability to restore social, mental and emotional functioning, as well as ensure continuity of care for members through community resources and social programs.

Care management

Care management supports the physician, the physician–patient relationship and the patient's plan of care. Our care coordinator nurses support your Peoples Health patients in complying with treatment plans in the outpatient setting. Care coordinator nurses provide resources for self-care and support for improved outcomes. They provide support for psychosocial issues, and they educate on treatment plans, how to properly follow treatment plans, and how to safely manage care in the home by utilizing additional services, including home health or caregiver services. Care management services also include transplant services to provide support for those preparing for a transplant.

Care coordinator nurses work with patients to identify needs, set goals and help establish a plan of care, which is then monitored. Nurses also help ensure that your patients utilize all plan benefits that can help treat their conditions and instruct in patient self-management of chronic conditions to help reduce readmissions and emergency department visits; prevent complications; and increase the patients' health care satisfaction to improve health status and quality of life. Care coordinator nurses can provide education to help your Peoples Health patients with:

- Diabetes
- Heart failure
- Chronic kidney disease, including ESRD
- COPD
- Cardiovascular disease
- Cancer
- Supportive care

They can also offer educational and resource materials to caregivers of patients with Alzheimer's disease or dementia.

Care management services may benefit patients that are:

- Admitted to inpatient care frequently
- In need of assistance with coordination of care for multiple complex health conditions

Social services

Our care coordinator social workers work closely with your Peoples Health patients, as well as the patients' other providers, to identify psychosocial issues that may impact health and independent living status. Our care coordinator social workers work with patients and caregivers to address these issues utilizing health, behavioral health and community resources. They help ensure continuity of care, a proper support system to manage care, and the tools to promote independence, safety and healthy living. They can also help with issues involving housing assistance, food stamps, transportation and behavioral health, as well as those related to access to community programs, utility assistance and financial resources.

Social services may benefit patients who need assistance in managing psychosocial issues that may impact the ability to remain safe, independent and healthy, or who need access to community resources or additional financial assistance to meet basic needs.

Important steps for providers:

- Refer patients as appropriate to Peoples Health social services or care management services
- Submit medical necessity request via fax to the medical management department at 1-866-464-5709
  - Provide supporting documentation for the request (e.g., physician notes, lab results, etc.)
- Indicate the appropriate time sensitivity for service requests
- Discuss patient needs with the care coordinator
- Respond to requests for information or recommendations from care coordinator nurses
- Encourage and reinforce patients' efforts to manage their diseases and conditions
- Accommodate appointment requests for patients when care coordinator nurses recommend the appointment

How patients can access care management or social services

Our inpatient staff monitors your Peoples Health patients at inpatient facilities (including hospitals, skilled nursing facilities and long-term acute care centers) to determine whether a patient would benefit from these services. Those patients not in an inpatient facility, but who have multiple complex conditions, may also be targeted for the programs.

Physicians can request services by submitting a medical necessity request.

Nurse Practitioner Program

Through the Nurse Practitioner (NP) Program, our team of NPs helps facilitate the care management of your Peoples Health patients outside of your office, such as in the patient's home or at one of our regional service centers. The role of the NP is to:

- Support you in providing health education and disease management information
- Provide support to your Peoples Health patients through annual comprehensive wellness assessments
- Facilitate your patients' access to care as appropriate by following-up on annual comprehensive wellness assessments

Patients who meet any of the following criteria are eligible for NP services:

- Have medically complex conditions
- Are chronically ill
- Are frail and elderly
- Require fall prevention assistance
- Were recently discharged from an inpatient facility
- Are in custodial care or confined to the home

To request NP services, discuss the services you are requesting with the patient, then submit a medical necessity request via fax to the medical management department at 1-866-464-5709.

Upon receipt of your request, a representative will contact your office to review it. For approved services, our NP will meet with your patient to conduct an evaluation or provide the needed services. We will fax a clinical progress note of the NP's assessment to your office and we may call you to follow up.

For questions about requesting NP services, please call the clinical health services department at **1-866-780-5788**, Monday–Friday, from 8 a.m.–5 p.m. CT.

Optum Cancer Guidance Program

Peoples Health works with the Optum® Cancer Guidance Program to manage and process prior authorization requests for outpatient injectable chemotherapy and related cancer therapies (including cancer-supportive drugs

and therapeutic radiopharmaceuticals) for Peoples Health patients. The Optum Cancer Guidance Program is an evidence-based cancer treatment, utilization management and analytics service.

Requests for these services must be submitted to the Optum Cancer Guidance Program through its MBMNow platform for approval, not to Peoples Health. Through MBMNow, the program offers select drug treatment regimens that are auto-approved, as well as quick turnaround times for custom requests.

This online tool is available through the UnitedHealthcare Provider Portal.

Note that you will continue to submit authorization requests for oral chemotherapy drugs to our pharmacy benefits manager, Optum Rx.

Preferred Care Network supplement

About Preferred Care Network

Preferred Care Network, a wholly owned subsidiary of UnitedHealthcare, is a Medicare Advantage (MA) health plan. We offer MA plans in 2 Florida counties: Broward and Miami-Dade.

Preferred Care Network participating health care providers are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. For protocols, policies and procedures not referenced in this supplement, refer to the appropriate chapter in the main guide.

Mission statement

We work to improve the health of our members by providing:

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

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

How to contact us

Questions or comments

Questions or comments about this Guide should be emailed to Network Management Services (NMS) at **pcp-networkmanagementservices@uhcsouthflorida.com**, or submitted by mail to:

Preferred Care Network
Network Management Services
1000 Northwest 57th Crt.
Suite 500
Miami, FL 33126-3293

Resource	Where to go	What you can do there
Authorizations and notifications	**EDI:** Transactions 278 and 278N **Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** **UHCprovider.com** (Policies, instructions and tips) **Phone: 1-800-995-0480**	• Submit notifications, prior authorizations, referrals, admissions and discharge planning • Initiate requests for notifications and authorizations electronically. If the request cannot be complete 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

Resource	Where to go	What you can do there
Authorizations and notifications (WellMed)	**Online:** eprg.wellmed.net **Outpatient notifications** **Phone:** 1-877-299-7213 **Inpatient notifications** **Phone:** 1-877-490-8982 **Fax:** 1-877-757-8885	
Eligibility and benefits verification	**Online: UHCprovider.com** > Sign In > Eligibility **Phone: 1-800-550-7691** **Phone: 1-800-348-5548** 8 a.m.–8 p.m. local time, 7 days a week	Verify eligibility and benefits of enrolled members.
Claims	**Online: UHCprovider.com** > Sign In > Claims & Payments **Information: UHCprovider.com/claims** **Phone: 1-800-348-5548** 8 a.m.–8 p.m. local time, 7 days a week **Fax:** 1-866-725-9337 **Mail** (delegated providers only): Preferred Care Network P.O. Box 30448 Salt Lake City, UT 84130-0448	• Submit or review claims, encounters, inquiries, status or review requests • Check claims, eligibility and benefits • Use payer ID 78857
Claims (WellMed)	**Online:** eprg.wellmed.net **Phone: 1-800-550-7691** **Mail** (delegated providers only): Wellmed Claims P.O. Box 30508 Salt Lake City, UT 84130-0508	Use payer ID WELM2.
Technical support for Change Healthcare Claims Submission Network	**Phone:** 1-800-845-6592	Obtain assistance with password or technical support issues.
Audit and recovery	**Phone: 1-800-550-7691**	Ask questions related to overpayments.

Resource	Where to go	What you can do there
Chiropractic, physical therapy, occupational therapy and speech therapy providers	**Phone: 1-877-670-8432** Monday–Friday, 9 a.m.–5 p.m. **Fax:** 1-888-659-0619 **Email:** pcp-networkmanagementservices@uhcsouthflorida.com	Access list of participating physical therapy providers in our directory.
Credentialing	**Phone: 1-800-963-6495** Monday–Friday, 9 a.m.–5 p.m. **Fax:** 1-844-897-6352	Update or complete credentialing, recredentialing, document changes, recent hires or terminations in your practice or facility.
DME and infusion (MedCare)	**Phone:** 1-800-819-0751 Monday–Friday, 9 a.m.–5 p.m. **On call:** 24 hours a day, 7 days a week	• Register for these services • On call 24 hours a day • You may also call Utilization Management or Network Management
Electronic remittance (facilitated by Change Healthcare)	**Phone:** 1-800-845-6592 **Online:** changehealthcare.com	Information and registration for electronic payment services.
Fraud, waste and abuse (FWA) hotline	**Online: uhc.com/fraud** **Phone**: **1-844-359-7736** (UnitedHealthcare fraud hotline) Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.	Report concerns related to fraud, waste or abuse.
Grievances and appeals	MA and MA Prescription Drug (MAPD) plans Preferred Care Partners P.O. Box 6106 Mail Stop CA 124-0157 Cypress, CA 90630 Medicare and Retirement Prescription Drug plans (PDP): Preferred Care Partners P.O. Box 6106 Mail Stop CA 124-0197 Cypress, CA 90630	Obtain information about filing a grievance or appeal on behalf of a member, status inquiries or requests for forms.
Home health (MedCare)	**Phone:** 1-305-883-2940	• Arrange for services • On call 24 hours a day • You may also call Utilization Management or Network Management

Resource	Where to go	What you can do there
Member Services	**Phone: 1-800-407-9069**, TTY **711** 8 a.m.–8 p.m. local time, 7 days a week	• Assist our members with questions, help locate specialists and perform other related functions • Also printed on the member's ID card
Network management services – provider relations and contracting	**Phone: 1-877-670-8432** Monday–Friday, 9 a.m.–5 p.m. **Fax:** 1-888-659-0619 **Email:** pcp-networkmanagementservices@uhcsouthflorida.com	• Ask questions regarding your agreement, servicing, follow-up and outreaches • Report demographic changes such as TIN changes, health care provider terminations and additions, submit informal complaints • Find or request forms, other materials or panel status
Pharmacy (Optum Rx)	**Online:** professionals.optumrx.com **Phone: 1-800-711-4555** **Mail:** Optum Rx P.O. Box 650287 Dallas, TX 75265-0287	Verify pharmacy benefits and eligibility, adjudications or authorizations.
Risk management	**Phone: 1-877-504-1179** **Email:** risk.management@uhc.com	Report incidents involving all privacy issues (potential breaches of PHI or PII) immediately to our Risk Manager.
Optum (behavioral health)	**Online:** Providerexpress.com Licensed clinicians available 24 hours a day Member Services – 24 hours **Phone: 1-800-985-2596** No D-SNP **1-800-496-5841** D-SNP and I-SNP	• Obtain information about behavioral health and substance use disorder services for all members • Access a list of behavioral health practitioners and health care providers in the provider directory
Dental (Solstice)	**Online:** solsticebenefits.com **Phone:** 1-855-351-8163	Access a list of Solstice dental providers in the provider directory.
Fitness (Renew Active)	**Online:** uhcrenewactive.com **Phone: 1-800-407-9069**	
Hearing (UnitedHealthcare hearing)	**Phone: 1-855-523-9355**, TTY **711** Monday–Friday 8 a.m.–8 p.m. CT	

Resource	Where to go	What you can do there
Laboratory Labcorp Quest Diagnostics	**Online:** labcorp.com **Phone:** 1-855-277-8669 Automated Line 1-800-877-7831 Live Scheduling **Online:** questdiagnostics.com **Phone:** 1-866-697-8378	Find information on locations, make an appointment, order lab tests and view results.
Mail order pharmacy (Optum Rx)	**Online: optumrx.com** **Phone: 1-877-889-6358**	Obtain mail-order medications.
Podiatry – network management services (Foot and Ankle Network)	**Phone: 1-877-679-8432** Monday–Friday, 9 a.m.–5 p.m.	Access a list of podiatrists in our provider directory.
Transportation (ModivCare)	**Phone:** 1-888-774-7772 Monday–Friday, 8 a.m.–5 p.m.	Request services.
Vision – network management services (iCare)	**Phone:** 1-877-670-8432 Monday–Friday, 9 a.m.–5 p.m.	Access a list of providers in our provider directory.

WellMed Medical Management, Inc. (WellMed)

For members who have a WellMed primary care physician (PCP) in the Preferred Care Partners, their utilization management (UM) and claim services are handled through WellMed. To identify these members, refer to the member ID card. The payer ID is listed as WELM2 and WellMed is listed in the lower right corner of the card.

Claims processing for WellMed Members

Submit claims electronically to payer ID WELM2. If mailing, send to:

WellMed Claims
P.O. Box 30508
Salt Lake City, UT 84130-0508

Confidentiality of protected health information (PHI)

All employees, contracting health care providers and delegates of Preferred Care Partners are required to maintain the confidentiality of all PHI. We keep all UM information confidential, following federal and state laws and regulations. We limit PHI access to the minimum necessary.

You must report all privacy issues immediately to Risk Management at **1-877-504-1179**.

Examples of privacy incidents include:

- Reports and correspondence containing PHI or personally identifiable information (PII) sent to the wrong recipient
- Member or provider correspondence that includes an incorrect member's information

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

Physician extender responsibilities

Physician extenders are state-licensed health care professionals who are employed or contracted by physicians to examine and treat Medicare members. These are advanced registered nurse practitioners (ARNPs) and physician assistants. When a physician extender provides care, they must:

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

Referrals

Preferred Care Network's Simple Referral Process helps PCPs coordinate patient care.

Referrals are needed for most participating specialists.* Requests for all nonparticipating health care providers need additional authorization.

- You may request a referral for 1 or multiple visits
- The referral is good for the number of visits approved, valid for 6 months from the date issued
- No supporting documentation is needed for referrals to participating specialists
- Submit all requests for referrals in the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > Referrals. For more information on referrals, go to **UHCprovider.com/referral**.
- Upon submitting a referral request, the system automatically generates the referral number
- For members, convenience, you may also provide members with a copy of the referral confirmation
- Specialists have the ability to view referrals via the UnitedHealthcare Provider Portal
- For additional questions call us at **1-877-670-8432** or email us at **pcp-networkmanagementservices@uhcsouthflorida.com**.

Prior authorizations

Preferred Care Network does not require prior authorization for certain services. Use the Enterprise Prior Authorization List to see what services do require authorization on **UHCprovider.com/priorauth** > **Advance notification** > Preferred Care Network and Preferred Care Partners Prior Authorization Requirements.

WellMed and utilization management

Prior authorization requests for Preferred Care Partners members assigned to a Primary Care Physician at one of our Optum clinics can be done online at eprg.wellmed.net.

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

Authorization requirements

- You are responsible for getting prior authorization for all services requiring authorization before the services are scheduled or rendered
- Submit prior authorization for outpatient services or planned inpatient admissions, including skilled nursing facilities (SNF), acute inpatient rehab (AIR) and long-term acute care hospital (LTACH) admissions, as far in advance of the planned service as possible to allow for review. You are required to submit prior authorizations at least 7 calendar days prior to the planned date of service.
- Prior authorizations for home health and home infusion services, durable medical equipment and medical supply items should be submitted to MedCare Home Health at 1-305-883-2940 and Infusion/DME at 1-800-819-0751. Note: Request an expedited (72 hours) review if waiting for a standard (14 calendar days) review could place the member's life, health or ability to regain maximum function in serious jeopardy. If the situation meets this definition, request a prior authorization be expedited by placing STAT or urgent on the Prior Authorization Form.
- Prior authorizations are required for referrals to out-of-network providers when the member requires a necessary service that is not within the Preferred Care Network. The referring physician must submit a completed prior authorization form for approval.
- It is important you and the member are fully aware of coverage decisions before you render services
- If you provide the service before a coverage decision is rendered, and we determine the service was not a covered benefit, we may deny the claim and you must not bill the member. Without a coverage determination, a member does not have the information needed to make an informed decision about receiving and paying for services.

Notification requirements

Prior to doing an inpatient or ambulatory outpatient service requiring prior authorization, the facility must confirm the coverage approval is on file. This promotes conversations between the facility and the member about the cost for the procedure.

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

Admission notification requirements

Facilities are responsible for admission notification for the following inpatient admissions, even if advance notification was provided by the physician and coverage approval is on file:

- Planned elective admissions for acute care
- Unplanned admissions for acute care
- Admissions following observation
- Admissions following outpatient surgery
- SNF admissions
- LTACH
- AIR

Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission (or by 5 p.m. ET on the next business day if 24-hour notification would require notification on a weekend or federal holiday). For after-hour, weekend and federal holiday admissions, call the Utilization Management department at **1-866-273-9444** for assistance.

- Even if the physician gave us the admission notification, the facility still needs to submit one
- Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services depends on:
  - The member's coverage
  - The facility being eligible for payment
  - Claim processing requirements
  - The facility's Agreement with us
- Admission notifications must contain:
  - Member name and member health plan ID number
  - Facility name
  - Admitting/attending physician name
  - Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
  - Actual admission date
  - Admission orders written by a physician
- For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us as soon as the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

If the requirements described are not followed, the services may be denied. The member may not be billed.
A notification or prior authorization approval does not ensure or authorize payment, subject to state rules and MA policies. Payment depends on the member's coverage, the health care provider's eligibility and agreement, and claim requirements.

How to request prior authorization

- **Online:** **UHCprovider.com** > Sign In > Prior Authorizations
- **Phone:** If you do not have electronic access, call the number on the back of the members' health plan ID card

Required information for prior authorizations

- Member information – Name, date of birth and membership ID number
- Requesting health care provider information – Name, specialty, designate PAR or non-PAR, address and phone and fax numbers
- Referral information – Name of referral health care provider, designate par or non-PAR, address, phone and fax numbers
- Diagnosis or symptoms – Include the diagnosis description and the corresponding ICD-10 code for each diagnosis to the highest specificity
- Services requested
  - Identify each procedure and its corresponding CPT code
  - Document any pertinent clinical summary information that would be helpful to that specialist or for the UM determination in the additional comments field
  - Enter the date of service and number of visits requested and sign where indicated

Where a clinical coverage review is required in the member's benefit plan, we may request additional information.

- We may not cover certain services within an individual member's benefit plan, regardless of whether prior authorization is required
- In the event of a conflict or inconsistency between applicable regulations and the advance notification requirements in this manual, we follow the notification process in accordance with applicable regulations

Time frames for processing prior authorization requests

We will make a determination within 14 calendar days of receipt, or within 72 hours for an expedited review.

It is important we have all necessary documentation at the time of your request to help with the decision.

Clinical coverage review

Certain services require prior authorization, which result in:

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

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

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

In addition:

- We may also use tools developed by third parties, such as the InterQual Care Guidelines, to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.
- For MA members, we use CMS coverage determinations, the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) to determine clinical criteria for Medicare members. There is a hierarchy used in applying clinical criteria.

Clinical coverage review criteria

We use scientifically based clinical evidence to identify safe and effective health services for members for inpatient and outpatient services. For inpatient care management (ICM), we use evidence-based InterQual Care Guidelines. Clinical coverage decisions are based on:

- The member's eligibility
- State and federal mandates
- The member's certificate of coverage, evidence of coverage or summary plan description
- UnitedHealthcare medical policies and medical technology assessment information
- CMS NCDs and LCDs, and other clinical-based literature (for Medicare and Retirement)

Coverage determination decisions

We base coverage determinations for health care services upon the member's benefit documents and applicable federal requirements. Our UM staff, its delegates and the physicians making these coverage decisions are not compensated or otherwise rewarded for issuing adverse noncoverage determinations.

Preferred Care Network and its delegates do not offer incentives to physicians to encourage underutilization of services or to encourage barriers to receiving the care and services needed.

Coverage decisions are made based on the definition of reasonable and necessary within Medicare coverage regulations and guidelines. We do not hire, promote or terminate physicians or other individuals based upon the likelihood or the perceived likelihood the individual will support or tend to support the denial of benefits.

Prior authorization denials

We may deny a prior authorization request for several reasons:

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

We must notify you and the member in writing of any adverse decision (partial or complete) within applicable time frames. The notice must state the specific reasons for the decision and reference 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 ICM, P2P requests may come in through the P2P support team. Providers can call **1-800-955-7615** to talk to a medical director.

P2P discussions may occur at different points during case activity in accordance with time frames once a medical director has rendered an adverse determination. A P2P reconsideration request may only occur before you file a formal appeal. UnitedHealthcare physicians conducting clinical review determinations are available by phone to discuss medical necessity review determinations with the member's physician requesting the service. We offer pre-denial P2P review. A clinician will contact you to initiate the P2P call. Follow the timeline provided by the nurse during the call.

Additional UM information

External agency services for members

Some members may require medical, psychological, social services or other external agencies outside the scope of their benefits (for example, from Health and Human Services or Social Services). If you encounter a member in this situation, you should either contact Network Management Services or have the member contact our Member Services department at **1-800-407-9069** for assistance with, and referral to, appropriate external agencies.

Technology assessment coverage determination

We use the technology assessment process to evaluate new technologies and new applications of existing technologies. Technology categories include medical procedures, drugs, pharmaceuticals or devices. This information allows us to support decisions about treatments that best improve members' health outcomes, efficiently manage utilization of health care resources, make changes in benefit coverage to keep pace with technology changes and to help ensure members have equitable access to safe and effective care. If you have any questions regarding whether a new technology or a new application of existing technologies are a covered benefit for our members, contact UM at **1-866-273-9444**.

Hospitalist program for inpatient hospital admissions

The hospitalist program is a voluntary program for members. Hospitalists are physicians who specialize in the care of members in an acute inpatient setting (acute care hospitals and skilled nursing facilities). A hospitalist oversees the member's inpatient admission and coordinates all inpatient care. The hospitalist is required to communicate with the member's selected physician by providing records and information, such as the discharge summary, upon the member's discharge from the hospital or facility.

Discharge planning

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

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

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

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

- An extension of the approval is needed. Contact must be made prior to the expiration of the approved days.
- The member's discharge plan indicates transfer to an alternative level of care is appropriate
- The member has a complex plan of treatment that includes home health services, home infusion therapy, total parenteral nutrition or multiple or specialized durable medical equipment identified prior to discharge
- Addressing lifestyle-related health issues and referring to programs for weight management, nutrition, smoking cessation, exercise, diabetes education and stress management, as appropriate
- Helping members understand and manage their condition and its implications
- Education for reducing risk factors, maintaining a healthy lifestyle and adhering to treatment plans and medication regimens

Appeal and reconsideration processes

Medicare Advantage hospital discharge appeal rights protocol

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

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

- Preferred Care Network facility on-site concurrent review staff completes the Detailed Notice of Discharge (DNOD) and delivers it to the member or their representative as soon as possible but no later than 12 p.m. ET of the day after the BFCC- QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO.
- When there are not any Preferred Care Network facility on-site staff, the facility completes the DNOD, and delivers the DNOD to the member or their representative as soon as possible but no later than 12 p.m. ET of the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO and Preferred Care Network.

Facility (SNF, HHA, CORF) Notice of Medicare Noncoverage (NOMNC) protocol

CMS requires SNFs, home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs) to deliver the NOMNC notice to members at least 2 calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member's services are expected to be fewer than 2 calendar days in duration, the notice should be delivered at the time of admission or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds 2 calendar days, the notice should be given no later than the next to last time services are furnished.

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

of Medicare Non-Coverage form. The standardized form and instructions regarding the NOMNC are on the CMS website or contact Acentra Health, the BFCC-QIO for Florida, at acentraqio.com. The NOMNC notification text may not be modified.

Clinical appeals: Standard and expedited

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

When we make the final decision, we notify you via mail. If the decision is to overturn the original determination, we will authorize the service. If the decision is to uphold the original denial determination, there will be no further action for you to undertake.

Benefit summaries

For information on benefit plans, visit **pcnhealth.com** > **Members**.

Member rights and responsibilities

The Member Rights and Responsibilities Statement is published each year in the Evidence of Coverage (EOC) available on the Preferred Care Network website at **pcnhealth.com**. You may get a copy of the Member Rights and Responsibilities Statement by contacting Network Management Services at **1-877-670-8432**. If your patient has questions about their rights as an MA member, refer them to the Member Services phone number on the back of their health plan ID Card.

Member participation in treatment options

Members have the right to freely communicate with their physician and participate in the decision-making process regarding their health care, regardless of their benefit coverage. Physicians should encourage and provide active member communication and participation in their treatment planning and course of care. This includes the member's right to withhold resuscitative services or to forgo or withdraw life-sustaining treatment in compliance with federal and state laws.

Each member has the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law, as applicable. Physicians must communicate information regarding the risks, benefits and consequences of treatment or non-treatment, at a level the member may understand, to decide among the treatment options.

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

During this time, the physician is responsible for providing continuity of care to the member.

Advance directives

For information on advance directives, refer to **Chapter 16: Member rights and responsibilities**.

Documentation and confidentiality of medical records

You are required to maintain records, correspondence and discussions regarding the member in the strictest of confidence and protection.

You must keep a medical records system that:

- Follows professional standards
- Allows quick access of information
- Provides legible information, accurately documented and available to appropriate health care providers
- Maintains confidentiality

Our member should sign a Medical Record Release Form as a part of their medical record. Call Network Management Services (**1-877-670-8432**) to request a copy of this form.

The following guidelines are applicable:

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

Exemption from release requirements

HIPAA regulations allow us to give PHI to government programs without member permission. We give this when it is necessary to determine member eligibility.

Medical records requirements

You must ensure your medical records meet our standards. The following are expanded descriptions of some of these requirements.

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

Advance directives: It is your responsibility to provide the member with advance directive information and to encourage the member to retain a copy for their personal records.

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

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

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

Past medical history: Documentation should include a detailed medical, surgical and social history.

Immunizations: Documentation of immunizations performed by the office should include the date the vaccine was administered, the manufacturer and lot number and the name and title of the person administering the vaccine. At a minimum, you must have their vaccination history.

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

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

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

Preventive screenings: You need to promote the appropriate use of age/gender specific preventive health services for members to achieve a positive impact on the member's health and better medical outcomes.

Required encounter documentation: For every visit, document the following:

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

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

As a part of their medical record, members should sign a Medical Record Release Form. They should sign a Refusal Form when declining a preventive screening referral.

We recommend medical records include copies of care plans whenever you provide home health or skilled nursing services.

Case management and disease management program information

Optum provides case management (CM) and disease management (DM) services for Preferred Care Network. Here are the criteria for referrals to Optum CM and DM programs:

- Complex Case Management – Special Needs Plan (SNP) members only
  - 3 or more unplanned admissions and/or emergency room (ER) visits in the past 6 months
  - Multiple, complex co-morbid conditions
  - Coordination of multiple community resources/financial supports to cover basic services
- Heart failure (HF) DM program
  - Diagnosis of HF
  - Has congestive heart failure (CHF) on an inpatient claim
  - HF admission in last 3 months
- Diabetes DM program
  - Diabetic with A1C 9% or greater
  - An inpatient admission related to diabetes in the past 12 months
  - 2 or more ER visits related to diabetes
- Advanced illness CM – 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 CM and network services bone marrow/stem cell including chimeric antigen receptor T-cell (CAR-T) therapy for certain hematologic malignancies, kidney and kidney/pancreas, heart, liver, intestinal, multi-organs and lung transplants
  - CM for 1 year post-transplant
- End-stage renal disease CM – The member is diagnosed with end-stage renal disease and is undergoing outpatient dialysis including in-center or home hemodialysis, home peritoneal dialysis, etc.

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

Note: Preferred Care Network no longer provides social worker evaluations without skilled services. Direct your patient to their local social services department or The Florida State Department of Elder Affairs Help Line at 1-800-963-5337.

To request CM or DM services for one of our members, select only 1 program that your member meets the criteria for, and email the CM/DM referral form available on **pcnhealth.com** > Provider > Resources > **Forms**.

When appropriate, we provide referrals to other internal programs such as mental health, employee assistance and disability. Case management services are voluntary, and a member may opt out at any time.

Optum (behavioral health)

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

Special Needs Plans (SNP)

SNP Model of Care (MOC)

The MOC is the framework for care management processes and systems to help enable coordinated care for SNP members. The MOC contains specific elements that delineate implementation, analysis and improvement of care.

These elements include description of SNP population (including health conditions), care coordination, provider network and quality measurement and performance improvement.

The MOC is a quality improvement tool, and MOC helps ensure the unique needs of our SNP members are identified and addressed through care management practices. MOC goals are evaluated annually to determine effectiveness. To learn more, contact us via email at: **snp_moc_providertraining@uhc.com**.

CMS requires initial and annual SNP MOC training for all health care providers who treat SNP members. The annual SNP MOC provider training is available at **UHCprovider.com**. Updates about training requirements are communicated annually on **UHCprovider.com/news** as described in **Chapter 18: Provider communication**.

Risk management

Risk management addresses liability, both proactively and reactively. Proactive is avoiding or preventing risk. Reactive is minimizing loss or damage after an adverse or bad event. Risk management in health care considers patient safety, quality assurance and patients' rights. The potential for risk is present in all aspects of health care, including medical mistakes, electronic record keeping, provider organizations and facility management.

An adverse event is defined as an event over which health care personnel could exercise control rather than as a result of the member's condition. Identifying something as an adverse event does not imply error, negligence or poor quality care. It simply indicates an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process. Examples of adverse events in health care include unexpected death,

failure to diagnose or treat disease or surgical mistakes or accidents. Adverse events interfere with a health 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) with the purpose of identifying, investigating, analyzing and evaluating actual or potential risk exposures by a state licensed risk manager. The RMP also corrects, reduces and eliminates identifiable risks through instruction and training to staff and health 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
- Performance of a wrong surgical procedure

For more information, go to the AHCA website at ahca.myflorida.com.

Provider reporting responsibilities

You are required to report all adverse events identified previously, whether actual or potential. To report such incidents, call **1-877-504-1179**.

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

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

Our provider contracts include the obligation to participate in quality management inquiries upon request.

What are the responsibilities of physicians and providers?

You must report the ICD-10-CM diagnosis codes to the highest level of specificity and accuracy. 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 **pcnhealth.com**.

CPT and HCPCS codes

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

If you submit your claim with an invalid or deleted procedure code, we will deny or return it. A valid procedure code is required for claims processing.

We encourage you to access CPT, HCPCS and ICD-10 coding resources and materials at the AMA's website ama-assn.org, or from another vendor.

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 3 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 health care provider networks around the needs of our members. This provides the best experience for our members and health care providers. We commit to give direct access to expert customer service representatives who understand member needs and may help them make informed choices.

How to contact us

Questions or comments

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

Preferred Care Partners Network Management Services
1000 Northwest 57th Crt.
Suite 500
Miami, FL 33126-3293

Contact us table

Resource	Where to go	What you can do there
Authorizations and notifications (WellMed)	**Online:** eprg.wellmed.net **Outpatient notifications** **Phone:** 1-877-299-7213 **Inpatient notifications** **Phone:** 1-877-490-8982 **Fax:** 1-877-757-8885	

Resource	Where to go	What you can do there
Authorizations and notifications	**EDI:** Transactions 278 and 278N **Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Information:** **UHCprovider.com** (Policies, instructions and tips) **Phone:** 1-800-995-0480	Submit notifications, prior authorizations, referrals, admissions and discharge planning. Initiate requests for notifications and authorizations electronically. If the request cannot be completed electronically, our staff is available to answer questions or discuss any issues with referrals, prior authorizations, case management, concurrent review and admission certification or notification.
Claims	**Online:** **UHCprovider.com** > Sign In > Claims & Payments **Information:** **UHCprovider.com/claims** **Phone:** **1-866-725-9334** 8 a.m.–8 p.m. local time, 7 days a week **Fax:** 1-866-725-9337 **Mail (delegated providers only):** Preferred Care Network P.O. Box 30448 Salt Lake City, UT 84130-0448	Check claims, eligibility and benefits. Use payer ID 65088.
Claims (WellMed)	**Online:** eprg.wellmed.net **Phone:** 1-800-550-7691 **Mail:** Wellmed Claims P.O. Box 30508 Salt Lake City, UT 84130-0508	Check claims, eligibility and benefits. Use payer WELM2.
Technical support for Change Healthcare Claims Submission Network	**Phone:** 1-800-845-6592	Obtain assistance with password or technical support issues. Obtain information on electronic claims submission.
Credentialing	**Phone:** **1-800-963-6495** Monday–Friday, 9 a.m.–5 p.m. ET **Fax:** 1-844-897-6352	Submit or update credentialing, recredentialing, document changes or recent hires or terminations in your practice or facility.
Electronic remittance (facilitated by Change Healthcare)	**Online:** changehealthcare.com **Phone:** 1-800-845-6592	Get information and register for electronic payment services.

Resource	Where to go	What you can do there
Eligibility and benefits verification	**Online:** UHCprovider.com > Sign In > Eligibility **Information:** UHCprovider.com/eligibility **Phone: 1-866-725-9334**	Verify eligibility and benefits of enrolled members. Access a summary of benefits for each plan online.
Fraud, waste and abuse (FWA) hotline	**Online:** uhc.com/fraud **Phone: 1-844-359-7736** (UnitedHealthcare fraud hotline) Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.	Report concerns related to fraud, waste or abuse.
Grievances and appeals	**MA and MA Prescription Drug (MAPD) plans** Preferred Care Partners P.O. Box 6106 Mail Stop CA 90630 Cypress, CA 90630 **Medicare and Retirement Prescription Drug plans (PDP)** Preferred Care Partners P.O. Box 6106 Mail Stop CA 124-0197 Cypress, CA 90630	For information about filing a grievance or appeal on behalf of a member, status inquiries or requests for forms.
Member services	**Online:** mypreferredcare.com **Phone: 1-866-231-7201**, TTY **711** Monday–Friday, 8 a.m.–8 p.m. local time	Members may ask questions about health 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: 1-877-670-8432** Monday–Friday, 9 a.m.–5 p.m. ET **Fax:** 1-888-659-0619 **Email:** pcp-networkmanagementservices@uhcsouthflorida.com	Ask questions regarding your Agreement, in-servicing and follow-up or outreaches. Report demographic changes. Submit informal complaints. Request forms or other materials.
Pharmacy (Optum Rx)	**Online:** professionals.optumrx.com **Phone: 1-800-711-4555** **Mail:** Optum Rx P.O. Box 650287 Dallas, TX 75265-0287	Verify pharmacy benefits and eligibility, adjudications or authorizations. See pharmacy benefit updates.

Resource	Where to go	What you can do there
Risk management	**Phone: 1-877-504-1179** **Email: risk.management@uhc.com**	Report incidents involving all privacy issues (potential breaches of PHI or PII) immediately to our Risk Manager.
Ancillary and enhanced benefit providers		
Optum (behavioral health)	**Online: Providerexpress.com** **Phone: 1-800-985-2596** No D-SNP **1-800-496-5841** D-SNP and I-SNP Member Services available 24 hours. Licensed clinicians are on call 24 hours a day, 7 days a week.	Obtain information about behavioral health and substance use disorder services for all members. Access a list of behavioral health care providers in the provider directory.
Dental (Solstice)	**Online:** solsticebenefits.com **Phone:** 1-855-351-8163	Access a list of Solstice dental providers in the provider directory.
DME/Infusion (MedCare)	**Phone:** 1-800-819-0751 Monday–Friday, 9 a.m.–5 p.m. ET On call: 24 hours a day, 7 days a week	• Register for these services • On call 24 hours a day • You may also call Utilization Management or Network Management
Fitness (Renew Active)	**Online: uhcrenewactive.com** **Phone: 1-866-231-7201**	
Hearing (UnitedHealthcare hearing)	**Phone: 1-855-523-9355**, TTY **711** Monday–Friday 8 a.m.–8 p.m. CT	
Home Health (MedCare)	**Phone:** 1-855-523-9355, TTY 711 On call: 24 hours a day, 7 days a week	• Register for these services • On call 24 hours a day • You may also call Utilization Management or Network Management
Laboratory Labcorp Quest Diagnostics	**Online:** labcorp.com **Phone:** 1-855-277-8669 Automated Line 1-800-877-7831 Live Scheduling **Online:** questdiagnostics.com **Phone:** 1-866-697-8378	Find information on locations, make an appointment, order lab tests and view results.
Mail order pharmacy (Optum Rx)	**Online: optumrx.com** **Phone: 1-877-889-6358**	Obtain mail-order medications.

Resource	Where to go	What you can do there
Podiatry – network management services (Foot and Ankle Network)	**Phone: 1-877-679-8432** Monday–Friday, 9 a.m.–5 p.m. ET	Access a list of podiatrists in our provider directory.
Transportation (ModivCare)	**Phone:** 1-888-774-7772 Monday–Friday, 9 a.m.–5 p.m. ET	Request services.
Vision – network management services (iCare)	**Phone:** 1-877-670-8432 Monday–Friday, 8 a.m.–5 p.m. ET	Access a list of vision providers in our provider directory.

Confidentiality of protected health information (PHI)

All employees, participating health care providers and delegates of Preferred Care Partners 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 **1-952-406-4806**.

Examples of privacy issues that must be reported include:

- Reports and correspondence containing PHI or personally identifiable information (PII) sent to the wrong recipient
- Member or health 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 (e.g., 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 and physician assistants. When physician extenders provide care, they must:

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

Prior authorizations

We do not require prior authorization for certain services. Use the Enterprise Prior Authorization List to see what services do require authorization on **UHCprovider.com/priorauth** > **Advance notification** > Preferred Care Network and Preferred Care Partners Prior Authorization Requirements.

WellMed and utilization management

Prior authorization requests for Preferred Care Partners members assigned to a Primary Care Physician at one of our Optum clinics can be done online at eprg.wellmed.net.

WellMed members

WellMed requires a referral from the assigned PCP before rendering services for selected specialty health care providers. The referral must be entered by the PCP in the WellMed provider portal at eprg.wellmed.net.

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

Authorization requirements

- Obtain prior authorization for all services requiring authorization before the services are scheduled or rendered
- Submit prior authorization for outpatient services or planned Acute Hospital Admissions and admissions to Skilled Nursing Facilities (SNF), Acute Rehabilitation Hospital and Long-Term Acute Care (LTAC) as far in advance of the planned service as possible to allow for coverage review. We require prior authorizations to be submitted at least 7 calendar days before the date of service.
- Submit prior authorizations for home health and home infusion services, durable medical equipment (DME) and medical supply items to MedCare Home Health at 1-305-883-2940 and Infusion/DME at 1-800-819-0751.

  Note: Request an expedited (72 hours) review if waiting for a standard (14 calendar days) review could place the member's life, health or ability to regain maximum function in serious jeopardy.
- We require prior authorizations to out-of-network specialty or ancillary health 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, before 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 preservice conversation. If the service will not be covered, the member may decide whether to receive and pay for the service.
- Facilities are responsible for admission notification for inpatient services, even if the coverage approval is on file
- If a member is admitted through the emergency room, you must notify us no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care
- If a member receives urgent care services, you must notify us within 24 hours of the services being rendered

Admission notification requirements

Facilities are responsible for admission notification for:

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

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

A notification or prior authorization approval does not ensure or authorize payment, subject to state rules and MA policies. Payment is dependent upon the member's coverage, the health care provider's eligibility and Agreement and claim requirements.

To initiate member discharge or to request authorization for transition to AIR and LTAC, call 1-800-995-0480.

Clinical coverage review

Certain services require prior authorization, which results in:

1. A request for clinical information
2. A clinical coverage review based on medical necessity
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 provider, you must respond to calls from our UM staff or medical director. You must provide complete clinical information as required within the time frame specified on the outreach form.

In addition:

- We may use tools developed by third parties, such as InterQual Care Guidelines, to assist us in administering health benefits. These tools assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. They do not constitute the practice of medicine or medical advice.
- For MA members, we use CMS coverage determinations, the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) to determine clinical criteria for Medicare members. There is a hierarchy used in applying clinical criteria.

Clinical coverage review criteria

We use scientifically based clinical evidence to identify safe and effective health services for members for inpatient and outpatient services. For Inpatient Care Management (ICM), we use evidence-based InterQual 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 noncoverage 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
- 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 **1-800-955-7615**.

P2P discussions may occur at different points during case activity in accordance with time frames, once a medical director has rendered an adverse determination.

The post-decision consult process must conclude for the Medicare population. This requires establishing a pre-decision medical director outreach for standard (14-day turnaround time) requests for both inpatient and outpatient adverse determinations. It excludes expedited preservice requests and administrative denials.

We must treat the following situations as reconsiderations or appeals:

- Clinical information received after notification is complete
- Peer-to-peer requests received after notification is complete

Additional UM information

External agency services for members

Some members may require medical, psychological and social services or other external agencies outside the scope of their plan benefits (e.g., from Health and Human Services or Social Services). If you encounter a member in this situation, contact Network Management Services. You may also have the member contact our Member Services Department at **1-866-231-7201** for assistance with, and referral to, appropriate external agencies.

Technology assessment coverage determination

The technology assessment process helps evaluate new technologies and new applications of existing technologies. Technology categories include medical procedures, drugs, pharmaceuticals or devices. This information allows us to support decisions about treatments that best improve member's health outcomes, efficiently manage utilization of health care resources and make changes in benefit coverage to keep pace with technology changes. It also helps ensure members have equitable access to safe and effective care. If you have any questions regarding whether a new technology or a new application of existing technologies are a covered benefit for our members, call Utilization Management at **1-800-995-0480.**

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 among 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 before 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 before discharge

To initiate patient discharge, update the case directly online by visiting **UHCprovider.com** > Sign In > Prior Authorizations or call us at **1-800-995-0480**.

Appeal and reconsideration processes

Medicare Advantage 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 Acentra Health.

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

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

Facility (SNF, HHA, CORF) notice of Medicare noncoverage (NOMNC) protocol

CMS requires SNFs, HHAs and CORFs deliver the NOMNC-required notice to members at least 2 calendar days before termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If a member's services are expected to be fewer than 2 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 2 calendar days, give the notice no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of the member or their authorized representative if the member is incompetent. You must use the most current version of the standard CMS-approved form titled, Notice of Medicare Non- Coverage (NOMNC). You may find the standardized form and instructions on the CMS website. You may also contact Acentra Health, the BFCC-QIO for Florida, at acentraqio.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. Medicare guidance allows the servicing health care provider to submit an appeal on behalf of the member.

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

Benefit summaries

For information on benefits, go to **mypreferredcareprovider.com** > Preferred Care Partners > **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 **1-877-670-8432**. If our member has questions about their rights, 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 physician may regard such refusal as incompatible with the continuance of the health care provider/patient relationship and the provision of proper medical care. If this occurs, and the physician believes that no professionally acceptable alternatives exist, they must so inform the member in writing, by certified mail. The physician must give the member 30 calendar days to find another health care provider. During this time, the physician is responsible for providing continuity of care to the member.

Advance directives

The federal Patient Self-Determination Act 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 health care providers and facilities to provide their patients with written information regarding treatment options.

Document this discussion at least once in the member's record.

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

Online resources – You may find the federal Patient Self-Determination Act at gpo.gov. You may download free forms from the state at quality.healthfinder.fl.gov/report-guides/advance-directives.

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

Member financial responsibility

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

If you prefer to collect payment at the time of service, you must make a good faith effort to estimate the member's responsibility. Visit **UHCprovider.com** > Sign In > Claims & Payments or learn more at **UHCprovider.com/claims**.

Documentation and confidentiality of medical records

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

You must keep a medical records system that:

- Follows professional standards
- Allows quick access of information
- Provides legible information that is correctly documented and available to appropriate health care providers
- Maintains confidentiality

Have our member sign a Medical Record Release Form as a part of their medical record. Contact Network Management Services, **1-877-670-8432**, to request a copy of this form. The member should sign a Refusal Form when declining a preventative screening referral.

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 disorder services or potential chronic medical conditions that may affect the member's plan benefits are subject to additional specific waivers for release and confidentiality

Exemption from release requirements

HIPAA regulations allow us to give PHI to government programs without member permission. This is given to determine member eligibility.

Medical records requirements

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

Patient identifiers: Consist of the patient name and a second unique identifier; they should appear on each page of the medical record.

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

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

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

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

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

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

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

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

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

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

Required encounter documentation: For every visit, document the following:

- Date
- Chief complaint or purpose
- Objective findings

- Diagnosis or medical impression
- Studies ordered (X-rays, etc.)
- Therapies administered or ordered
- Education provided, disposition, recommendations or instructions to the member and evidence of whether there was a follow-up
- Outcome of services

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

We recommend that medical records include copies of care plans whenever you provide home health or skilled nursing services.

Case management and disease management program information

Optum provides case management (CM) and disease management (DM) services for Preferred Care Partners.

Here are the criteria for referrals to Optum CM and DM Programs:

- **Complex case management – (Special Needs Plan [SNP] members only)**
  - 3 or more unplanned admissions and/or emergency room (ER) visits in the past 6 months
  - Multiple, complex co-morbid conditions
  - Coordination of multiple community resources/financial supports to cover basic services
- **Heart failure (HF) disease management program**
  - Diagnosis of HF
  - Has CHF on an inpatient claim
  - HF admission in last 3 months
- **Diabetes disease management program**
  - Diabetic with A1C 9% or greater
  - An inpatient admission related to diabetes in the past 12 months
  - 2 or more ER visits related to diabetes
- **Advanced illness case management** – the primary goal is to facilitate and support end-of-life wishes and services
  - Life expectancy of 12–18 months
  - Chronic, irreversible disease or conditions and declining health
  - Reduce disease and symptom burden
- **Transplant case management and network services**
  - Bone marrow/stem cell, including chimeric antigen receptor T-cell (CAR-T) therapy for certain hematologic malignancies, kidney and kidney/pancreas, heart, liver, intestinal, multi-organs and lung transplants
  - Case management for 1 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. Direct your patient to their local social services department or the Florida State Department of Elder Affairs Help Line at 1-800-963-5337.

To request CM or DM services for one of our members, select only 1 program based on the program criteria that most closely matches the member's medical condition. Then submit the CM/DM referral form, available on **mypreferredprovider.com**, to **southfl@optum.com**.

Behavioral health care programs

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

Special needs plans

Special Needs Plans (SNP) model of care (MOC)

The MOC is the framework for care management processes and systems to help enable coordinated care for SNP members. The MOC contains specific elements that delineate implementation, analysis and improvement of care.

These elements include a description of SNP population (including health conditions), Care Coordination, Provider Network and Quality Measurement and Performance Improvement.

The MOC is a quality improvement tool, and MOC helps ensure the unique needs of our SNP members are identified and addressed through care management practices. MOC goals are evaluated annually to determine effectiveness. To learn more, contact us by email at: **snp_moc_providertraining@uhc.com**.

The Centers for Medicare and Medicaid (CMS) requires initial and annual SNP MOC training for all health care providers who treat SNP members. The Annual SNP MOC Provider Training is available at **UHCprovider.com**. We communicate updates about the training requirements annually on **UHCprovider.com/news**. Learn more about provider news in **Chapter 18: Provider communication**.

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, health 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 health 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 health care providers.

For more information, go to the AHCA website at ahca.myflorida.com.

Health care provider reporting responsibilities

You are required to report all adverse events as identified in previous sections, whether actual or potential. To report such incidents, call 1-952-406-4806.

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

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

Health care provider contracts include the obligation to participate in quality management inquiries upon request.

What are the responsibilities of physicians and health care providers?

You must report the ICD-10-CM diagnosis codes to the highest level of specificity and accuracy. 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 Jan. 1 of each year. CPT and HCPCS codes may be added, deleted or revised to reflect changes in health care and medical practices.

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

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

River Valley entities supplement

Information regarding the use of this supplement

This supplement applies to covered services rendered to River Valley entities members. This supplement does not apply to Medicare Advantage, Medicaid or CHIP benefit plans.

It also applies to health care providers who have the following:

1. A UnitedHealthcare Agreement with one of the following:
   - A reference to the River Valley or John Deere Health protocols or guides
   - A direct contract with 1 or more River Valley entities that participate in River Valley entities networks
2. Location in Arkansas, Georgia, Iowa, Tennessee, Virginia, Wisconsin 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 the member's ID card (bottom left).

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

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

For policies and procedures relating to the TennCare and Secure Plus Complete Medicaid Plans, refer to the UnitedHealthcare Community Plan administrative guides available on **UHCprovider.com/guides**.

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 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 plan identification (ID) cards** in **Chapter 2: Provider responsibilities and standards**, for more information about ID cards.

How to contact River Valley

Health care providers who practice in Illinois, Iowa and Wisconsin may refer to the Midwest references in the following grid. Health care providers who practice in Arkansas, Georgia, Tennessee and Virginia may refer to the Southeast references in the following grid.

Resource	Where to go
UnitedHealthcare provider website	**UHCprovider.com**
Cardiology Diagnostic catheterization electrophysiology implants echocardiogram Stress echocardiogram	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/cardiology** **Phone: 1-866-889-8054**
Case management/UM Initiate case management and UM	Congenital Heart Disease: Number on the back of the member's ID card Kidney Resource Services: Number on the back of the member's ID card Transplant Resource Services fax: 1-855-250-8157 Ventricular Assist Devices phone: **1-888-936-7246**, option 2
Claims (information and submissions)	**EDI:** Medical claims payer ID: 87726 Dental claims payer ID: 95378 **Online: UHCprovider.com** > Sign In > Claims & Payments **Information: UHCprovider.com/claims** **Phone: 1-866-509-1593**
Claims reconsiderations and appeals	**Online: UHCprovider.com** > Sign In > Claims & Payments Refer to the **Claim reconsideration and appeals process** section in **Chapter 10: Our claims process** for more information, or: **Fax:** 1-801-938-2100
Disease management	**Phone: 1-800-369-2704**, option 4 (Monday–Friday, 8 a.m.–4:30 p.m. CT) **Fax:** 1-866-950-7759, Attn: CMT Coordinator **Email: mailwebcdm@uhc.com**
Electronic Data Interchange (EDI) EDI Support	**Online: UHCprovider.com/edi** **Help: UHCprovider.com** > Our network > Contact us > Technical support for providers and staff **Phone: 1-800-842-1109** (Monday–Friday, 7 a.m.–9 p.m. CT)
Eligibility (member)	**EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse **Online: UHCprovider.com** > Sign In > Eligibility **Information: UHCprovider.com/eligibility**

Resource	Where to go
Eligibility for: • End-of-life care • Home health care • Infusion services (prior authorizations)	**Online:** **UHCprovider.com** > Sign In > Eligibility Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. **Mail:** UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive Moline, IL 61265
Inpatient admissions (notifications)	**EDI:** Transactions 278N **Online:** **UHCprovider.com** > Sign In > Eligibility Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Mental health/substance use disorder **Vision** **Transplant services**	Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
Optum Pay	**Online:** • **UHCprovider.com/optumpay** • **optum.com/optumpay** • Optum Pay in the UnitedHealthcare Provider Portal **Help Desk: 1-877-620-6194**
Pharmacy services/prescription drugs requiring preauthorization	**Online:** **UHCprovider.com/pharmacy** or **professionals.optumrx.com** **Phone Optum Rx: 1-800-711-4555** **Urgent Pharmacy Appeal fax:** 1-801-994-1058
Prior authorization Including preauthorization for certain DME. See cardiology, radiology, inpatient admissions and end-of-life care for specific contact information	**EDI:** See EDI transactions and code sets on **UHCprovider.com/edi**. We accept EDI 278 submissions directly to UnitedHealthcare or through a clearinghouse. **Online:** **UHCprovider.com** > Sign In > Prior Authorizations Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**. **Information:** **UHCprovider.com/priorauth**
Appeals (urgent)	**Fax:** 1-801-994-1058 (urgent appeals only)

Resource	Where to go
Radiology/advanced outpatient imaging procedures CT scans MRIs MRAs PET scans and nuclear medicine studies, including nuclear cardiology	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/radiology** **Phone: 1-866-889-8054**
Skilled/extended care	**Online: UHCprovider.com** > Sign In > Prior Authorizations Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.
TIN/provider ID numbers	**Phone: 1-866-509-1593** or email **rvitedisolutions@uhc.com**
United Voice Portal (Provider Services)	Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Use the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In to perform secure transactions, check member eligibility and benefits, and manage claims and prior authorization requests.

Reimbursement policies

Claim payment is subject to reimbursement policies on **UHCprovider.com/policies** > For Commercial Plans > **Reimbursement Policies for UnitedHealthcare Commercial Plans**. Claims Estimator tools are not available for River Valley members.

We will inform you of changes to these policies on **UHCprovider.com/news**.

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

Referrals

Network referrals

Primary Care Coordinator Plans (PCC Plans) do not require a referral.

Out-of-network referrals

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

Out-of-network referral approval

A referral to an out-of-network provider must be approved by us before the services are rendered. We must also give prior approval for modified or expired out-of-network referrals as described in this supplement. We may approve an out-of-network referral when services are needed but not available from a participating health care provider. Prior approval of an out-of-network 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 out-of-network referral is necessary under a member's benefit plan, contact us at the number on the back of the member's ID card.

Refer to the section **Nonparticipating health care providers (all commercial plans)**, in **Chapter 6: Referrals**, for more instructions.

- We will make decisions within the time frames required by state and federal law (including ERISA) and in accordance with NCQA standards
- We will send a letter confirming our approval or denial of a referral to the member and your office

If a member requests approval after the fact, advise them this is against policy. Ask them to connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Participating health care providers may not refer their own family members to nonparticipating physicians/facilities due to conflict of interest. If the health care provider denies a referral, the health care provider must refer the member to their benefit document for any appeal rights, or have them connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

Utilization Management (UM)

The term prior authorization is also referred to as preauthorization.

Our UM Program has several parts. These include but are not limited to:

- Preauthorization for various procedures, medical services, treatments, prescription drugs and DME
- Review of the appropriateness of inpatient admissions and ongoing inpatient care coverage
- Prior approval for referrals to nonparticipating health 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 health care provider.

Health 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 and drug policies

River Valley uses the UnitedHealthcare Medical Policies and Medical Benefit Drug Policies on **UHCprovider.com/policies** > For Commercial Plans > **Medical & Drug Policies for UnitedHealthcare Commercial Plans**.

For more information refer to **Medical and drug policies for commercial members** in **Chapter 7: 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 > **UnitedHealthcare of the River Valley Prior Authorization Requirements**.

Submit adequate clinical documentation

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

Refer to our Medical & Drug Policies for what information to provide.

How to request preauthorization

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

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

Preauthorization review hours of operation

Staff may review your preauthorization requests. Medical directors are available to discuss clinical policies or decisions. The office is closed for national holidays and the day after Thanksgiving. Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

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 health 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.

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

Facility utilization review

Notification of inpatient admission required

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

Facilities are responsible for admission notification even if advance notification was provided by the physician and coverage approval is on file.

Failure to notify

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

Inpatient review

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

Where appropriate, River Valley also uses InterQual 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 subacute medical, rehabilitation, 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, subacute 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 health care provider.

You may speak with our medical director within 1 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 prior authorization and notification of admission date to an 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 and discharge plan
- We authorize admission consistent with the level of care required based on the treatment plan

Concurrent review

- The skilled facility provider must provide appropriate documentation, including changes in the level of care
- Approval for additional days of authorized coverage must be obtained before the authorization expires
- Decisions about levels of care must consider not only the level of service but the member's medical stability
- Our medical director will speak with the physician managing the member in the skilled facility about disagreements concerning the level of care required. The member or authorized representative may request an appeal when coverage is not approved. We determine whether the admission, stay and care are covered and medically necessary based on the following clinical guidelines, among others:
  - Physicians must order services. The services must be necessary for treatment. They must align with the nature and severity of the illness or injury, medical needs and accepted medical practice standards. The member must be stable. Clinical and laboratory 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, 7 days a 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 5 days a week. Skilled services, however, are required and provided at least 3 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 health 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 is 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 out-of-network facility, is not medically necessary at the facility's level of care
- Preauthorization was not obtained for a procedure or service that needed it
- A medical director determines the member's condition is custodial and is not covered
- A medical director, upon consulting with the attending physician, determines continued acute inpatient rehabilitation/SNF level of care is no longer medically necessary, but the member refuses discharge
- The member has used all inpatient or skilled care benefits under their benefit plan. If a noncoverage 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 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 nonemergent/urgent services performed outside the network varies by benefit plan. Determinations on benefit coverage may include but are not limited to noncovered, covered at a lower benefit level or covered at the network level with a referral. Call Member Services if you have questions.

Special requirements DME

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

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

- 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 3-month supply list is on **UHCprovider.com/pharmacy**.
- River Valley's 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 (i.e., sleep lab versus 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 preauthorization contact information.

Transplants

- We require preauthorization for transplants. Call the Optum transplant case manager at **1-888-936-7246**. They will request medical records to see whether the transplant is appropriate for a member. We send all information to a physician expert in the related transplantation field for review.
- If authorized, the case manager coordinates referrals and helps select a transplant center based on the member's needs. They also provide information about our transplant management program.
- If a transplant candidate needs home care or is involved with a participating center, the transplant care manager will arrange service
- Any post-transplant lab or pathology that cannot be performed or interpreted by a network physician may be sent to the transplant center for interpretation. Tell the transplant case manager if you need help making arrangements. Most of these services are covered under the transplant contract. The transplant center should be involved in the member's continuing care.

Post-transplant care

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

End-of-life care

Some members have end-of-life care benefits, which may include hospice services. These services require preauthorization. Approved care is coordinated by our care managers.

Claims process

EDI

Use EDI to submit claims and conduct other business with us electronically. To enroll, call EDI customer service at **1-866-509-1593**, 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 and 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, was 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.

Electronic claims submission and billing

We require you to submit claims electronically. For electronic claims submission requirements, refer to **Requirements for complete claims and encounter data submission** section in **Chapter 10: 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**.

Special rules for electronic submission

- **Corrected claims** must include the words corrected claims in the notes field. Your software vendor may help you with correct placement of all notes.
- **Unlisted procedure code claims** must include details in the notes field. If you cannot, you must submit a paper claim.
- **Claims for occupational therapy, speech therapy, physical therapy, dialysis and mental health or substance use disorder services** must have the date of service by line item. We do not accept span dates for these types of claims.
- **Secondary COB claims** must include the following fields:
  - **Institutional:** Payer Prior Payment, Medicare Total Paid Amount, Total Noncovered 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 health 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 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	Nonroutine Dialysis
305	Hematology
306	Bacteriology & Microbiology
307	Urology
309	Other Laboratory
310	Laboratory-Pathology (General Classification)
311	Cytology
312	Histology
319	Other Laboratory Pathological

Revenue codes requiring CPT® and HCPCS codes	
320	Radiology-Diagnostic (General Classification)
321	Angiocardiography
322	Arthrography
323	Arteriography
324	Chest X-Ray
329	Other Radiology-Diagnostic
330	Radiology-Therapeutic and/or Chemotherapy Administration (General Classification)
331	Chemotherapy Administration-Injected
332	Chemotherapy Administration-Oral
333	Radiation Therapy
335	Chemotherapy Administration-IV
339	Other Radiology-Therapeutic
340	Nuclear Medicine (General Classification)
341	Diagnostic Procedures
342	Therapeutic Procedures
350	CT Scan (General Classification)
351	CT-Head Scan
352	CT-Body Scan
359	CT-Other
360	Operating Room Services (General Classification)
361	Minor Surgery
362	Organ Transplant-Other Than Kidney

Revenue codes requiring CPT® and HCPCS codes	
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
483	Echocardiology
489	Other Cardiology
490	Ambulatory Surgical Care (General Classification)
499	Other Ambulatory Surgical Care

Revenue codes requiring CPT® and HCPCS codes	
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

Revenue codes requiring CPT® and HCPCS codes	
922	Electromyogram
923	Pap Smear
924	Allergy Test
925	Pregnancy Test
929	Additional Diagnostic Services

Revenue codes requiring CPT® and HCPCS codes	
940	Other Therapeutic Services General Classification)
941	Recreational Therapy
942	Education/Training (Diabetic Education)
949	Other Therapeutic Services (HRSA-approved weight loss providers)

Claim reconsideration and appeals process and resolving disputes

Refer to **Claim reconsideration and appeals process** in **Chapter 10: Our claims process** and in the **How to contact RiverValley** section of this supplement.

If you have a question about a preservice appeal, see **Preservice appeals** in **Chapter 7: Medical management**.

Student Resources supplement

UnitedHealthcare is dedicated to helping people live healthier lives and making the health system work better for everyone. To that end, UnitedHealthcare Student Resources (UHCSR) offers a single solution aligned to meet higher education's diverse and complex health care benefits and objectives for their domestic and international student population.

Applicability of this supplement

You are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location. Refer to the main guide for anything not found in this supplement.

How to contact Student Resources

Resource	Where to go	Requirements and notes
UnitedHealthcare Provider Portal	**Online:** UHCprovider.com > Sign In **Phone:** 1-888-224-4875 **Real-time eligibility (270/271):** 74227 **Real-time claim status (276/277):** 74227	Verify Student Resources member eligibility, benefits and claims status in the United Healthcare Provider Portal or UHCSR Customer Service.
Claims submission	**Electronic claims submission** Payer ID: 74227 **Paper claims submission** Mail to the address listed on the back of the member's ID card.	Send claims directly to Student Resources payer ID 74227. Always include the subscriber ID and rendering address on the claim. • One of the most common billing errors is easy to correct – inaccurate payer ID or mailing address for paper claims • Claims should be submitted to Student Resources with the Student Resources payer ID, not to UnitedHealthcare with the UnitedHealthcare payer ID

Resource	Where to go	Requirements and notes
Prior authorization and notification	**Pre-determinations submission** You need to submit medical records with all the appropriate diagnosis and procedure codes. **Email:** customerservice@uhcsr.com **Fax:** 1-469-229-5510	To service our members and expedite care, Student Resources' policies do not require the same prior authorizations as many of the UnitedHealthcare commercial plans. We recommend a pre-determination for the following covered medical services that have criteria that must be met or to establish medical necessity. **Gender dysphoria treatment** **UnitedHealthcare Commercial Medical Policy for Gender Dysphoria Treatment** **Infertility** Please see the policy brochure for all infertility criteria and benefits. **Bariatric surgery** **UnitedHealthcare Commercial Medical Policy for Bariatric Surgery** **Medical drug review** Please contact customer service at **1-888-224-4875** to inquire if the drug prescribed needs a medical review. **Physiotherapy** Most policies require concurrent review after 12 visits. Please check each policy for any limitations You can access the criteria for these services at **UHCprovider.com** > Resources > Health plans, policies, protocols and guides > For Commercial Plans > **Medical & Drug Policies for UnitedHealthcare Commercial Plans**

Our claims process

Follow these steps for fast payment:

1. Prepare a complete and accurate claim form according to UnitedHealthcare guidelines. Be sure to include subscriber ID and accurate rendering address on all submissions.
2. Submit electronic claims using payer ID 74227. Submit paper claims to the address listed on the back of the member's ID card.
3. For contracted health care providers who submit electronic claims and would like to receive electronic payments and statements use the sign up link below to enroll with Optum Pay. You will need to upload a copy of your W-9

form and a voided check or bank letter for the account where the payments will be deposited. If you don't have a W9 available, there is a link on the site to download a copy. The process takes a few weeks to verify your bank information. Once complete payments will be sent via EFT.

Sign up

User guide for enrolling

There are 2 options for receiving electronic payments:

- **Option 1: ACH basic – free**
  This portal experience includes:
  - Access to 13 months of payment data
  - Online access to detailed remittance information in the form of downloadable PRAs and 835 files for each payment processed through Optum Pay
  - 2 portal users and the ability to associate a third-party billing service to aid in claim management efforts
  - Payment and remittance notification emails to support timely reconciliation of new claim payments
- **Option 2: ACH premium – 0.5% per payment fee**
  This portal experience includes all the features of basic, plus:
  - Access to the Optum Pay portal for an unlimited number of users
  - Enhanced practice management features to quickly identify new payments and payments pending reconciliation as well as the ability to identify and mark payments fully reconciled
  - Up to 36 months of expanded claims payment data to search for and identify the data you need, plus a quick view of the number of claims consolidated within a payment
  - Access to data aggregation tools, eliminating individual data file downloads

Claim reimbursement (adjustments)

If you think your claim was processed incorrectly, call UHCSR Customer Service at **1-888-224-4875**. If you find a claim where you were overpaid, send us the overpayment within 30 calendar days. If we find a claim was overpaid, payment is due within 30 calendar days.

If you disagree with our decision regarding a claim adjustment, you may appeal.

Claim reconsideration, appeals and disputes

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

How to submit your reconsideration or appeal

For claim reconsiderations (pricing or other), you can submit one of the following ways:

Email: customerservice@uhcsr.com

Mail: UnitedHealthcare Student Resources
Attn: Claims
P.O. Box 8098025
Dallas, TX 75380

Fax: 1-469-229-5510

Please remember to send to the attention of a person you have spoken to, if applicable.

For clinical appeals (pre-determination or other), you can submit one of the following ways:

Email: customerservice@uhcsr.com

Mail: UnitedHealthcare Student Resources
Attn: Appeals
P.O. Box 8098025
Dallas, TX 75380

Fax: 1-469-229-5510

You must submit all supporting materials to the appeal request, including member-specific treatment plans or clinical records. Please note: Clinical appeals are only for services that received a medical necessity review and were determined to lack medical necessity.

What to submit

As the health care provider of service, you submit the dispute with the following information:

- Member's name and health plan 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

Notice to Texas health care providers

To verify Student Resources members' benefits, call the number on the back of the health plan ID card.

As an affiliate of UnitedHealthcare, Student Resources uses the UnitedHealthcare medical policies as guidance. These policies are available on **UHCprovider.com/policies**.

Notification does not guarantee coverage or payment (unless mandated by law). We determine the member's eligibility. For benefit or coverage information, call the phone number on the back of the health plan ID card.

Surest supplement

Surest, a UnitedHealthcare company, offers fully-insured, self-funded and level-funded health plans with an innovative and personalized benefit design. Surest plans have neither deductibles nor coinsurance. Members, who have access to the UnitedHealthcare and Optum networks, can check costs and care options in advance. In addition, some plans have a feature called flexible coverage. This means – for a small set of plannable, non-emergent procedures or treatments – the member must activate coverage at least 3 business days in advance, and this coverage is active for 120 days. Providers are encouraged to check eligibility to verify this coverage in advance.

Applicability of this supplement

You are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location.

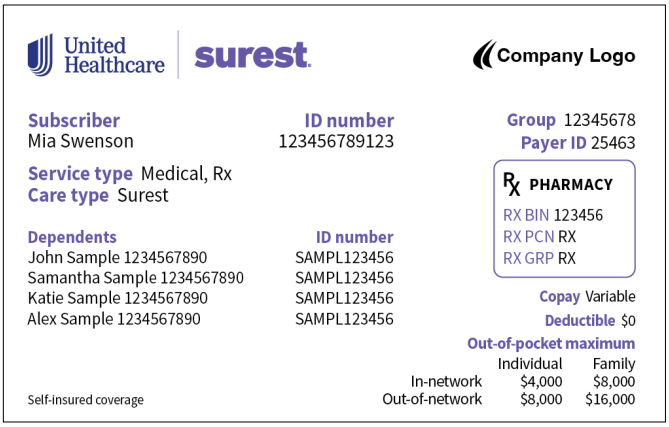
Surest plan resources

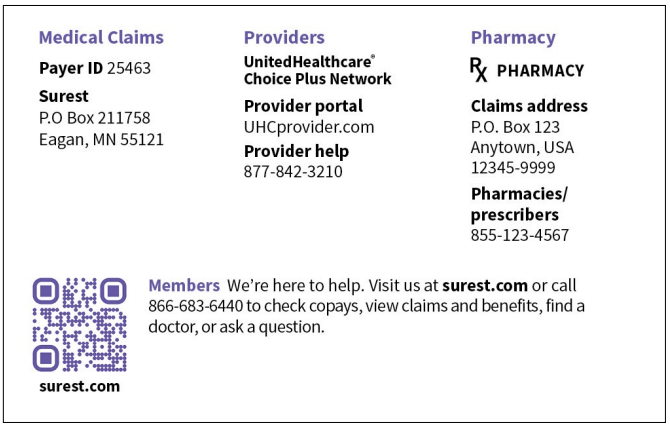
Benefit and eligibility	Where to go	Requirements and notes
UnitedHealthcare Shared Services (UHSS) and UnitedHealthcare Provider Portal	**Online:** UHCprovider.com > Sign In **Chat:** UnitedHealthcare Provider Portal **Information:** surest.com/providers UHCprovider.com/surest **Real-time eligibility (270/271):** 25463 and/or Surest	Verify Surest member eligibility and benefits with the UnitedHealthcare Provider Portal, EDI, Provider Services or chat live with an advocate from 7 a.m.–7 p.m. To enable Surest copay information through EDI, please follow the guide found here: **270/271 EDI Surest Guide**.
Claims submission	**Electronic claims submission** Payer ID: 25463 **Paper claims submission** Mail to the address listed on the back of the member's ID card.	Send claims directly to Surest payer ID 25463. Always include the subscriber ID and rendering address on the claim. This confirms the copay/member price. If not included, the copay/member price may be incorrect from what was originally quoted. One of the most common billing errors is easy to correct – inaccurate payer ID or mailing address for paper claims.

Resource	Where to go	Requirements and notes
Prior authorization and notification	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Chat: UnitedHealthcare Provider Portal** **Information:** • **surest.com/providers** • **UHCprovider.com/surest**	Prior authorization and notification is required as described in **Chapter 7: Medical Management**, except for Flexible Coverages that must be activated in advance. In an outpatient setting, Surest Flex does NOT require prior authorization for procedures requiring activation. However, consistent with UnitedHealthcare concurrent review guidelines, if the procedure is done in an inpatient setting, pre-admission notification is required. We recommend that you submit advance notification with supporting documentation as soon as possible, but at least 2 weeks before the planned service (unless the Advance Notification Requirements state otherwise). Just because a service does not require prior authorization, it does not mean that a service is covered. Verify Surest member eligibility and benefits with the UnitedHealthcare Provider Portal, EDI, Provider Services or chat live with an advocate from 7 a.m.–7 p.m.
Claim status	**Online: UHCprovider.com** > Sign In > Claims & Payments **Chat: UnitedHealthcare Provider Portal**	Please enter subscriber ID when prompted. For dependents, you will still enter subscriber ID.

Surest health plan ID card

Surest members receive health plan ID cards with information that helps you submit claims. The cards list the claims address, provider portal information and phone numbers. Sample member ID card for illustration only; actual information varies depending on payer, plan and other requirements.





Our claims process

Follow these steps for fast payment:

1. Prepare a complete and accurate claim form according to UnitedHealthcare guidelines. Be sure to include subscriber ID and accurate rendering address on all submissions.
2. For Surest plan members, submit electronic claims using payer ID 25463. Submit paper claims to the address listed on the back of the member's ID card.
3. For contracted health care providers who submit electronic claims and would like to receive electronic payments and statements, call Optum Financial Services at **1-877-620-6194** or go to **optumbank.com** > Partners > **Providers**.

How to submit your appeal

You can submit one of the following ways:

Mail: Surest Appeals
P.O. Box 31270
Salt Lake City, UT 84131

Urgent appeal fax line: 1-866-748-7304

Non-urgent appeal fax line: 1-866-748-7820

You must submit all supporting materials to the appeal request, including member-specific treatment plans or clinical records.

Still have questions?

Go to **UHCprovider.com/surest** for more information about Surest.

UMR supplement

Applicability of this supplement

UMR is a wholly owned subsidiary of UnitedHealthcare, a part of UnitedHealth Group. UMR is a third-party administrator (TPA) and not an insurance company. UMR delivers solutions for self-funded employer groups to ensure claims are paid correctly according to the member's benefit plan. In addition to offering self-funded employer groups access to the UnitedHealthcare networks, UMR is a full-service TPA with a range of capabilities and solutions from medical claim administration to stop loss coverage and pharmacy benefits administration, to proprietary care management and wellness programs. UMR has a proprietary claims platform with dedicated customer service.

UnitedHealthcare Shared Services (UHSS) is a unique service model that allows plan sponsors who self-administer their benefit plans or already have a TPA, to access the UnitedHealthcare network and clinical programs. UHSS is NOT a leased network arrangement. It is a partnership between the customer/plan administrator and UnitedHealthcare designed to meet the needs of the customer and member.

You are subject to both the UnitedHealthcare Care Provider Administrative Guide and this UMR supplement. This supplement supersedes the main guide if there is conflicting information. If there are additional protocols, policies or procedures online, we will direct you to that location when applicable. For protocols, policies and procedures not referenced in this supplement, refer to the appropriate chapter in the main guide.

How to contact UMR

Contact area	Where to go
Claims, benefits and eligibility	**Online:** umr.com **Phone:** Call the number listed on the back of the member ID card or call **1-877-233-1800** **Mail:** Use the address listed on the back of the member ID card **For UHSS:** Contact information is listed on the back of the member ID card uhss.umr.edu **Online:** uhss.umr.com
Appeals (preservice)	**Mail:** UHC Appeals – CARE P.O. Box 400046 San Antonio, TX 78229 **Online:** umr.com **For UHSS:** **Mail:** P.O. Box 400046 San Antonio, TX 78229

Contact area	Where to go
Reconsiderations and appeals (post-service)	**Mail:** UMR - Claim Appeals P.O. Box 30546 Salt Lake City, UT 84130-0546 (or send to the address listed on the provider ERA) **Online:** umr.com **Phone:** Call the number listed on the back of the member ID card **For UHSS:** **Mail:** P.O. Box 30783 Salt Lake City, UT 84130-0783
Electronic Data Interchange (EDI)	See the back of the member ID card for the payer ID
Forms	**Online:** umr.com
Prior authorization (request for clinical decision, including inpatient admission notification, advance notification or medical specialty injectable drug/ medication)	**Prior Authorization serviced by UMR** **Online:** Get Prior Authorization | Portal (umr.com) **Phone (only where telephonic submission is permitted):** Call the number listed on the back of the member ID card. Contact information is listed on the back of the member ID card. **Online:** uhss.umr.com
Pre-determination	**Online:** provider.umr.com **Mail:** UMR P.O. Box 8033 Wausau, WI 54402-8023 **For overnight mail delivery:** UMR 115 W. Wausau Avenue Wausau, WI 54401
Overpayment/refund	**Regular mail:** UMR P.O. Box 8033 Wausau, WI 54402 **Overnight mail:** UMR 115 W Wausau Ave Wausau, WI 54402 **For UHSS:** UHSS P.O. Box 30783 Salt Lake City, UT 84130-0783
Pharmacy or specialty pharmacy	**Phone:** Call the number listed on the back of the member ID card

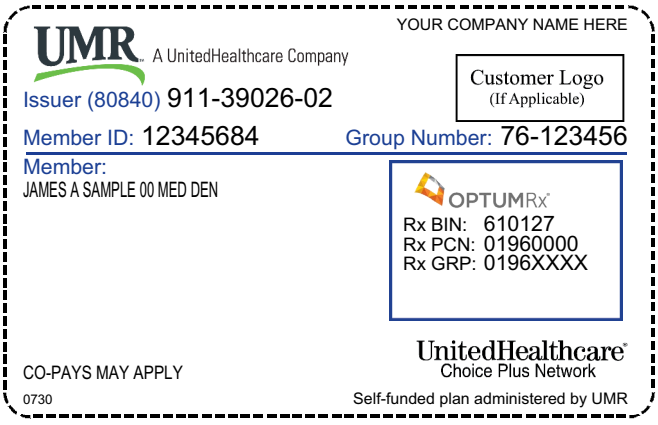
Contact area	Where to go
Online technical support for umr.com	**Phone: 1-866-922-8266** **For UHSS:** Contact information is listed on the back of the member ID card
Medical record/itemized bill submission	**Fax:** Use fax number noted on the medical record/itemized bill request letter **Mail:** Use address noted on the medical record/itemized bill request letter
UnitedHealthcare provider pricing and participation disputes	**Phone: 1-844-598-7538** **Mail:** UMR United Provider Advocacy Team P.O. Box 30546 Salt Lake City, UT 84130-0546
Electronic Funds Transfer (EFT) vendors	Optum Financial Health **Optum Pay** **Phone: 1-877-620-6194** **Online: myservices.optumhealthpaymentservices.com** **Vpay** **Phone:** 1-888-704-0096 **Email:** support@vpayusa.com **Zelis** **Phone:** 1-877-828-8770 **Online:** zelis.com **ECHO** **Phone:** 1-800-895-0621 **Online:** providerpayments.com

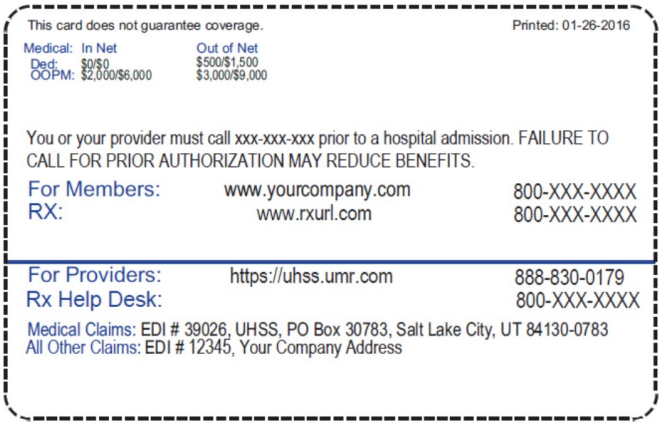
Health plan identification cards

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

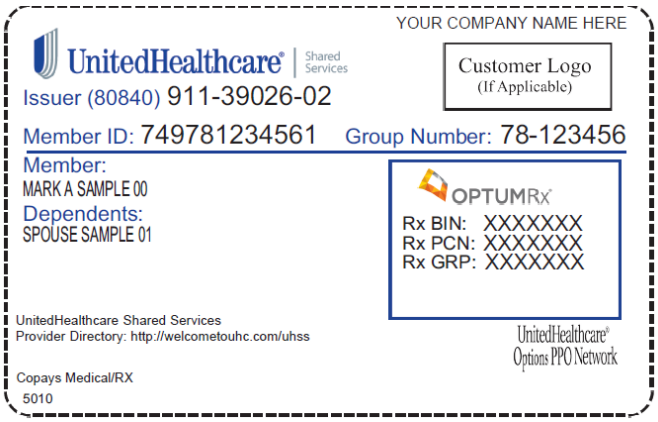
Check the member's ID card at each visit. You may keep a copy of both sides of the ID card for your records. Having a health plan ID card is not proof of eligibility and is not considered a guarantee of benefits.

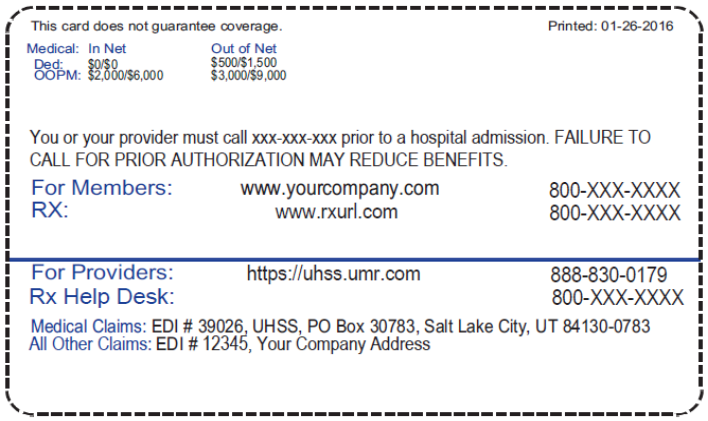
UMR ID card sample





The primary network(s) can be found on the front of the ID card.





UHSS cards may vary depending on customer.

The member ID cards do not specify which service requires prior notification. However, they include information to begin the notification process. (See previous sample ID card.) The care management vendor phone number is on the back of the ID card. Use this number to initiate authorization and notification.

Prior authorization and notification requirements

UMR prior authorizations and/or notifications must be submitted online at **Get Prior Authorization | Portal (umr.com)**. UMR prior authorization capabilities are not available on the UnitedHealthcare Provider Portal.

We may refer to the terms preauthorization, prior authorization or precertification in the supplement and in our resources. These terms are used interchangeably.

Advance notification/prior authorization requirements

Services requiring advance notification and prior authorization vary by plan and can change. Services requiring prior authorization require a clinical coverage review based on medical necessity.

Advance notification/prior authorization requirements are available at **Get Prior Authorization | Portal (umr.com)** through a lookup feature best used in the Google Chrome web browser. You can view the most up-to-date plan-specific requirements. You must have the member's ID card to obtain accurate information.

How to submit advance notification or prior authorization requests

The UnitedHealthcare prior authorization and notification tool does not access UMR membership. Instead, you may submit an advance notification or prior authorization in 1 of 3 ways, all of which require the member's ID card:

- **Online: Get Prior Authorization | Portal (umr.com)**
- **Phone (only where telephonic submission is permitted):** Call the number listed on the back of the member ID card
  - After submitting a request, you will be given a request reference number. This is not a determination. When we make a coverage decision, we will issue the decision under the same request number.
  - For UHSS, call the number listed on the back of the member ID card

Clinical request forms

Some clinical requests for predetermination or prior authorization (i.e., spinal surgery or genetic testing) require specific forms that you must submit with the request. Find clinical request forms at **umr.com** > Provider > **Find a Form**.

Updating advance notification or prior authorization requests

Before services are rendered, you may make certain updates to your notification/prior authorization request, depending on the status of the request and whether the service date has passed.

You may request an update at **umr.com** or call the number provided on the member's ID card.

Clinical trials, experimental or investigational services

Evaluations, tests and consultations coverage varies by plan. You must confirm benefit eligibility by calling the number on the back of the member ID card.

Pharmacy and specialty pharmacy benefits

Pharmacy and specialty pharmacy vendors vary by UMR customer. You must confirm benefit eligibility by calling the number on the back of the member ID card. Coverage may be available under the medical benefit plan or the pharmacy benefit plan.

Specific protocols

Benefits vary by UMR customer. For example, nonemergent ambulance transportation may not have the same protocols to determine coverage. You must confirm the benefit eligibility by calling the number on the back of the member ID card.

Our claims process

UMR/UHSS claims, benefits and eligibility are not available on **UHCprovider.com**. Refer to the **How to contact UMR** section of the UMR supplement for tools and resources.

UMR

- **Online:** umr.com
- **Phone:** Call the number listed on the back of the member ID card or call **1-877-233-1800**
- **Mail:** Use the address listed on the back of the member ID card

For UHSS

Contact information is listed on the back of the member ID card.

Overpayments for UMR

If we inform you of an overpaid claim that you do not disagree with, send us the refund check within 30 calendar days (or as required by your Agreement) from the date of notification.

We may apply the overpayment against future claim payments, unless your Agreement states otherwise. If an overpayment is eligible for recoupment, UMR will attempt to recoup the overpayment for 120 days. If recoupment is unsuccessful, there is no activity within 120 days, or the customer and/or health care provider opted out of the recoupment process, the overpayment will be sent to Payment Resolution Solutions for recovery assistance. In some situations, we may handle overpayment recoveries internally, or the customer may use their own overpayment vendor for recoveries. If you identify an overpaid claim, send the refund along with the Overpayment Refund/ Notification Form to the following address:

UMR
P.O. Box 8033
Wausau, WI 54402-8033

For overpayment questions, call **1-877-233-1800** or the customer service number listed on the back of the member ID card.

Claim reconsideration and appeals process

If you disagree with the outcome of a processed claim (payment, correction or denial), you can complete the Claim Reconsideration Request Form and check "Previously denied/closed for additional information" as your reason for request.

Include the following information on the form to prevent processing delays:

- Member name
- Member ID number
- Date of service/claim information
- Provider name, address and TIN
- All supporting materials to the request, including member-specific treatment plans or clinical records. The decision is based on the materials you provide.

UMR

Online: **umr.com** > Provider > **Claim appeal submission**. Follow prompts for submitting the inquiry.

Mail: UMR - Claim Appeals
P.O. Box 30546
Salt Lake City, UT 84130-0546

(or send to the address listed on the provider RA)

Phone: Call the number listed on the back of the member ID card.

For UHSS

Mail: UHSS
P.O. Box 30783
Salt Lake City, UT 84130-0783

Health and disease management

Care management programs (CARE) vary by UMR customer. Locate a list of a member's programs at **umr.com** using the information on the member ID card.

Frequently asked questions

What are the timely filing requirements for UMR?

Timely filing requirements are determined by the self-funded customer, as well as the provider-contracted timely filing provisions. You must file the claim within the timely filing limit, or it may be denied. If you dispute a claim that was denied due to timely filing, you must submit proof that you filed the claim within the timely filing limits. Timely filing limits can vary based on your contract and/or the self-funded benefit plan.

What are the major differences between customer benefit plans serviced by UMR?

Our process is similar to UnitedHealthcare. As a TPA, we work to customize the health care needs of the customer. Differences include the types of services selected as part of the administration and the level of benefits at which covered services are processed. Examples of services available include medical and dental claim administration, a flexible spending account (FSA), pharmacy benefits manager, stop loss carriers, vision plans, care management, case management, utilization management and disease management.

Can I access a list of UMR denial codes and definitions?

UMR uses the American National Standards Institute (ANSI) denial codes and definitions.

If I mistakenly call UnitedHealthcare customer service for UMR or UHSS-related issues, will they transfer me to the correct service agent?

We have a dedicated customer service line. UnitedHealthcare cannot transfer these calls.

What is the customer service number for physicians, facilities and other health care professionals to call for eligibility, benefits and follow-up on claim issues?

Our Interactive Voice Response (IVR) system number is **1-877-233-1800**. The IVR system offers information via faxback. If you have additional questions, the faxback contains a passcode and number to call to speak with a representative.

Our web portal, **umr.com**, is a convenient resource for accessing claim information. The site also includes the phone number and passcode you can use to speak with a representative.

How do I obtain a passcode on umr.com to speak with a representative?

Sign into **umr.com** > Enter in the member ID number > Select the family member > Select Summary view > Select Search.

Go to Need additional information on this member? > Select Provider service center and the passcode will be provided.

Call **1-877-233-1800**, follow the prompts and enter the passcode to speak with a representative.

For UHSS, refer to the back of the member ID card for contact information.

How do I access online resources for UMR members?

Go to **umr.com**. On the first visit, you will need to register all your tax identification numbers (TINs).

This website is an efficient way to check claim status, obtain benefits and much more. Be sure **all** TINs used are registered. If you are having trouble registering, you can contact Technical Support at **1-866-922-8266**.

Note: This is a secure website for UMR member claim and benefit information.

What types of forms are available on umr.com?

The following forms can be found on **umr.com**:

- Prior authorization
- Dental claim
- Remittance advice
- Itemized statement
- Preservice appeals designation of authorized representative
- Various clinical request forms

If I only have a member's Social Security number, will I be able to verify member information online?

Yes. You can search using the employee's Social Security number, and the results will include the member's unique health care ID number. Due to HIPAA requirements, UMR will not show the Social Security number online.

Can UMR customer service representatives make claim adjustments over the phone?

Yes. UMR Customer First Representatives (CFRs) can address claim adjustments over the phone, depending on the claim details. CFRs cannot change a claim if inappropriate modifiers or CPT/HCPCS codes are listed. Such issues require a resubmission of the claim with corrected codes from the servicing health care provider.

Note: CFRs cannot advise you on how to bill

How do I know what network the member uses?

The primary network(s) are listed on the front of the ID card.

How can I check a claim status?

Visit **umr.com** or call **1-877-233-1800**.

For UHSS visit **uhss.umr.com** or contact the number listed on the back of the ID card.

If a payment is not received, how can I request a check tracer?

We can initiate the check tracer process 30 days after the check was issued. After the check tracer has been initiated, we work with the employer group to verify if the check has been cashed. This process can take up to an additional 30 days.

A claim denied for medical records. What are the next steps?

Return the letter request with the medical records. This will ensure the records are routed to the correct department for review and prevent any potential delays. Do not re-submit the original claim with the medical records.

Medical records can be submitted using the following 3 options:

Online: Refer to online portal at **umr.com**.

Fax: Use the fax number noted on the request letter.

Mail: Use the mailing address noted on the request letter.

For UHSS: Follow directions provided in the initial adverse determination letter.

What should I do if a claim denied as a duplicate to a Medicaid claim?

Medicaid is responsible for billing UMR for reimbursement of what was previously paid to the provider.

If Medicaid returns the UMR payment, we can reconsider your claim at that time. UMR customer plan provisions will apply.

Where can I go on the website to display refund tracking?

Sign in to **umr.com** > Select Refund tracking under myMenu > Enter the Financial Control Number (FCN).

All FCNs must be 11 digits long. The FCN is located on the remittance advice.

If I did not receive a remit with the paper check, what should I do?

Sign in to **umr.com** > Select Advanced claims under myMenu > Select Check number > Enter the 10-digit check number > Enter the Group number > Select Search.

The results will show all claims paid on the given check. The remit is now available on **umr.com**. If the remit is not available, you may call the customer service number on the back of the ID card to request a copy of the remit.

What happens if I switched remittance advice delivery from paper to electronic or want to keep both options?

UMR will keep you on dual delivery of both for up to 6 months.

If you would like to stop the dual delivery, sign in to **umr.com** > Select Provider > Select Forms and select the Remittance Advice (RA) form.

Electronic funds transfer (EFT) and remittance advice (RA):

UMR Payer ID: 39026 (unless noted differently on the ID card).

EFT enrollment does not guarantee that all payments coming from UMR will be sent using this electronic option. EFT approval must also be received from UMR customer groups. UMR is a TPA paying claims from each customer's bank account.

Note: There is no charge to the provider to enroll in the EFT/RA process.

When UMR processes a claim, the check/EFT issue date will determine the date that the funds are sent to the electronic vendor. The electronic vendor will make a deposit into the provider's account. Please note that this time frame varies and could take up to

10 days after UMR sends the funds to the electronic vendor.

Note: The customer chooses which day of the week/month to release payment.

UnitedHealthcare FlexWork supplement

Applicability of this supplement

You are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location. Refer to the main guide for anything not found in this supplement.

How to contact FlexWork

Group Numbers 928276, 924699*

*Does not require prior authorization.

Resource	Where to go	Requirements and notes
Cardiology Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** UHCprovider.com/cardiology **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient cardiology prior authorization protocol** section of **Chapter 7: Medical management**.
Claims submission	**Online:** UHCprovider.com > Sign In > Claims & Payments **Payer ID:** 81400 **Paper claims submission:** Mail to the address listed on the back of the member's ID Card. **Information:** UHCprovider.com/claims	
Genetic and molecular testing	**Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** UHCprovider.com/priorauth > **Genetic and molecular testing**	
Outpatient injectable chemotherapy and related cancer therapies	**Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** UHCprovider.com/oncology **Phone: 1-888-397-8129**	Policies and instructions

Resource	Where to go	Requirements and notes
Pharmacy services	**Prior authorizations:** **1-800-711-4555** **Benefit information:** Call the number on the back of the member ID Card.	For information on the PDL, **myallsaversconnect.com**
Prior authorization and notification	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information:** **UHCprovider.com/priorauth** **Phone (only where telephonic submission is permitted):** **1-800-999-3404**	Prior authorization and admission notification is required as described in **Chapter 7: 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** > Sign In > Prior Authorizations **Information:** **UHCprovider.com/radiology** **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient radiology prior authorization protocol** section of **Chapter 7: Medical management**.

Health plan ID card

UnitedHealthcare FlexWork™ members receive health plan ID cards with information that helps you to submit claims. The cards list the claims address, copayment information and phone numbers.

A sample ID card and more information is in the **Health plan identification (ID) cards** section in **Chapter 2**.

Our claims process

Follow these steps for fast payment:

1. Notify UnitedHealthcare FlexWork
2. Prepare a complete and accurate claim form
3. For UnitedHealthcare FlexWork members, submit electronic claims using payer ID number 81400. Submit paper claims to the address on the member's ID card.
4. For contracted health care providers who submit electronic claims and would like to receive electronic payments and statements, call Optum Financial Services Customer Service line at **1-877-620-6194** or visit **optumbank.com** > Partners > **Providers**

Claim reimbursement (adjustments)

If you think your claim was processed incorrectly, call the number on the member's ID card. If you find a claim where you were overpaid, send us the overpayment within 30 calendar days. If we find a claim was overpaid, payment is due within 30 calendar days.

If you disagree with our decision regarding a claim adjustment, you may appeal.

Claim reconsideration, appeals and disputes

Claim reconsideration does not apply to some states based on applicable state legislation.

There is a 2-step process available for review of your concern. Step 1 is a claim reconsideration. If you disagree with the outcome of the claim reconsideration, you may request a claim appeal (step 2).

How to submit your reconsideration or appeal

For claims reconsideration (pricing or other), you can submit one of the following ways:

Mail: FlexWork
Attn: Claims
P.O. Box 31375
Salt Lake City, UT 84131-0375

Fax: 1-801-478-7582

Phone: 1-855-892-2401

For claims appeals, you can submit one of the following ways:

Mail: Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371

Fax: 1-801-478-5463

Phone: 1-855-892-2401

If you feel the situation is urgent, request an expedited appeal by phone, fax or writing:

Grievance Administrator
2020 Innovation Dr
DePere, WI 54115

Expedited fax: 1-866-654-6323

Phone: 1-855-892-2401

Time frame

You must submit your claim reconsideration and/or appeal to us within 12 months (or as required by law or your Agreement), from the date of the original EOB or denial. The 2-step process allows for a total of 12 months for timely submission, not 12 months for step 1 and 12 months for step 2.

What to submit

As the health care provider of service, you submit the dispute with the following information:

- Member's name and health plan ID number
- Claim number
- Specific item in dispute
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved

If you disagree with the outcome of the claim appeal, you may file for an arbitration proceeding (a description of this process is in your Agreement.

Refer to **Claim reconsideration and appeals process** section in **Chapter 10: Our claims process** for more information.

UnitedHealthcare Level Funded supplement

Applicability of this supplement

You are subject to both the main guide and this supplement. This supplement controls if it conflicts with information in the main guide. If there are additional protocols, policies or procedures online, you will be directed to that location. Refer to the main guide for anything not found in this supplement.

How to contact us

Resource	Where to go	Requirements and notes
Cardiology Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/cardiology** **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient cardiology prior authorization protocol** section of **Chapter 7: Medical management**.
Claims submission	**Online: UHCprovider.com** > Sign In > Claims & Payments **Payer ID:** 87726 **Information: UHCprovider.com/claims**	
Genetic and molecular testing	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/priorauth > Genetic and molecular testing**	
Outpatient injectable chemotherapy and related cancer therapies	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/oncology** **Phone: 1-888-397-8129**	Policies and instructions
Pharmacy services	**Prior authorizations: 1-800-711-4555** **Benefit information:** Call the number on the back of the member ID Card.	For information on the Prescription Drug List, **UHCprovider.com/pharmacy**

Resource	Where to go	Requirements and notes
Prior authorization and notification	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/priorauth** **Phone (only where telephonic submission is permitted): 1-877-797-8819**	Prior authorization and admission notification is required as described in **Chapter 7: 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** > Sign In > Prior Authorizations **Information: UHCprovider.com/radiology** **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient radiology prior authorization protocol** section of **Chapter 7: Medical management**.

Our claims process

Follow these steps for fast payment:

1. Notify UnitedHealthcare Level Funded
2. Prepare a complete and accurate claim form
3. For UnitedHealthcare Level Funded members, submit electronic claims using payer ID number 87726
4. For contracted health care providers who submit electronic claims and would like to receive electronic payments and statements, call Optum Financial Services Customer Service line at **1-877-620-6194** or visit **optumbank.com** > Partners > **Providers**

Claim reimbursement (adjustments)

If you think your claim was processed incorrectly, call the number on the member ID card. If you find a claim where you were overpaid, send us the overpayment within 30 calendar days. If we find a claim was overpaid, payment is due within 30 calendar days.

If you disagree with our decision regarding a claim adjustment, you may appeal.

Claim reconsideration, appeals and disputes

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

There is a 2-step process available for review of your concern. Step 1 is a claim reconsideration. If you disagree with the outcome of the claim reconsideration, you may request a claim appeal (step 2).

How to submit your reconsideration or appeal

Claims payment issues or outcome of a reconsideration review

If you disagree with claim payment issues or the outcome of your reconsideration review, submit your request using our electronic tools:

Online: **UHCprovider.com** > Sign In > Claims & Payments

Information: **UHCprovider.com/claims**

API: Submit reconsiderations and appeals (with attachments) using API. Go to **UHCprovider.com/api** for more information.

Overpayment recoveries, pharmacy, medical management disputes or contractual issues

If you disagree with overpayment recoveries, pharmacy, medical management disputes or contractual issues, send a letter requesting a review to:

UnitedHealthcare Level Funded members:

Grievance Administrator
P.O. Box 31393
Salt Lake City, UT 84131-0371

Fax: 1-801-994-1416

Time frame

You must submit your claim reconsideration and/or appeal to us within 12 months (or as required by law or your Agreement), from the date of the original EOB or denial. The 2-step process allows for a total of 12 months for timely submission, not 12 months for step 1 and 12 months for step 2.

What to submit

As the health care provider of service, you submit the dispute with the following information:

- Member's name and health plan ID number
- Claim number
- Specific item in dispute
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved If you disagree with the outcome of the claim appeal, you may file for an arbitration proceeding (a description of this process is in your Agreement)

Refer to **Claim reconsideration and appeals process** section in **Chapter 10: Our claims process** for more information.

UnitedHealthcare West supplement

Applicability of this supplement

This supplement is intended for use by physicians, health care professionals, facilities, ancillary health care providers and their respective staff when seeing non-capitated or non-delegated members in their respective state. Unless otherwise specified, any references to UnitedHealthcare West in this supplement are intended to apply to any or all of the following entities and benefit plans. 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, refer to the **Capitation and/or delegation supplement** of the guide as this supplement does not apply to you.

Health 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, refer to appropriate chapter in the main guide.

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

You may see more detailed information on ID cards and a sample health plan ID card, in the section titled **Health plan identification (ID) cards** in **Chapter 2: Provider responsibilities and standards**. You may see a sample ID card image specific to the member when you verify eligibility and benefits in the UnitedHealthcare Provider Portal.

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.

Medicare Advantage

In 2025, UnitedHealthcare Medicare Advantage plan names include a unique identifier code for each plan. Please refer to the **2025 Medicare Advantage Benefit Plan Names** resource on **UHCprovider.com** for a complete list of the plan names.

State	Products offered	Benefit
Arizona	Medicare Advantage (MA)	AARP® Medicare Advantage from UHC AARP Medicare Advantage Essentials from UHC AARP Medicare Advantage Extras from UHC UHC Complete Care (Chronic SNP) UnitedHealthcare® Group Medicare Advantage (HMO)
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 • UnitedHealthcare SignatureValue Harmony **Medicare:** • AARP Medicare Advantage from UHC • AARP Medicare Advantage Giveback from UHC • AARP Medicare Advantage Patriot No Rx • UHC Sharp Medicare Advantage • UHC Sharp Medicare Advantage ValueRx • UHC Complete Care (Chronic SNP) • UHC Complete Care Support (Chronic SNP) • UnitedHealthcare® Group Medicare Advantage (HMO)
California	Commercial	UnitedHealthcare Core Essential Refer to the main guide for regulations, processes and contact information.
Oklahoma	Commercial	UnitedHealthcare SignatureValue®
Oregon	Commercial	UnitedHealthcare SignatureValue®
Texas	Commercial	UnitedHealthcare SignatureValue®
Washington	Commercial	UnitedHealthcare SignatureValue®

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.

Medicare Advantage products

Refer to **Chapter 5: Medicare products** for a description of Medicare Advantage (MA) products offered. You may see a complete list of health plans on **UHCprovider.com/plans**.

Administrative services are provided by the following affiliated companies: UnitedHealthcare Services, Inc., Optum Rx or OptumHealth Care Solutions, LLC.

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

Special Needs Plans (SNP) model of care (MOC)

The MOC is the framework for care management processes and systems to help enable coordinated care for SNP members. The MOC contains specific elements that delineate implementation, analysis and improvement of care.

These elements include a description of SNP population (including health conditions), care coordination, provider network and quality measurement, and performance improvement.

The MOC is a quality improvement tool, and MOC helps ensure the unique needs of our SNP members are identified and addressed through care management practices. MOC goals are evaluated annually to determine effectiveness. To learn more, contact us by email at **snp_m0c_providertraining@uhc.com**. The Centers for Medicare & Medicaid Services (CMS) requires annual SNP MOC training for all health care providers who treat SNP members. The annual SNP MOC Provider Training is available at **UHCprovider.com**. We communicate updates about the training annually on **UHCprovider.com/news**. Learn more about provider news in **Chapter 18: Provider communication**.

UnitedHealthcare West information regarding our health care provider website

This supplement is located at **UHCprovider.com**, our health care provider website. Visit **UHCprovider.com/news** for the latest updates. Certain health care providers will also receive notices by mail, where required by state law.

To access the UnitedHealthcare Provider Portal online solutions, go to **UHCprovider.com** and click Sign In in the upper right corner. Sign in with your One Healthcare ID. To learn more about these and other tools that can simplify your administrative workflow, visit **UHCprovider.com/digitalsolutions**. We offer several live webinar options; information and registration is available on **UHCprovider.com/training**.

A One Healthcare ID is required to access the UnitedHealthcare Provider Portal and perform online transactions, such as eligibility verification, claims status, claims reconsideration, referrals and prior authorizations. To get a One Healthcare ID, go to **UHCprovider.com/access** to register for the UnitedHealthcare Provider Portal.

Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

How to contact UnitedHealthcare West resources

Resource	Where to go
Helpful health plan service phone numbers	**UHCprovider.com/contactus** > State-specific health plan and network support
Benefit interpretation policies and medical policies	**Benefit Interpretation Policies: UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® West Benefit Interpretation Policies** **Medical Policies: UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare® West Medical Management Guidelines**
Provider website	**UHCprovider.com**
Preauthorization	**EDI:** Transaction 278 **Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/priorauth** Arizona **Medicare Advantage Phone: 1-800-746-7405** California, Oregon and Washington: SignatureValue, Medicare Advantage, direct contract network and medical group/IPA carve-out **Phone: 1-800-762-8456** Texas: SignatureValue Oklahoma: SignatureValue Inpatient Notification/Utilization Management **Phone: 1-800-668-8139** To view the most current and complete Advance Notification List, including procedure codes and associated services, go to **UHCprovider.com/priorauth**.
Radiology/advanced outpatient imaging procedures CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/radiology** **Phone: 1-866-889-8054** Request prior authorization of radiology services as described in **Outpatient radiology prior authorization protocol** in **Chapter 7: Medical management**.
Cardiology Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Information: UHCprovider.com/cardiology** **Phone: 1-866-889-8054** Request prior authorization of cardiology services as described in **Outpatient cardiology prior authorization protocol** in **Chapter 7: Medical management**.

Resource	Where to go
Hospital inpatient notification (Non-delegated) inpatient includes: acute inpatient, skilled nursing admission, long-term acute care, inpatient rehabilitation places of service	**EDI:** Transaction 278N **Online:** **UHCprovider.com** > Sign In > Prior Authorizations **Phone: 1-800-799-5252** **Mental Health (Medicare Advantage): 1-800-508-0088** Transplant **Phone: 1-866-300-7736** **Fax:** 1-888-361-0502
EDI support Encounter collection, submission and 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 support and resources **EDI Transaction Support Form** **Phone: 1-800-842-1109** (For UnitedHealthcare West ERA/835 questions, select option 4 and then option 2) **Email:** **supportedi@uhc.com** **Payer IDs:** UnitedHealthcare West encounters, 95958. For claims, the payer ID is 87726. For a complete list of payer IDs, refer to the **Claims Payer List**.
Eligibility	**EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse **Online:** **UHCprovider.com** > Sign In > Eligibility **Information:** **UHCprovider.com/eligibility**
United Voice Portal (follow prompts to access information)	Commercial and Medicare Advantage HMO/MCO: California: **1-800-542-8789** Arizona (MA): **1-888-866-8297** Oklahoma (Commercial)/Texas (Commercial): **1-877-847-2862** Oregon: **1-800-920-9202** Washington MCO: **1-800-213-7356**
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: **1-800-624-8822** Oklahoma/Texas: **1-800-825-9355** Oregon/Washington: **1-800-932-3004** **Fax:** 1-866-704-3420

Resource	Where to go
Medicare Advantage member appeals (The member appeals process is never delegated)	UnitedHealthcare P.O. Box 6106 Mail Stop CA 124-0157 Cypress, CA 90630 **Fax:** 1-888-517-7113 **uhc.com/medicare**
Expedited commercial member appeals (applies only to commercial UnitedHealthcare SignatureValue HMO/MCO)	California, Oklahoma, Oregon, Texas, Washington **Phone: 1-888-277-4232** **Fax:** 1-800-346-0930
Urgent clinical appeals (medical or pharmacy appeals)	**Fax:** 1-800-346-0930
Pharmacy services	Commercial products: **UHCprovider.com** **UHCprovider.com/specialtyrx** **UHCprovider.com/pharmacy** Medicare products: **uhc.com/medicare** > Shop Medicare plans > **Medicare prescription drug plans** **Phone: 1-855-812-4301**
Mental health/substance use disorder, vision or transplant services	See ID card for carrier information and contact numbers. View the ID card when you verify eligibility at **UHCprovider.com** > Sign In > Eligibility
California Language Assistance Program (applies only to commercial products in California)	**Online: uhc.com** > Legal > **California Language Assistance Program** **Phone: 1-800-752-6096**
Health management and disease management programs	**Phone: 1-877-840-4085** **Fax** completed referral form to: 1-877-406-8212

Health care provider responsibilities

Electronic Data Interchange

The fastest way for us to talk is electronically. Electronic Data Interchange (EDI) is the preferred method for doing business transactions. Find more information on **UHCprovider.com/edi**.

Professional independence

The issues of confidentiality and objective medical observations are the key in the diagnosis and treatment of our members. Therefore, a health 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 2 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 2 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** > Sign In > Eligibility
- **EDI:** 270/271 transactions through your vendor or clearinghouse
- **Phone:** See **How to contact UnitedHealthcare West resources** for specific numbers
- Electronic eligibility lists (upon request)

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

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

Health plan identification (ID) cards

Each member receives a health plan 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. You may identify a UnitedHealthcare West member by a reference to WEST on the ID card. Information may vary in appearance or location on the card due to unique benefit plan requirements. You can view and download current ID cards when you verify eligibility and benefits at **UHCprovider.com** > Sign In > Eligibility.

For more detailed information on ID cards and to see a sample ID card, refer to the **Health plan identification (ID) cards** section of **Chapter 2: Provider responsibilities and standards**.

Services provided to ineligible members (does not apply in CA)

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

Eligibility verification guarantee (TX commercial)

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

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

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

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

Submit service verification requests to:

- **Phone: 1-877-847-2862**
  or
- **Mail:** Care Provider Correspondence
  P.O. Box 30975
  Salt Lake City, UT 84130-0975

Access and availability: Standards and exceptions

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

Health plans in California must conduct an annual Provider Appointment and Availability Survey. The overall plan results are available at **myuhc.com**.

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 nonurgent PCP within 10 business days of request, within 15 business days for non-urgent specialist request. Texas: Within 3 weeks for medical conditions.
Preventive care	UnitedHealthcare Standard: 4 weeks Exceptions: As directed by PCP Texas: Within 2 months for child and within 3 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.

Type of care	Guideline
In-office wait time	California: In-office wait time is less than 30 minutes.
Referral process	Complete notification to the member in a timely manner, not to exceed 5 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 cooperate with our Medical Management Department toward:
   - Managing inpatient and outpatient utilization
   - Member care and member satisfaction
5. Use your best efforts to refer members to our network providers. You must use only our network laboratory and radiology health care providers unless specifically authorized by us.

Timely access to nonemergency health care services (applies to commercial in California)

For details on these access standards refer to **Chapter 2: Provider responsibilities and standards**, **Timely access to nonemergency health care services (applies to commercial in California)**.

Notification of practice or demographic changes

Report all demographic changes, open/closed status, product participation or termination to us.

For complete information, refer to the **Demographic changes** section of **Chapter 2: Provider responsibilities and standards**.

Compliance with the medical management program

Compliance with the Medical Management Program includes:

- Allowing our staff to have on-site access to members and their families while the member is an inpatient
- Allowing our staff to participate in individual case conferences
- Facilitating the availability and accessibility of key personnel for case reviews and discussions with the medical director or designee representing UnitedHealthcare West, upon request
- Providing appropriate services in a timely manner

Benefit Interpretation Policies and Medical Policies

A complete library of Benefit Interpretation Policies (BIPs) is available on **UHCprovider.com/policies** > For Commercial Plans > **UnitedHealthcare West® Benefit Interpretation Policies**.

A complete library of medical policies is available on **UHCprovider.com/policies** > For Commercial Plans > **Medical & Drug Policies**. We publish monthly editions of the BIP and Medical Policy Update Bulletins. These online resources provide notice to our network providers of changes to our BIPs and Medical Policies. The bulletins are posted on the first calendar day of every month on:

- **UHCprovider.com/policies** > For Commercial Plans > UnitedHealthcare West® Benefit Interpretation Policies > **Benefit Interpretation Policy Update Bulletins**
- **UHCprovider.com/policies** > For Commercial Plans > **Medicare & Drug Policies**
- We post a supplemental link to the policy updates announced in the BIP and Medical Policy Update Bulletins monthly on **UHCprovider.com/news**

Continuity of care

Continuity of care is a short-term transition period, allowing members to temporarily continue to receive service from a nonparticipating health care provider. Continuity of Care is detailed under the **Consolidated Appropriations Act, 2021 (CAA) requirements** section in **Chapter 2: Provider responsibilities and standards** of this guide. If the specific requirements in this section expand the coverage for Continuity of Care, then this section applies for UnitedHealthcare West members.

Examples of an active course of treatment or condition 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, persists without full cure, worsens over an extended period of time, 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 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 health care provider or the non-network provider and as applicable, the receiving network provider, consistent with good professional practice. Completion of covered services for this condition will not exceed 12 months from the Agreement's termination date, or 12 months after the effective date of coverage for a newly enrolled member.
- **A terminal illness** is an incurable or irreversible condition that has a high probability of causing death within 1 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 health care provider prior to the Agreement termination date, or (ii) non-network provider prior to the newly enrolled member's effective date of coverage with UnitedHealthcare West.
- **A pregnancy** diagnosed and documented (i) by the terminated health care provider prior to termination of the Agreement, or (ii) by the non-network 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 the earliest of: (i) 12 months from Agreement termination date, (ii) 12 months from the newly enrolled member's effective date of coverage with UnitedHealthcare West, or (iii) the child's third birthday.
- **Surgery or other procedure**
  Performance of a surgery or other procedure that was authorized by UnitedHealthcare West or the member's PCP. Parts of a documented course of treatment have been recommended and documented by (i) the terminating health care provider to occur within 180 calendar days of the Agreement's termination date or (ii) the non-network 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 group 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)

Some UnitedHealthcare of California HMO member benefit plans include Virtual Visits. We define Virtual Visits as primary care services that include the diagnosis and treatment of low-acuity medical conditions for members through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology.

Virtual Visit primary care services are typically delivered by the capitated provider groups. Not all UnitedHealthcare West benefit plans will have the Virtual Visit benefit option.

To read more about Virtual Visits, refer to the **Capitation and/or delegation supplement**.

Utilization and medical management

Medical emergencies and emergency medical conditions

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

Direct the member to call 911, or its local equivalent, or to go to the nearest emergency room. Prior authorization or advance notification is not required for emergency services. However, you should tell us about the member's emergency by calling **1-800-799-5252** between 8 a.m. and 5 p.m. PT, Monday–Friday.

Provide after-hours and weekend emergency services as clinically appropriate; enter the notification online or call **1-800-799-5252** the next business day.

Urgently needed services

Check the member's benefits with Member Services or at **UHCprovider.com** > Sign In > Eligibility, as applicable, for the benefit plan definition of urgent care. For our commercial members, you must contact the member's PCP or hospitalist on arrival for urgently needed services. Request these services by calling **1-800-799-5252** between 8 a.m. and 5 p.m. PT, Monday–Friday.

Routine authorizations

We consider all other services as routine. To request preauthorization for urgent or routine services, the PCP must enter all the necessary information into online at **UHCprovider.com** > Sign In > Prior Authorizations, contact the delegated medical group for approval, or complete and submit the appropriate preauthorization request form to obtain approval. Routine and urgent requests are responded to within the following time frames, if all required clinical information is received:

Product	State	Time frame
Medicare Advantage (urgent)	All	72 hours Part B drugs (including step therapy drugs) are reviewed in 24 hours
Medicare Advantage (routine)	All	14 calendar days Part B drugs (including step therapy drugs) are reviewed in 72 hours

Product	State	Time frame
Commercial (urgent)	OR WA	2 business days 1 business day for electronic and 2 business days for phone/fax
	CA, OK	72 hours
	TX	Approvals: Within 2 business days (Not to exceed 72 hours from receipt of request.) Clinical Med Nec Adverse Determinations: Within 3 calendar days from receipt of request Administrative denials: Within 2 business days (Not to exceed 72 hours from receipt of request.)
Commercial (routine)	OR	2 business days; exception – a delay of decision (DOD) letter
	CA	5 business days; exception – a delay of decision (DOD) letter
	OK	Effective Jan. 1, 2025, 7 days upon receipt of all information. HMO only: Managed care plans must approve or disapprove requests for nonformularly drugs or a drug that requires prior authorization within 24 hours of receipt of the request.
	TX	Approvals: Within 2 business days (Not to exceed 72 hours from receipt of request.) Clinical Med Nec Adverse Determinations: Within 3 calendar days from receipt of request issue Administrative denials: Within 2 business days issue (Not to exceed 72 hours from receipt of request.)
	WA	WA requires different TATs for electronic vs. phone/fax. Commercial routine is 3 business days for electronic and 5 business days for phone/fax.

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 online at **UHCprovider.com** > Sign In > Prior Authorizations.

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

Primary care services

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

1. The PCP/requesting health 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 by visiting **UHCprovider.com** > Sign In > Prior Authorizations
4. If approved, the treatment request is given a reference number that may be viewed when you check the status, or by contacting the delegated medical group, or faxed back to the physician office depending on how the PCP/servicing health 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 health care providers should refer members to network providers. Referrals to non-network providers require prior authorization.
8. Once the PCP refers a member to a network specialist, that specialist may see the member as needed for the referring diagnosis. The specialist is not required to direct the member back to the PCP to order tests and/or treatment.
9. If a specialist feels a member needs other services related to the treatment of the referral diagnosis, the specialist may refer the member to another participating health 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 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 provided by a designated participating health 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 health 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 health care provider.

5. Female MA members older than 40 years may self-refer to a participating radiology health 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 health care provider for routine obstetrical (OB) care. If the member is referred by her PCP to a nonparticipating health care specialist, the specialist must notify us using online tools. This helps ensure accurate claims payment for ante and postpartum care.
2. Routine OB care includes office visits and 2 ultrasounds.
3. Plain film radiography that is performed by a participating health care provider or in the obstetrician's office in support of an authorized visit requires prior authorization.
4. Routine labs performed in the obstetrician's office, or provided by a participating health care provider in support of an authorized visit, do not require prior authorization. In-office tests must follow CMS in-office testing CLIA requirements. Specimens collected in the physician's office and sent out to a nonparticipating laboratory for processing must follow the out-of-network member consent requirements.

Maternal mental health screening requirement (California commercial plans)

UnitedHealthcare is pleased to share the details of its maternal mental health program with you. The law[1] requires licensed health care professionals who provide prenatal and/or postpartum care to perform a maternal mental health screening at least once during pregnancy and an additional screening during the first 6 weeks of the postpartum period. Additional postpartum screenings should be conducted as medically necessary and clinically indicated in the judgment of the licensed health care professional.

Guidelines for maternal mental health screenings

The American College of Obstetricians and Gynecologists (ACOG) recommends OB-GYNs and other obstetric health care professionals screen patients for depression and anxiety at the initial prenatal visit, later in pregnancy, and at postpartum visits using a standardized, validated tool.

Clinical staff should be prepared to start medical therapy and/or refer patients to appropriate behavioral health resources.

How to perform maternal mental health screenings

ACOG recommends you use the following guidelines when performing maternal mental health screenings:

- Use the Patient Health Questionnaire (PHQ-9) or Edinburgh Postnatal Depression Scale (EPDS) tool during pregnancy and/or the postpartum period. You can download a copy of the PHQ-9 at the following link: **uhcprovider.com/en/resource-library/behavioral-health-resources.html**
  - Read the test instructions before giving and scoring the test
- Refer the member to behavioral health and/or substance abuse services as needed
  - Monitor the referral process to help ensure the member successfully receives treatment

Behavioral health contacts

Please refer to resources that assist patients who may need mental health and/or substance use disorder treatment:

- Mental Health and Substance Use Disorder OptumHealth Behavioral Solutions of California
  - Support Line: **1-866-209-9320**
  - **Providerexpress.com**

Support services for members

Please have members check with their employer group to verify their maternity benefit. If an Administrative Services Only (ASO) customer wants a deeper reach on maternity support, please refer them to the Personal Health Support page. We offer maternal health support services, such as:

- **Maternity Support Program**
  - Maternity management program that promotes healthy birth outcomes for pregnant members, through telephone maternal coaching and online maternity educational videos
- **High-Risk Solutions**
  - This is a program that promotes healthy birth outcomes for pregnant members, especially those with high-risk pregnancies. Maternity nurse engagement will engage the member with their health plan and their health care provider as needed.

Quality monitoring for maternal mental health care

The UnitedHealthcare quality team reviews medical records to help ensure you are complying with maternal mental health screening requirements. We assess records for mental health screening during the patient's second or third trimester and/or at the postpartum visit.

Questions? We're here to help.

Please email **ca_pr_team@uhc.com** to contact a provider advocate.

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 1 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 health 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 health care provider and has serious concerns about the diagnosis or treatment plan

Turnaround time for second opinion reviews

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

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

- UnitedHealthcare West Benefit Interpretation Policy titled **Member Initiated Second and Third Opinion: CA**
- UnitedHealthcare West Benefit Interpretation Policy titled **Member Initiated Second and Third Opinion: OK, OR, TX, WA**

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

We request that you notify the case management department when a member is referred for evaluation and/or is 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 at a facility in the Optum VAD network, or facility approved by UnitedHealthcare West medical directors, to align with heart transplant service centers

Extension of prior authorization services

The specialist must request an extension of prior authorization online or by contacting the delegated medical group/IPA 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
- Health 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
- Requested services (e.g., additional visits, procedures)

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

Facility-based outpatient surgery (CA, OR, WA and NV)

Facility-based outpatient surgery services are defined using CMS Guidelines, CPT/HCPCS coding conventions, and clinical and/or proprietary standards. The following denotes services considered facility-based outpatient surgery services under this definition:

- A procedure with an ASC grouping assigned
- A procedure with a global period of 90 days (according to the health care provider fee schedule)
- Core needle biopsies

- Unlisted or new codes may be considered surgery in the following situation:
  - Unlisted or new code is related to other codes in the same APC group that had an ASC assigned is considered facility-based outpatient surgery
- A procedure with surgical risk or anesthetic risk as determined by clinical review

Hospital notifications

Independent from prior authorization, notification by the facility is required for inpatient admissions on the day of admission, even if an advanced notification was provided prior to the actual admission date.

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

Facilities are responsible for admission notification, even if advance notification was provided by the physician and coverage approval is on file.

UHC West Admission Notification List

Prior authorization and notification of admission date required for these facilities providing post-acute inpatient services:

- Acute care hospitals
- Acute inpatient rehabilitation
- Critical access hospital
- Long-term acute care hospitals
- Skilled nursing facilities

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

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

Admission notifications must contain the following details regarding the admission:

- Member name, health plan 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 online, by EDI or by phone 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
- Face sheets to report outpatient surgeries and SNF admissions
- 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 plan 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
- Providing the PCP with discharge summaries

After-hour admissions/SNF transfers

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

Out-of-network admissions

- A referral/transfer to a non-network facility requires prior authorization. However, in the case of an emergency, a non-participating hospital may be used without prior authorization.
- After initial emergency treatment and stabilization, we may request that a member be transferred to a network hospital, when medically appropriate.
- If a PCP directs a member to a non-network hospital for nonemergent 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 health care provider during an inpatient stay. However, consultation with a non-network provider requires prior authorization.

Concurrent review

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

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

Emergency and/or direct urgent admissions

Commercial plans

If a hospital does not receive authorization from us within 1 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.

Medicare Advantage plans

When we receive the notification of admission, we request clinical information and make a determination within 1 business day of receiving complete clinical information from the facility. If complete clinical information is not received within the 3 business days, the case is denied for lack of information.

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 with 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 an SNF or custodial care facility
- Approved authorizations for necessary post-discharge plan
- 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 InterQual 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 Implant Guidelines
- Claim check or modifier edits based on our claim payment software
- Foreign country claims
- 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 7 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 and other institutional providers, we may reduce the payable dollars if line item charges have been incorrectly unbundled from room and board charges.

Minimum content denials, delays or modification requests

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

- The specific service(s) denied, delayed in delivery, modified or partially approved
- The specific reference to the benefit plan provisions to support the decision
- The reason the service is being denied, delayed in delivery, modified or partially approved, including:
  - Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties may understand the rationale behind the decision
  - Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based
  - Clinical reasons for decisions regarding medical necessity
  - Contractual rationale for benefit denials
- Notification that the member may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request
- Notification that the member's physician may request a peer-to-peer review
- Alternative treatment options offered, if applicable
- Description of any additional material or information necessary from the member to complete the request, and why that information is necessary
- Description of grievance rights and an explanation of the appeals and grievances processes, including:
  - Information regarding the member's right to appoint a representative to file an appeal on the member's behalf

- The member's right to submit written comments, documents or other additional relevant information
- Information notifying the member and their treating health 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 health care provider, the name and direct phone number of the health care professional responsible for the decision

Pharmacy benefit

A member may fill prescriptions from any network 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 (urgent or emergent prescriptions, after-hours, out of the service area or Part D-covered vaccines provided by the health care provider).

Home delivery service

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

When appropriate, you may write prescriptions for a 3-month, 90-calendar-day supply and up to 3 additional refills. Only medications taken for chronic conditions should be ordered through the home delivery service. 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 home delivery service for medications where large quantities dispensed at one time to the member may pose a problem (e.g., tranquilizer).

Pharmacy prescription drug list

Commercial

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

We update the prescription drug list 3 times a year — January, May and September. Health care provider requests for formulary review of medications or preauthorization guidelines are welcome. Find formulary changes on **UHCprovider.com/pharmacy**, or **UHCprovider.com/priorauth** > **Clinical and specialty pharmacy**.

Medicare Advantage

See **Chapter 8: Specialty pharmacy and Medicare Advantage pharmacy**.

Non-formulary medications

Non-formulary prescriptions/medications not provided as a plan benefit are the member's financial responsibility, unless the prescribing health 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 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 health 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, health 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 Optum Rx. Optum Rx staff adhere to benefit plan-approved criteria, National Pharmacy and Therapeutics Committee (NPTC) practice guidelines, and other professionally recognized standards.

Request authorizations:

- **Online: professionals.optumrx.com > Prior authorizations**
- To simplify the prior authorization experience, health care professionals can submit a real-time prior authorization request 24 hours per day, 7 days per week, through one of the online services found at **professionals.optumrx.com**. After logging on with your unique National Provider Identifier (NPI) number and password, you may submit member details securely online, enter a diagnosis and medication justification for the requested medication and, in many cases, receive authorization instantly. Otherwise, you may verbally submit a prior authorization request by:
- **Phone: 1-800-711-4555**

California commercial products: Prescribing providers in California must use the **Prescription Drug Prior Authorization Request Form** when submitting authorization requests to Optum Rx.

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 health care providers, the delegate must also require the use of Optum **Prescription Drug Prior Authorization Request Form**. The delegate must have a policy and process in place and be able to demonstrate compliance.

You can call the Optum Rx Prior Authorization department at **1-800-711-4555** to either submit a verbal prior authorization request or to request a California state-mandated fax form.

Claims process

Find instructions and quick tips for EDI on **UHCprovider.com/edi.**

Claims and encounters

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

Do not resubmit claims using EDI or paper claims forms. Resubmit claims online using the UnitedHealthcare Provider Portal at **UHCprovider.com** > Sign In > Claims & Payments.

Refer to our online Companion Guides for the data elements required for these transactions. You'll find them at **UHCprovider.com/edi** > **EDI transactions and code** sets.

For information on EDI claim submission methods and connections, go to **UHCprovider.com/edi837**.

Optum® Intelligent EDI, the UnitedHealthcare managed gateway, is also available to help you begin submitting and receiving electronic transactions. For more information, call **1-800-341-6141**.

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 **Claims Payer List**.

In some cases, the payer ID listed on **UHCprovider.com/edi** may be different from the numbers issued by your clearinghouse. To avoid processing delays, you must validate with your clearinghouse for the appropriate payer ID number or refer to your clearinghouse published Payer Lists.

Electronic Funds Transfer

You may enroll or make changes to Electronic Funds Transfer (EFT) and ERA/835 for your UnitedHealthcare West claims using the UnitedHealthcare West EFT Enrollment tool in the UnitedHealthcare Provider Portal. 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 **ERA Payer List** to determine the correct payer ID to use for ERA/835 transactions.

For more information, go to **UHCprovider.com/claims** > **Digital payment options**.

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, 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 10: Our claims process**.

National Provider Identification

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

- **Online:** **UHCprovider.com** > Sign In > Practice Management > My Practice Profile
- Connect with us 24/7 from the **UnitedHealthcare Provider Portal**. For chat options and contact information, visit **UHCprovider.com/contactus**.

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 health care providers to use the most current service codes (i.e., ICD-10-CM, UB and CPT codes) and appropriate bill type.

Member financial responsibility

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

No balance billing

You may not balance bill our members. You may not collect payment from the member for covered services beyond the member's copayment, coinsurance, deductible and for noncovered services unless the member specifically agreed in writing before receiving the service. In addition, you shall not bill a UnitedHealthcare West member for missed office visit appointments.

Claims status follow-up

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

- **EDI:** 276/277 Claim Status Inquiry and Response transactions are available through your vendor or clearinghouse
- **Online:** **UHCprovider.com** > Sign In > Claims & Payments > Look up a Claim
- **Phone:** See **How to contact UnitedHealthcare West resources** section for telephone numbers. This system provides a fax of the claim status detail information that is available.

Claims submission requirements

Refer to the **Prompt claims processing** section of **Chapter 10: 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
- 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
  - Make medical records available upon request for all related services identified under the reinsurance provisions (e.g., ER face sheets)

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

Interim bills

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

The following process increases efficiencies for both us and the hospital/SNF business offices:

- 112 Interim – First claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise)
- 113 Interim – Continuing claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise)
- 114 Interim – Last claim: Review admits to discharge and 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 health 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 health care providers (if applicable), you and/or your subcontracted health 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

Follow the instructions in the **Overpayments** section of **Chapter 10: Our claims process**.

ESRD

If a member has or develops ESRD while covered under an employer's group benefit plan, the member must use the benefits of the plan for the first 30 months after becoming eligible for Medicare 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): Follow the instructions in the **Member financial responsibility** section of **Chapter 11: 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 Explanation of Payment (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
2. The time specified in your Agreement or
3. The time frame specified in the state guidelines, whichever is greatest

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

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

Health care provider claims, appeals and disputes

Claims research and resolution (OK and TX commercial plans)

The Claims Research & Resolution process applies:

- If you do not agree with the payment decision after the initial processing of the claim
- 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, health care provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

Claim reconsideration requests

You may request a reconsideration of a claim determination. These requests typically can be resolved with the appropriate documents to support claim payment or adjustments (i.e., 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 requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your Agreement contains other filing guidelines. Submit your requests in the UnitedHealthcare Provider Portal by visiting **UHCprovider.com** > Sign In > Claims & Payments.

To mail your request, refer to the chart titled UnitedHealthcare West Provider Rework or Dispute Process Reference Table at the end of this section.

Submission of bulk claim inquiries

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

Provider's state	Contact information	Notes
Arizona	UnitedHealthcare Attn: WR Claims Project Management P.O. Box 52078 Phoenix, AZ 85072-2078	For requests with 20+ claims
California	Claims Research Projects CA120-0360 P.O. Box 30968 Salt Lake City, UT 84130-0968	For requests with 19+ claims
Oklahoma	Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967	For requests with 20+ claims
Oregon	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	For requests with 10+ claims
Texas	Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975	For requests with 20+ claims
Washington	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	For requests with 10+ claims

The UnitedHealthcare West 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 5 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 **1-877-847-2862** to obtain a status.

Health care provider dispute resolution (CA Commercial HMO, OR HMO claims, OR and WA commercial plans)

If you disagree with our claim determination, you must initiate and complete the PDR process before commencing

arbitration on a claim. You must submit a PDR in writing and with additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the adverse payment determination on the claim, unless your Agreement or state law dictate otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

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

What to submit

As the health care provider of service, submit the dispute with the following information:

- Member's name and health plan 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 contact 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 bulk claims rework reference table** at the end of this section.

Accountability for review of a health 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/health care provider.

Excluded from the PDR process

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

- A member has filed an appeal, and you have filed a dispute regarding the same issue. In these cases, the member's appeal is reviewed first. You may submit a health 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/health care provider and does not involve an issue of medical necessity or medical management

UnitedHealthcare West bulk claims rework reference table		
Provider's state	**Contact information**	**Notes**
Arizona	UnitedHealthcare Benefits of Texas, Inc. 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 1 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 1 year from the date the first-level grievance resolution was communicated to the health care provider.
California	**Online: UHCprovider.com** > Sign In > Claims & Payments UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	UnitedHealthcare acknowledges receipt of paper disputes within 15 business days and within 2 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.
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 health 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 health care providers to initiate the dispute resolution process. We render a decision on health 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 1-800-752-6096.

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 health 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
- 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): **1-800-624-8822**; Dial **711** TDHI

Where to obtain the member's language preference

The member's preferences for spoken language, written language and eligibility for written language service is displayed when checking eligibility and benefits in the UnitedHealthcare Provider Portal.

Cultural and linguistic support

UnitedHealthcare commercial health plans in the West serve a diverse group of individuals. Each state has unique membership that has its own cultural and language needs. Language information about our membership is collected and analyzed to provide our members with health care services that meet their individual cultural and language needs. An example of some of our diverse membership by state can be found in the table below:

State	Second language	Third language	Fourth language	Fifth language
California	Spanish	Chinese (including Mandarin, Cantonese)	Tagalog (including Filipino)	Vietnamese

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 members, document the member's preferred language in the member's medical record.

Member complaints and 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 health care provider organization or medical group level. We summarize the results at the provider organization or 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.

Availability of grievance forms

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

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

California commercial HMO members may access grievance forms online. Direct members to **myuhc.com** > **View Forms**. The form is accessible in 2 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 with obtaining a form if the member asks. You may print a form from **myuhc.com** or by providing 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. The CA-QIC activities are carried out in collaboration with the West Regional Quality Oversight Committee (RQOC) to avoid duplication of effort.

The CA-QIC is chaired by the chief medical officer physician licensed in CA. The committee meets at least quarterly and reports to the UnitedHealthcare of CA Board of Directors and, as needed, to the West RQOC.

UnitedHealthOne Individual Plans supplement

Applicability of this supplement

UnitedHealthOne® is the brand name of the UnitedHealthcare family of companies that offers individual personal health products, including Golden Rule Insurance Company (GRIC), UnitedHealthcare Life Insurance Company, (UHCLIC), UnitedHealthcare Insurance Company (UHIC) and UnitedHealthcare Oxford Navigate Individual plans 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 the main guide, 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; Oxford – Group Number 908410		
Notification Admission notification is required for all inpatient services as described in **Chapter 7: Medical management**.	**Online: UHCprovider.com** > Sign In > Prior Authorizations **Online: UHCprovider.com/priorauth**	Inpatient notification required for group number 705214. Group number 918831 does not require notification.
Benefits and eligibility	**EDI:** Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse. **Online: UHCprovider.com** > Sign In > Eligibility **Information: UHCprovider.com/eligibility**	To inquire about a member's plan benefits or eligibility.
Claims	**EDI:** Medical claims payer ID 37602 **Online: UHCprovider.com** > Sign In > Claims & Payments **Information: UHCprovider.com/claims**	To view pending and processed claims.
Pharmacy services	Prior Authorizations: **Online: professionals.optumrx.com** **Benefit information:** Call the pharmacy number on the back of the member ID card.	For information on the PDL, go to **UHCprovider.com/pharmacy**.

Resource	Where to go	Requirements and notes
Oxford – Group Number 908410		
Behavioral health services	**Online:** Providerexpress.com **Phone:** 1-855-779-2859	Submit admission notification or prior authorization for behavioral health, including substance use disorder and autism.
Cardiology Diagnostic catheterization, electrophysiology implants, echocardiogram and stress echocardiogram	**Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** UHCprovider.com/cardiology **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient cardiology prior authorization protocol** section of **Chapter 7: Medical management**.
Chiropractic, physical and occupational therapy	**Online** (clinical submission request): myoptumhealthphysicalhealth.com **Phone: 1-888-676-7768**	Follow the clinical submission process for chiropractic, physical and occupational therapy as described in **Chapter 7: Medical management**.
Claims submission	**Electronic claims submission:** Payer ID 37602 **Paper claims submission:** See mailing address on back of member's ID card.	To view pending and processed claims.
Pharmacy services	**Prior authorizations:** **Online:** professionals.optumrx.com **Benefit information:** Call the pharmacy number on the back of the ID card.	For information on the PDL, go to UHCprovider.com/pharmacy.
Prior authorization and notification	**EDI:** Transactions 278 and 278N **Online:** UHCprovider.com > Sign In > Prior Authorizations **Information:** UHCprovider.com/priorauth **Phone (only where telephonic submission is permitted): 1-800-999-3404**	Prior authorization and admission notification is required as described in **Chapter 7: 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 > Sign in > Prior Authorizations **Information:** UHCprovider.com/radiology **Phone: 1-866-889-8054**	Request prior authorization for services as described in the **Outpatient radiology prior authorization protocol** section of **Chapter 7: Medical management**.

Health plan ID card

Members receive health plan 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, phone numbers).

You can view and download current ID cards when you verify eligibility and benefits in the **UnitedHealthcare Provider Portal**.

For more detailed information and to see a sample ID card, refer to the **Health plan identification (ID) cards** section of **Chapter 2: Provider responsibilities and standards**.

Claims process

We know you want to be paid promptly for your services. To help prompt payment:

1. Notify us based on the notification requirements in this supplement
   - For Navigate referrals, refer to **Chapter 6: Referrals**
2. Prepare a complete and accurate claim form. For facility (UB-04/8371) claims, see number 4
3. Submit electronic claims using the electronic payer ID on the health plan ID card. GRIC payer ID is 37602
4. Requirements for claims reporting revenue codes:
   - All claims reporting revenue codes require the exact dates of service if there is a span of dates
   - If you report revenue codes 274, 275, 276, 277, 278, 279 with a billed amount of $500 or greater, you are required to provide a valid CPT or HCPCS code
   - If you report revenue codes 25X with a billed amount of $1,000 or greater, and the codes are not billed with NDC, you are required to provide a valid CPT/HCPCS code

Claim adjustments

If you believe your claim was processed wrong, call the number on the back of the member ID card. Request an adjustment as soon as possible, in accordance with applicable statutes and regulations. If you identify a claim overpayment, or we notify you of an overpayment, send us the overpayment within 30 calendar days from the date of identification or notification.

Claim reconsideration, appeals and disputes

If you disagree with a claim payment determination or adjustment, you may appeal. Request a review by mail, fax or phone:

Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard fax: 1-801-478-5463
Email: uhoappealsandgrievances@uhc.com
Phone: 1-800-657-8205

If you feel your situation is urgent, request an expedited (urgent) appeal by mail, fax or phone:

Grievance Administrator
2020 Innovation Drive
DePere, WI 54115
Expedited fax: 1-866-654-6323
Phone: 1-800-657-8205

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.

Refer to **Claim reconsideration and appeals process** section in **Chapter 10: Our claims process**.

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

Claim reconsideration does not apply to some states based on applicable state law (Arizona, California, Colorado, New Jersey, Texas). For states with applicable law, dispute requests will follow the state-specific process.

New Jersey health care provider dispute process

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

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

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

UM denials include prescription quantity limit denials and requests for in-plan exception denials.
You may appeal a UM denial by going through the Internal UM Appeals Process described under the **Member complaints and grievances** section. You must submit a completed Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims form to begin the UM appeal process.

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

The process does apply for the following situations:

- The claim was not paid for any reason other than previously listed
- The claim was paid at a rate you did not expect based on your network contract or the terms of the plan
- The claim was paid at a rate you did not expect because of differences in our treatment of the codes in the claim from what you believe is appropriate
- We required additional substantiating documentation to support the claim, and you believe the required information is inconsistent with our stated claims handling policies and procedures or is not relevant to the claim
- You believe we failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law and the terms of your network contract, if any
- Our denial was due to lack of appropriate authorization, but you believe you obtained appropriate authorization from us or another carrier for the services
- You believe we failed to appropriately pay interest on the claim
- You believe our statement that we overpaid on 1 or more claims. A claim is erroneous or the amount we calculated as overpaid is erroneous
- You believe we have attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims

If the dispute is eligible, the following process will apply:

Submit a written request for appeal using the Health Care Provider Application to Appeal a Claims Determination Form created by the New Jersey Department of Banking and Insurance. Submit the request within 90 days following receipt of our initial determination notice to:

UnitedHealthcare Oxford Navigate Individual Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Standard fax: 1-801-478-5463

We will review the request and tell you our decision in writing within 30 calendar days of receipt of the form.

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

Member complaints and grievances

Member disputes may arise from time to time with UnitedHealthOne or with our participating health 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. Refer to **Member appeals, grievances or complaints** section in **Chapter 10: Our claims process** for detailed information about your role in the member appeal process.

UnitedHealthcare Oxford Navigate individual – Internal utilization management appeals process

You or the member should identify UM appeals 180 calendar days from initial adverse UM determination receipt. UM appeals include denials as not medically necessary, experimental or investigational, cosmetic, dental rather than medical, prescription quantity limit denial, denial of a request for an in-plan exception, or excluded as a pre-existing condition.

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

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371

Standard fax: 1-801-478-5463

If you feel the situation is urgent, request an expedited (urgent) appeal by mail, fax or phone:

UnitedHealthcare Oxford Navigate Individual
Grievance Administrator
2020 Innovation Drive
DePere, WI 54115

Expedited fax: 1-866-654-6323
Phone: 1-800-291-2634

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

Expedited appeal requests involving continued inpatient care in a network facility for a substance use disorder are determined within 24 hours. Expedited appeal requests for urgent care, emergency care, an admission, availability

of care, continued stay, or health care services for which the member received emergency services but has not been discharged from a facility, are determined within 72 hours. Standard UM appeals are determined within 10 calendar days of appeal receipt.

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

- We fail to meet the deadlines for completion of the internal appeals process:
  - Without demonstrating good cause
  - Because of matters beyond our control
  - While in the context of an ongoing, good faith exchange of information between parties
  - It is not a pattern or practice of noncompliance
- We, for any reason, expressly waive our rights to an internal review of an appeal
- The treating health 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:

- File a written request with the New Jersey Department of Banking and Insurance within 4 months of receiving a final determination on an appeal
- Sign a release that allows the IURO to review all the necessary medical records related to the appeal
- 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

The IURO completes the review within 45 days of receipt.

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

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

If UnitedHealthcare Oxford Navigate Individual has good cause for not meeting the appeal process deadlines, members or their designee and/or their health care provider may request a written explanation of the delay. UnitedHealthcare Oxford Navigate Individual must provide the explanation within 10 days of the request. If an external reviewer or court agrees with UnitedHealthcare Oxford Navigate Individual and rejects the request for immediate review, the member has the opportunity to resubmit their appeal.

Internal administrative appeal process

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

- Denials based on benefit exclusions or limitations not involving UM decisions
- Claims payment disputes

- Administrative issues concerning other requirements of the health plan. Administrative issues include but are not limited to issues involving:
  - Eligibility
  - Enrollment issues
  - Rescission of coverage

Note: Benefit and administrative issues do not include initial determinations that the service or supply is not medically necessary, experimental or investigational, cosmetic, dental rather than medical, prescription quantity limit denials, denials of a request for an in-plan exception, or treatment of a pre-existing condition. Those determinations are UM decisions.

You or the member must initiate administrative appeals in writing unless expedited.

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

Notice to Texas providers

To verify benefits for GRIC members, call **1-800-657-8205**.

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

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

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

To obtain a verification as required by 28 TAC §19.1719, call **1-800-842-1792**.

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 health care providers with a program to help prevent the onset of clinical diabetes. We have adopted the ADA Clinical Practice Guidelines.

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

Subscription information for the American Diabetes Journals is available on the website. You may also call 1-800-232-3472 and select option 1, 8:30 a.m. to 8 p.m. ET, Monday–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, such as 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 health 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:

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

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

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

Authorized health care provider: A health care provider who meets the UnitedHealthcare licensing and certification requirements and has been authorized by UnitedHealthcare to provide services.

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 provider a fixed amount for every member they care for, regardless of the care provided for a specific period of time.

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 1 benefit plan).

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

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

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

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

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

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

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

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

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

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 nonphysician.

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

Dual-eligibles: Members who qualify for both Medicare and Medicaid.

Durable Medical Equipment (DME): Medical equipment that is all of the following:

- Ordered or provided by a physician for outpatient use primarily in a home setting
- Used for medical purposes
- Not consumable or disposable except as needed for the effective use of covered DME
- Not of use to a person in the absence of a disease or disability
- Serves a medical purpose for the treatment of a sickness or injury
- Primarily used within the home

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

Electronic Data Interchange (EDI): The electronic exchange of information between 2 or more organizations.

Electronic Funds Transfer (EFT): The electronic exchange of funds between 2 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 to follow).

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

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

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

Fee for service: Health 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 adverse action.

Health care provider: A person who provides medical or other health care (doctor, nurse, therapist or social worker) or office support staff. A health care provider

may be a doctor practicing alone, in a hospital setting or in a group practice. A health care provider could work from a remote location, in a public space or any combination of locations.

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 National Committee for Quality Assurance (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 specialty recommendations, professional standards of care and other evidence-based, industry-recognized resources and guidelines, such as InterQual® Care Guidelines.

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

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

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

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

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

Non-network provider: A non-network provider does not have an Agreement with UnitedHealthcare but is certified to provide care to UnitedHealthcare members. There are 2 types of non-network providers: nonparticipating and participating.

Nonparticipating health care provider: A nonparticipating health 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 health care provider may only charge up to 15% above the UnitedHealthcare allowable charge.

Participating health 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 providers may participate on a claim-by-claim basis. Participating health 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 health 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 that prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

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

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

Password owners: Individuals at a health care provider's organization who set up and maintain co-workers' access to the UnitedHealthcare Provider Portal.

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 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.

Preservice appeals: A preservice appeal is a request to change a denial of coverage for a planned health care service. The member's rights in the member's benefit plan govern this process.

Primary care team: A team comprised of a care manager, a PCP and a nurse practitioner or physician assistant.

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

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

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

Qualified Medicare Beneficiary (QMB): A Medicaid program for beneficiaries who need help paying for Medicare services.

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

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

Risk adjustment data: All data used in the development and application of a risk adjustment payment model, as defined in 42 CFR 422.310, 42 USC 18063 and 45 CFR Part 153.

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

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 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 are living in a community setting, 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 the UnitedHealthcare affiliates
- 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 member ID card

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

- Exclusively enrolls special-needs individuals who, for 90 calendar days or longer, have had or are expected to need the level of service requiring an institutional level of care (as defined in 42 CFR 422.2)
- Is issued by UnitedHealthcare Insurance Company or by one of the UnitedHealthcare affiliates
- 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 member 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 guide.

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.

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