2017 Medica HealthCare Care Provider Manual

for Medicare Advantage Plan Care Providers

Welcome

We want to thank you for choosing to participate in Medica HealthCare's network. Medica HealthCare is committed to improving the health of our members through a managed care environment that provides access to quality healthcare services, resulting in better outcomes and general health status.

This manual is a key resource for you and your staff in understanding our plans, our policies and procedures, and the responsibilities of our network of healthcare professionals. We recommend that you and your staff read this manual and refer to it as necessary.

Our Network Management Services representatives are available to assist you and your staff in understanding the policies, procedures and information contained in this manual. Reach us at **877-670-8432**. We value your feedback and want to hear from you.

We look forward to a long and productive relationship with you and your staff. Thank you again for choosing Medica HealthCare.

NOTE: Effective Jan. 1, 2018, the Medica HealthCare provider manual will be retired. You may find information for Medica HealthCare in the UnitedHealthcare Care Provider Administrative Guide as a supplement.

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Chapter 1: Introduction

About Medica HealthCare

Medica HealthCare, (a wholly owned subsidiary of UnitedHealthcare), is a Medicare Advantage health plan. We offer Medicare Advantage plans in two Florida counties: Broward and Miami-Dade.

We are committed to delivering quality health care services to our members and quality customer service to care providers. Our mission is to provide affordable health care choices to meet health care needs. A key element of choice is helping members obtain the information they need to make informed choices and to understand the health and financial impact of those decisions. We currently offer a full range of Medicare Advantage health care coverage choices to our members.

Mission Statement

Our primary mission is to improve the health of our members by providing ready access to health care services, choices regarding their health care needs, and simplification of the health care delivery system. We work to streamline authorization and referral processes and to build care provider networks around the many needs of our members. This provides the best experience for both our members and care providers. We commit to provide direct access to expert customer service representatives who understand member needs and can help them make informed choices.

Using This Manual

The 2017 care provider manual (this "manual") applies to covered services you provide to members under a Medica HealthCare benefit plan insured by UnitedHealthcare. This manual is an extension of your provider agreement. Except when indicated, this manual is effective on September 1, 2017 for physicians, health care professionals, facilities and ancillary providers currently participating in the Medica network and effective immediately for healthcare providers who join our network on or after June 1, 2017.

Terms used in this manual include:

> "Member" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your agreement with us.

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

> "Our," "us," "we," or "Medica" refers to Medica HealthCare.

In the event of a conflict or inconsistency between your agreement with us and this manual, the provisions of your agreement with us will control. This entire manual is subject to change.

This manual is available on our provider website, at medicaplans.com. Alternatively, you may request a copy of this manual from Network Management Services (NMS) via fax at **888-659-0619**.

How to Contact Us

Questions or Comments

Questions or comments about this manual should be emailed to Network Management Services (NMS) at pcp-NetworkManagementServices@uhcsouthflorida.com, or submitted by mail to:

Medica HealthCare
Network Management Services
9100 South Dadeland Blvd.
Suite 1250
Miami, FL 33156-6420

Contact Us Table

Resources	Where to Go	What you can do there
Authorizations and Notifications	**Phone: 866-273-9444** **Fax: 855-307-8531** M-F 9 a.m. to 5 p.m. **Online:** UnitedHealthcareOnline.com **After Hours Phone:** **305-421-1220** M-F 5 p.m. to 11 p.m. S-S, Holidays 8 a.m.-5 p.m.	> Notifications, prior authorizations, referrals, admissions, and discharge planning > For after-hours or weekend emergencies, notifications or hospital admissions
Eligibility and Benefits Verification	**Phone: 800-348-5548** **Fax: 305-421-1220** **Online:** UnitedHealthcareOnline.com	> Verify eligibility and benefits of enrolled members
Claims	**Phone: 800-348-5548** M-F, 8 a.m. to 5 p.m. ET **Fax: 866-725-9337** **Online:** UnitedHealthcareOnline.com	> For claims, encounters, inquiries, status, or review requests
Technical Support for Change Healthcare claims submission network	**Phone: 800-845-6592**	> Password or technical support issues
Audit and Recovery	**Phone: 877-842-3210**	> Questions related to overpayments
Credentialing	**Phone: 800-963-6495** M-F, 9 a.m. to 5 p.m. **Fax: 866-567-0144**	> For issues regarding credentialing, re-credentialing, document changes, or recent hires or terminations in your practice or facility
DME and Infusion (MedCare)	**Phone: 800-819-0751**	> To arrange for these services. > On call 24 hours a day > You may also call Utilization Management or Network Management
Electronic Remittance (Facilitated by Change Healthcare)	**Phone: 800-845-6592** **Online:** changehealthcare.com	> Information and registration for electronic payment services
Fraud, Waste, and Abuse (FWA) Hotline	**Phone: 800-455-4521**, M-F, 9 a.m. to 5 p.m. **Fax: 888-659-0617** **Online:** medicaplans.com **Email:** ReportFraud@UHCsouthflorida.com **Mail:** Medica HealthCare Special Investigations Unit P.O. Box 56-6596 Miami FL 33256-6596	> Report concerns related to fraud, waste, or abuse.

Resources	Where to Go	What you can do there
Grievances & Appeals	**Phone:** Call the provider number listed on the back of the member's identification card. **Mail:** Medica Healthcare Grievances & Appeals Department P.O. Box 30997 Salt Lake City, UT 84130	> For questions about filing a grievance or appeal on behalf of a member, status inquiries, or requests for forms.
Home Health (MedCare)	**Phone: 305-883-2940**	> Arrange for services > On-call 24 hours a day > You may also call Utilization Management or Network Management
Member Services	**Phone: 800-407-9069** M-F 9 a.m. to 5 p.m. **TTY:** 711 **Fax: 800-5174-6924**	> To assist our members with any questions, help locate specialists, and perform other related functions. > Also printed on the member's Plan ID card
Network Management Services	**Phone: 877-670-8432** M-F 9 a.m. to 5 p.m. **Fax: 888-659-0619** **Email:** pcp-NetworkManagementServices@uhcsouthflorida.com	> For questions regarding provider agreements, in-servicing and follow-up and outreaches > Report demographic changes > Informal complaints > Find or request forms or other materials > Verify a member's eligibility, including plan benefits, deductibles, and information on the member's primary care provider, as applicable > Submit, search for, and print authorizations for outpatient services or inpatient stays > Search for, view, and check the status of claims
Pharmacy (OptumRx)	**Phone: 800-711-4555** **Fax: 800-527-0531**	> Verify pharmacy benefits and eligibility, adjudications, or authorizations
Risk Management	**Phone: 952-406-4806**	> Report incidents involving all privacy issues (potential breeches of PHI or PII) immediately to our Risk Manager
Utilization Management (UM)	We recommend that you initiate requests for notifications and authorizations electronically. **Phone: 866-273-9444** M-F 9 a.m. to 5 p.m. **Fax: 855-307-8531**	> If additional medical information is needed, or the request cannot be completed electronically > UM staff is available to answer any of your questions or discuss any UM issue you may have and to assist with information regarding referrals, prior authorizations, case management, concurrent review, and admission certification or notification

Resources	Where to Go	What you can do there
Ancillary and Enhanced Benefit Providers		
24-Hour Nurse Hotline **Optum Nurse Line**	**Phone: 855-575-0293**	> Only available under certain plans > Nurses are available to triage callers to emergency or urgent care, or to refer them to their primary care physician
Behavior Health Svc **(Beacon Health Options, LLC)**	**Phone: 855-371-2285** Licensed clinicians are available 24 hours. Member Services – 8 a.m. to 8 p.m.	> Behavioral health and substance abuse services for all members > A list of behavioral health practitioners and care providers are included in the provider directory
Dental **(Solstice)**	**Phone: 855-351-8163** **Online:** SolsticeBenefit.com	> A list of Solstice dental providers is available in the provider directory
Fitness **(Silver Sneakers®)**	**Phone: 877-427-4788** M-F 8 a.m. to 9 p.m. **Online:** silversneakers.com	
Hearing **(Hear-X/HearUSA)**	**Phone: 877-670-8432** M-F 9 a.m. to 5 p.m.	
Laboratory **(LabCorp)**	**Phone: 855-277-8669** Automated Line **Phone: 800-877-7831** Live Scheduling **Online:** labcorp.com	> Information on locations, to make an appointment, and to order lab tests and view results
Mail Order Pharmacy **(OptumRx)**	**Phone: 877-889-6358** **Online:** optumrx.com	> Obtain mail-order medications
Podiatry - Network Mgmt Services **(Foot and Ankle Network)**	**Phone: 877-670-8432** M-F 9 a.m. to 5 p.m.	> A list of podiatrists is included in our provider directory
Transportation **(Member Services)**	**Phone: 888-774-7772** M-F 9 a.m. to 5 p.m.	
Vision - Network Mgmt Services (iCare)	**Phone: 877-670-8432** M-F 9 a.m. to 5 p.m.	> A list of vision providers is included in our provider directory

Chapter 2: Provider Administrative Responsibilities

General Administrative Requirements

These are basic guidelines to which you have agreed to follow in your provider agreement. We update you, as necessary, regarding changes to these responsibilities.

Non-Discrimination

Do not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a member of Medica, or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to show you do not discriminate in delivery of service and treatment for any members in need of the services you provide.

Cooperate with Quality Management Activities

All participating care providers must follow all of our quality management and patient safety activities. These include:

> Timely provision of medical records upon requests including contracted business associates requests if the provision of copies or access to such records will be free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax;

> Cooperation with quality of care investigations including timely response to queries and completion of improvement action plans;

> Participation in quality audits, including site visits and medical record standards reviews, and annual Health Care Effectiveness Data and Information Set (HEDIS®) record review;

> If we request medical records, provision of copies or access to such records free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax;

> Allowing use of provider performance data.

Demographic Changes

Medica is committed to providing our members with the most accurate and up-to-date information about our network. Report changes to your practice information 30 days prior to the date of the change. Unless otherwise stated below, these demographic changes can be submitted by fax to **888-659-0619**. Demographic changes include changes to any of the following: Taxpayer Identification Number, address, service locations, and additions and deletions to practice professional staff.

You may submit demographic changes by faxing a completed *Provider Demographic Change Request Form* found at UnitedHealthcareOnline.com > Tools & Resources > Forms or by faxing a written, detailed description of the change and its effective date. Any notice of a change to a Taxpayer Identification Number and any addition of a physician or other healthcare professional must include a completed W-9 form (found at IRS.gov).

Official Notice Requirements

You must send notice to us at the address noted in your agreement with us and delivered via the method required, within 10 calendar days of your knowledge of the occurrence of any of the following:

> 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 closing of your practice, and, if applicable, transfer of member records to another physician or facility.

Access Standards

We check physician accessibility and availability on an ongoing basis to measure performance against established standards for:

> Reasonable location of healthcare providers

> Number of care providers

> Appointment availability

> Emergency care and after-hours services

Monitoring activities may include surveys (including geo-access surveys), on-site visits, evaluation of member experience, and evaluation of complaints.

The following table includes the established standards for appointment access and after-hours care help ensure members have prompt and timely access to medical care and services. Performance against these established standards is measured at least annually.

Type of Service	Appointment Standard
Preventive Care	Within four weeks
Regular/Routine Care	Within 14 days
Urgent Care	Same day
Emergency Care	Immediately
After-Hours Care	24 hours/seven days a week for primary care physicians

The guidelines listed above are general UnitedHealthcare guidelines; state or federal regulations may require more stringent standards.

After-Hours Care

After-hours callers must be directed on how to receive care.

Direct callers with emergencies to:

> Hang up and dial 911; or

> Go to the nearest emergency room.

Direct callers with non-emergencies to:

> Go to an in-network urgent care center, if unable to wait to be seen;

> Stay on the line to be connected to the physician on call; or

> 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.

Substitute Coverage

If you are unable to provide care and are arranging for a substitute, you must substitute care with a Medica provider. Visit UnitedHealthcareOnline.com > Provider Directory for a current list of network care providers. If the covering physician is not recognized by us, their claims will
be denied.

Confidentiality of Protected Health Information (PHI)

Our UM Program complies with the policies of UnitedHealth Group related to ethics and integrity. Through application of the policies related to privacy, the program seeks to retain the trust and respect of our members and the public in handling of private information including health, financial, and other personal information in the conduct of our activities.

All employees, contracting care providers, and delegates of MHP are required to maintain the confidentiality of PHI, including member records. All information used for UM activities is maintained as confidential in accordance with federal and state laws and regulations, including HIPAA privacy and security requirements. Reasonable efforts are made to limit PHI access to the minimum necessary required to accomplish the intended purpose, in order to conduct health plan operations.

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

Examples of privacy incidents that must be reported include but are not limited to:

> Reports and correspondence containing PHI or Personally Identifiable Information (PII) sent to the wrong recipient

> Member or provider correspondence that includes an incorrect member's information

> Complaint received indicating that PHI or PII may have been misused

> Concern about compliance with a privacy or security policy

> PHI or PII sent unencrypted outside of your office

> Lost or theft of laptops, PDAs, CDs, DVDs, flash/USB drives and other electronic devices

> Caller mentions he/she is 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 is advising your office of a privacy risk

For more information on confidentiality, refer to *Chapter 6: Medical Records*.

Physician Extender Responsibilities

Physician extenders are state licensed healthcare professionals who may be employed or contracted by physicians to examine and treat Medicare members. Physician extenders are Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA). When care is provided by a physician extender, the following requirements must be met:

Physician extenders must be under direct supervision of a physician when providing care. This means that a physician must be present on the premises at all times when the physician extender is seeing patients.

> The member must be notified of the physician extender's credentials and the possibility of not being seen by a medical doctor.

> All progress notes made by the physician extender must be signed by the sponsoring physicians.

> Physician extenders will provide services as defined by protocol developed and signed (approved) by the sponsoring physician.

Inform Members of Rights and Advance Directives

You must communicate information, regarding the risks, benefits, and consequences of treatment or non-treatment, at a level the member can understand to decide among the treatment options. Health care professionals must 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.

According to the Federal Patient Self-Determination Act of 1990, physicians and care providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about patients' rights to accept or refuse treatment, and about their own policies regarding advance directives. For more information on member rights and responsibilities, refer to *Chapter 5: Member Rights & Responsibilities*.

Access to Medical Records

Medical records may be requested from you to help us with utilization and care management, quality assurance and improvement, claims payment, and other administrative processes. They also may be needed when reviewing your compliance with your participation agreement and billing practices. Unless your agreement states otherwise, the medical records are to be provided at no cost.

You must provide access to any medical, financial or administrative records related to your services within 14 calendar days of our request. Records may be required sooner for cases involving alleged fraud and abuse, member grievances, appeals, or a regulatory/accreditation agency requirement, unless your participation agreement states otherwise.

Medical records must be kept and protected for confidentiality for a minimum of ten years to comply with state and federal regulations. It may be longer if there is a government inquiry or investigation. You must provide access to medical records for the time in which you had your agreement, regardless of current participation status. For more information on medical records requirements, refer to *Chapter 6: Medical Records.*

Additional Medicare Advantage Requirements

If you participate in the network for our Medicare Advantage products, you must comply with the following:

- Do not discriminate against members in any way based on health status.
- Allow members to directly access screening mammography and influenza vaccination services.
- Do not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services.
- Provide female members with direct access to a women's health specialist for routine and preventive health care services.
- Help ensure members have adequate access to covered health services.
- Help ensure your hours of operation are convenient to members and medically necessary services are available to members 24 hours a day, seven days a week. Primary Care Physicians must have backup for absences.
- Make available or distribute plan marketing materials to members in accordance with CMS requirements.
- Provide services to members in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
- Cooperate with our procedures to inform members of health care needs that require follow-up and provide necessary training to members in self-care.
- Document in a prominent part of the member's medical record whether the customer has executed an advance directive.
- Provide covered health services in a manner consistent with professionally recognized standards of health care.
- Help ensure that 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.
- Cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- Cooperate with our processes for notifying members of network participation agreement terminations.
- Comply with our Medicare Advantage medical policies, quality improvement programs and medical management procedures.
- Cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators as specified by CMS.
- Cooperate with our procedures for handling grievances, appeals and expedited appeals.

Termination of Contract Agreements

We may terminate your agreement, with cause, via written notice. If your participation agreement ends for any reason, you may be required to assist in the transition of our members' care to another physician or health care professional who participates in the Medica network. This may include providing services for a reasonable time at our contracted rate during the continuation period, per your participation agreement and any applicable laws. Our UM staff is available to help you and our members with the transition. We will notify affected members at least 30 calendar days prior to the effective date of termination of your agreement, or as required under applicable laws.

As a participating physician, the records of the members that were under your care must be made available to the next physician at no cost to that physician or the member, and must be available to us upon request.

In the event that a member chooses to change to another healthcare provider in or out of network, the current care provider must supply all the necessary information and documentation to allow for a timely and smooth transition at no cost to the member, recipient physician or us.

Resolving Disputes – Agreement, Concern, or Complaint

If you have a concern or a complaint about your relationship with us, send a letter containing the details to the address listed in your agreement. A representative will look into your complaint and try to resolve it through an informal discussion. If our internal process does not resolve the dispute, please refer to your agreement's dispute resolution section, if applicable, for more information.

Chapter 3: Utilization Management

The UM Program is designed to interface with and support the Medicare Advantage Quality Management (QM) Program.

The scope of the UM Program covers all clinical aspects of preventive, diagnostic and treatment services in both the inpatient and outpatient settings, which include behavioral health, substance abuse, and case and disease management.

UM clinical review is performed by health care professionals utilizing pre-established clinical decision making criteria to assist in decisions regarding requests for health care services that require authorization.

Services Not Requiring Prior Authorization

Medica does not require prior authorization for certain services. Please use the Enterprise Prior Authorizaiton List (EPAL) to see what services do require authorization.

Simple Referral Process

Medica HealthCare's Simple Referral Process serves as a tool to help Primary Care Physicians better coordinate patient's care.

Referrals are necessary for most participating specialists*. Requests for non-participating care providers will need additional authorization.

> Register on our website to get online access at UnitedHealthcareOnline.com.

> You can request a referral for one or multiple visits

> The referral is good for the number of visits approved, valid for six months from the date issued

> No supporting documentation is needed for referrals to specialists

> Requests for referrals must be submitted through our online provider portal at UnitedHealthcareOnline.com beginning 1/1/2017

> Upon submitting a referral request, the system automatically generates the referral number to be printed

> For member convenience, you can also provide members with a copy of the referral confirmation

> Specialists have the ability to view referral via UnitedHealthcare portal

> For additional questions call us at (877) 670-8432 or email us at pcp-NetworkManagementServices@uhcsouthflorida.com

Contact Network Management Services for a comprehensive list of specialty types that require referrals.

Why is Authorization or Notification Required?
Information gathered about planned member services supports the pre-service clinical coverage review process, where applicable, and the care coordination process, which allows us to support our members throughout their course of treatment, including pre-service planning and coordination of home care and other discharge plans.

Authorization Requirements

> Physicians, health care professionals and ancillary providers are responsible for obtaining prior authorization for all services requiring authorization before these services are scheduled or rendered, such as, outpatient services or planned hospital admissions.

> Prior authorization for outpatient services or planned hospital admissions, including Acute Inpatient Rehab (AIR) and Long Term Acute Care Hospital (LTACH) admissions, should be submitted as far in advance of the planned service as possible to allow for coverage review. Prior authorizations are required to be submitted at least seven calendar days prior to the planned date of service.

> Prior authorizations for home health and home infusion services, durable medical equipment, and medical supply items should be submitted to MedCare Home Health is **305-883-2940** and Infusion/DME is **800-819-0751**.
Note: You should not request an expedited (72 hours) review unless it is determine that waiting for a standard (14 calendar days) review determination could place the member's life, health, or ability to regain maximum function in serious jeopardy. Once you determine the situation meets this definition, request that a prior authorization be expedited by placing 'STAT' or 'urgent' on the Prior Authorization Form.

> Prior authorizations are required for referrals to out-of-network specialty or ancillary providers when the member requires a necessary service that cannot be provided within the available Medica network. The referring physician must submit a completed Prior Authorization Form for approval.

> It is important that you and the member are fully aware of coverage decisions before services are rendered.

> If you provide the service before a coverage decision is rendered, and we determine that the service was not a covered benefit, we may deny the claim and you must not bill the member; Without a coverage determination, a member does not have the information needed to make an informed decision about receiving and paying for services.

Notification Requirements

For any inpatient or ambulatory outpatient service requiring prior authorization, the facility must confirm, prior to rendering the service that the coverage approval is on file. The purpose of this protocol is to enable the facility and the member to have an informed pre-service conversation; in cases where it is determined that the service will not be covered; the member can then 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, notification is required no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.

> If a member receives urgent care services, you must notify us within 48 hours of the services being rendered.

Admission Notification Requirements

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

- Planned elective admissions for acute care
- Unplanned admissions for acute care
- Skilled Nursing Facility (SNF) admissions
  - Notification of admissions to SNF should be done within 24 hours.
- Prior authorizations are not a requirement.
- Admissions following outpatient surgery
  - LTACH and AIR require prior authorization.
- Admissions following observation
- Acute inpatient rehabilitation admission
- LTACH admissions

> Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission (or by 5 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For after-hour, weekend and federal holiday admissions, please call the Utilization Management Department at **866-273-9444** for assistance.

> Admission notification by the facility is required even if notification was supplied by the physician and a coverage approval is on file.

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

> Admission notifications must contain the following details regarding the admission:

- Member name and member health care ID number
- Facility name
- Admitting/attending physician name
- Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
- Actual admission date
- Admission orders written by a physician

> For emergency admissions when a member is unstable and not capable of providing coverage information, the facility should notify us as soon as the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

If the requirements described are not followed, the services may be denied and the member held harmless.

A notification or prior authorization approval does not ensure or authorize payment, subject to state rules and Medicare Advantage policies. Payment is dependent upon the member's coverage, the care provider's eligibility and participation agreement and claim requirements.

How to Request Prior Authorization

> It is recommended that you initiate prior authorization requests electronically via the provider web portal at UnitedHealthcareOnline.com. You must register with us prior to using this service.

> If you do not have electronic access, you may call us at the number on the back of the members' health care ID card.

> For manual prior authorizations, the requesting care provider must complete and sign the Prior Authorization Form, and fax it to the Utilization Management Department at **855-307-8531**. This form can be used by both primary care physicians and specialists.

Required Information for Prior Authorization

Prior authorizations must contain the following information about the planned service:

> Member information: Name, DOB, and membership ID number

> Requesting care provider information: Name, specialty, designate par or non-par, address and phone and fax numbers

> Primary care physician information, if different from the requesting care provider: Name, phone and fax numbers

> Referral information: Name of referral care provider, designate par or non-par, address, phone and fax numbers

> Diagnosis or symptoms: Include the diagnosis description and the corresponding ICD-10 code for each diagnosis to the highest specificity

> Service(s) Requested:

- Identify each procedure, and its corresponding CPT code,
- Document any pertinent clinical summary information which would be helpful to that specialist or for the UM determination in the additional comments field, and
- Enter the date of service and number of visits requested, and sign where indicated.

Where a clinical coverage review is required in the member's benefit plan, we may request additional information in order to make the necessary determination, as described in more detail in the Clinical Coverage Review: Clinical Information section of this chapter.

> Certain services may not be covered 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, the notification process will be administered in accordance with applicable regulations.

Timeframes for Processing Prior Authorization Requests

Our determination is made within 14 calendar days of receipt, or within 72 hours for an expedited review. It is important that we have all of the necessary documentation at the time of your request to help with the decision.

Clinical Coverage Review

Certain services require prior authorization which results in:

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

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

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

In addition:

> We may also use tools developed by third parties, such as the MCG™ guidelines, to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

> For Medicare Advantage members, we use CMS coverage determinations, the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) to determine clinical criteria for Medicare members. There is a hierarchy that is utilized in applying clinical criteria.

Clinical Coverage Review Criteria

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

Coverage Determination Decisions

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

Coverage decisions are made based on the definition of "reasonable and necessary" within Medicare coverage regulations and guidelines. Hiring, promoting or terminating physicians or other individuals are not

based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Prior Authorization Denials

We may deny a prior authorization request for several reasons:

> Member is not eligible;

> Service requested is not a covered benefit;

> Member's benefit has been exhausted; or

> Service requested is identified as not medically necessary (based upon clinical criteria guidelines).

We must notify you and the member in writing of any adverse decision (partial or complete) within applicable time frames. The notice must state the specific reasons for the decision, and reference to the benefit provision and clinical review criteria used in the decision making process. We will provide the clinical criteria used in the review process for making a coverage determination along with the notification of denial.

Peer-to-Peer (P2P) Clinical Review

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

P2P discussions can occur at different points during case activity in accordance with timeframes, once a Medical Director has rendered an Adverse Determination. A P2P reconsideration request can only occur before a formal appeal is filed.

Medica physicians conducting clinical review determinations are available, by telephone, to discuss medical necessity review determinations with the member's physician requesting the service. We offer pre-denial P2P review. A clinician will contact you to initiate the P2P call. Please follow time line provided by the nurse during the call.

Additional UM Information

External Agency Services for Members

Some members may require medical, psychological, social services or other external agencies outside the scope of their benefits (for example, from Health and Human Services or Social Services). If you encounter a member in this situation, you should either contact Network Management Services, or have the member contact our Member Services Department at **800-407-9069** for assistance with, and referral to, appropriate external agencies.

Technology Assessment Coverage Determination

The technology assessment process is utilized to evaluate new technologies and new applications of existing technologies. Technology categories include medical procedures, drugs, pharmaceuticals, or devices. This information allows us to support decisions about treatments which best improve member's health outcomes, efficiently manage utilization of healthcare resources, and make changes in benefit coverage to keep pace with technology changes and to help ensure members have equitable access to safe and effective care. If you have any questions regarding whether a new technology or a new application of existing technologies are a covered benefit for your patients, please contact Utilization Management at **866-273-9444**.

Hospitalist Program for Inpatient Hospital Admissions

The Hospitalist Program is a voluntary program for members. Hospitalists are physicians who specialize in the care of members in an acute inpatient setting (acute care hospitals and skilled nursing facilities). A hospitalist oversees the member's inpatient admission and coordinates all inpatient care. The hospitalist is required to communicate with the member's selected physician by providing records and information such as the discharge summary, upon the member's discharge from the hospital or facility.

Discharge Planning

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

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

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

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

> An extension of the approval is needed. Contact must be made prior to the expiration of the approved days.

> The member's discharge plan indicates that transfer to an alternative level of care is appropriate.

> The member has a complex plan of treatment that includes home health services, home infusion therapy, total parenteral nutrition, or multiple or specialized durable medical equipment identified prior to discharge.

> Addressing lifestyle-related health issues and referring to programs for weight management, nutrition, smoking cessation, exercise, diabetes education and stress management, as appropriate.

> Helping members understand and manage their condition and its implications.

> Education for reducing risk factors, maintaining a healthy lifestyle, and adhering to treatment plans and medication regimens.

Appeal and Reconsideration Processes

Medicare Advantage Hospital Discharge Appeal Rights Protocol

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

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

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

> When there are not any Medica facility onsite staff, the facility completes the DNOD, and delivers the DNOD to the Medicare Advantage member or their representative as soon as possible but no later than 12 p.m. local time of the day after the BFCC-QIO notification of the appeal is received. The facility faxes a copy of the DNOD to the BFCC-QIO and Medica.

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

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

Delivery of notice is valid only upon signature and date of Customer or Customer's authorized representative. If the Customer is incompetent, you must use the standard CMS approved notice entitled, *Notice of Medicare Non-coverage (NOMNC) form*. The form and instructions regarding the NOMNC is on the CMS website or contact KEPRO the BFCC-QIO for Florida at this link: keproqio.com/. There can be no modification of the NOMNC notification text.

Clinical Appeals: Standard and Expedited

To appeal an adverse decision (a decision to deny authorization of a service or procedure because the service is determined not to be medically necessary or appropriate), on behalf of a member, you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter you received provides you with the filing deadlines and the address to use to submit the appeal. In the event a member designates a healthcare professional to appeal the decision on the members' behalf a copy of the member's written consent is required and must be submitted with the appeal.

When the final decision is made, you will be notified via mail. If the decision is to overturn the original determination, the service will be authorized. If the decision is to uphold the original denial determination, there will be no further action for you to undertake.

Chapter 4: Pharmacy

Drug Formulary

We offer an extensive drug formulary. Generic prescriptions, when appropriate, are the most cost effective alternatives. Our formulary includes a complete list of the drugs we cover, generic and brand name, and any requirements, limits, or restrictions for each drug, if applicable. The formulary is available at professionals.optumrx.com > Quick Links > Formulary and drug lists, or call our OptumRx at **800-711-4555**.

Our formulary offers five drug tiers:

> Tier 1: Preferred generic drugs

> Tier 2: Non-preferred generic drugs

> Tier 3: Preferred brand-name drugs

> Tier 4: Non-preferred brand-name drugs and non-preferred generic drugs

> Tier 5: Specialty drugs

You can look up a drug in our formulary to find out which tier it is in. The formulary is subject to change.

If a drug is not on our formulary, members can possibly be switched to a different drug that we do cover, or you can request a formulary exception. While the exception is being evaluated, we may provide members with a temporary supply. For details, refer to *Transition Policy* section below.

Coverage Limitations

The following highlights some of our drug coverage limitations:

> A maximum quantity of a 90-day supply per prescription when obtained from a pharmacy or from the OptumRx mail order pharmacy.

> For some drugs we may require authorization before the drug can be prescribed (prior authorization), there may be limits on the quantity that can be prescribed per prescription (quantity limits), or we may require that you prescribe drugs in a sequence (step therapy), trying one drug before another drug. For details, refer to *Utilization Management Rules* on the next page.

An exception process is provided to allow for cases in which the formulary may not accommodate the unique medical needs of a patient. To make an exception to these restrictions or limits, you must fill out and submit a *prior authorization form*. The forms are available on professionals.optumrx.com > prior authorizations > fax forms.

Part B Drug Coverage

Drugs covered under Part B are typically administered and obtained at the care provider's office. Some examples are certain cancer drugs, administered by a physician in their office; insulin when administered via pump and diabetes test strips.

Diabetes Monitoring Supplies

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

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

OneTouch® Ultra® 2,

OneTouch® Verio™,

OneTouch® Verio Flex™,

OneTouch® UltraMini™,

ACCU-CHEK® Aviva Plus, and

ACCU-CHEK® SmartView.

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

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

Drugs Covered Under Part B or Part D

Some drugs can fall under either Part B or Part D. The determination of coverage as to whether the drug is Part B or Part D is based on several factors such as diagnosis, route of administration and method of administration. For a list of medications in each category, refer to the CMS website at cms.gov; choose Medicare > Prescription Drug Coverage-General Information > Downloads, and select the appropriate document. Alternatively, you may contact our Pharmacy department.

Long Term Care Facility (Includes Mental Health Facilities) Pharmacies

We provide convenient access to network long-term care (LTC) pharmacies for all members residing in LTC and mental health facilities. For a list of network pharmacies covering long term care facilities, refer to the Provider Directory.

Home Infusion

We cover drugs for home infusion therapy if the home infusion services are provided by a home infusion therapy network pharmacy. However, Medicare Part D does not cover the supplies and equipment needed for administration. For information on home infusion therapy, contact our Pharmacy department.

Vaccines

Most vaccines and the associated administration fees are covered under Part D. Our plan provides coverage of a number of vaccines, some of which are considered to be medical benefits (Part B medications) and others of which are considered to be Part D drugs.

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

The rules for coverage of vaccinations are complex and dependent on a number of factors. If you are unsure of how a vaccine will be covered, contact the Pharmacy department at **800-711-4555**. For a list of vaccines and how they are covered, refer to our formulary available on professionals.optumrx.com > Quick Links > Formulary and drug lists.

Injectable Medications

Injectable medications administrated in the care provider's office and self-administered medications can be obtained from specialty pharmacy suppliers and are covered under the Part D benefit. Prior authorization may be required for these drugs. Refer to the *Prior Authorization* section below for more information.

Injectable medication authorizations should be ordered one to two weeks in advance of the service date to allow for eligibility and coverage review and for shipping. To order injectable medications, complete and submit a prior authorization form to our Pharmacy department. The forms are available at professionals.optumrx.com > prior authorizations > fax forms.

Contact our Pharmacy department at **800-711-4555** for details on the rules governing injectable medications.

Utilization Management Rules

For certain prescription drugs, we may have additional requirements for coverage or limits on coverage. The medications subject to utilization management rules are subject to change. Prior to prescribing medications you should check our formulary online at professionals.optumrx.com > Quick Links > Formulary and drug lists or call the Pharmacy department. Certain drugs may require:

> Prior Authorization

> Quantity Limits - We may limit the amount of the drug that we will cover per prescription or for a defined period of time.

> Generic Substitution - We recommend the generic version, unless the care provider has told us that the member must take the brand-name drug and we have approved the request.

> Step Therapy - We require you to first try certain drugs before we will cover another drug for that condition.

If a drug is subject to one of the above restrictions or limitations and the restrictions are not followed we will reject the claim.

If a drug is subject to one of these restrictions and our member is not able to meet the additional restriction for medical necessity reasons, you or the member may request an exception. For more information, refer to the *Exceptions* section of this chapter.

Prior Authorization

Drugs that require prior authorization are marked PA in our formulary. Prior authorizations can be submitted online at professionals.optumrx.com > Prior authorizations. Forms are also available at that link.

Response Times

For Part D drugs that require prior authorization we will respond within 72 hours for standard requests and 24 hours for expedited requests.

For Part B drugs our response time is 14 days for standard requests and 72 hours for expedited requests.

Quantity Limits

Quantity limits ensure that prescription drug coverage reflects drug manufacturers and FDA dosing guidelines. Medications subject to quantity limits are identified in the formulary. These limits specify that coverage is allowed for a maximum quantity of prescribed medication, per prescription. You can find out if a drug is subject to these quantity limits by checking our formulary at professionals.optumrx.com > Quick Links > Formulary and drug lists or by calling our Pharmacy department at **800-711-4555**.

Both retail and mail order pharmacy drugs can be prescribed for up to a 90 day supply for Tiers 1, 2, 3, and 4. Tier 5 drugs may be limited to a 30 day supply per prescription.

Generic Substitution

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

Therapeutic Interchange

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

Step Therapy

Step therapy requires the use of a designated prerequisite drug first, in order for another drug to be covered. Medications subject to the step therapy requirement are identified in our formulary with an "ST."

If you determine that the prerequisite drug is medically unacceptable, you must submit a prior authorization.

Coverage Determinations

A coverage determination is a decision we make about Plan D benefits and coverage or about the amount we will pay for prescribed drugs. The prescribing physician or the member may request a coverage determination. It may be requested orally, in writing, or by fax. Coverage determinations may include:

Deciding whether or not a drug is medically necessary

> Determining if a drug falls into the benefit exclusion list

> Determining if a drug meets the established prescribing criteria

> Quantity limitations (i.e., requesting more than are typically allowed).

Exceptions

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

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

New members taking drugs that are not on our formulary or for which we have restrictions should talk with you to decide if they should switch to another appropriate drug that we do cover, or if you should request an exception. In certain cases, we will cover the drug during the member's first 90 days of membership with us while you and the member determine the desired course of action.

To request an exception, please fill out a prior authorization form. These forms are found on professionals.optumrx.com > prior-authorization > fax forms. Fax the form and any supporting documentation to 800-527-0531. For urgent requests, call 800-711-4555.

Transition Policy

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

Note:

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

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

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

	Current Member (> 90 days)	New Member (< 90 days)
Retail Pharmacy (Not in a Long Term Care Facility)	Length of the prescription up to a maximum of 30 days. During first 90 days of plan calendar year only.	Length of the prescription up to a maximum of 30 days. During first 90 days of plan calendar year only.
Long Term Care Facility Pharmacy	Length of the prescription up to a maximum of 34 days.	Length of the prescription up to a maximum of 34 days. We will cover refills if necessary. During first 90 days of plan calendar year only.

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

Pharmacy Network

Members must go to a network pharmacy to receive covered drugs. Refer to the Provider or Pharmacy Directory for a list of participating retail, chain, long-term care, home infusion, and mail-order pharmacies, and other relevant information.

Physicians must prescribe a 30 to 90 day supply (a 30-day supply with two refills is not the same). Members may obtain the Mail Order form at OptumRx.com > Forms. You may also call Member Services at **800-407-9069**.

Drug Utilization Review

We conduct drug utilization reviews to make sure members are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. Reviews occur every time a prescription is filled as well as when we review the member's records.

We look for medication problems such as:

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

If we identify any problems that warrant a modification, we will share our findings with you and discuss a possible alternate course of action with respect to how drugs are being prescribed. You may receive calls or faxes from our Pharmacy department following up on any findings. If you have any questions, please contact the Pharmacy department.

Medication Therapy Management (MTM)

The MTM Program is a free service we offer to members. We conduct reviews on members who:

- Have multiple chronic conditions;
- Are taking at least eight unique Part D Drugs; and
- Incur an annual cost of at least $3,919 for all covered Part D drugs.

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

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

2017 Medica Pharmacy Benefit Summaries

The 2017 Medica benefit summaries are available at medicaplans.com > Plans and Services.

Chapter 5: Member Rights & Responsibilities

We inform our members that they have specific rights and responsibilities as outlined in the member materials for Medicare Advantage benefit plans, all of which are intended to help uphold the quality of care and services that they receive from you.

The Member Rights and Responsibilities Statement is published each year in the Evidence of Coverage (EOC) available on the Medica website at medicaplans.com. A copy of the *Member Rights and Responsibilities Statement* can also be obtained by contacting Network Management Services at **877-670-8432**. If your patient has questions about their rights as a Medicare Advantage member, please refer them to the Member Services phone number on the back of their ID Card.

Member Participation in Treatment Options

Members have the right to freely communicate with their physician and participate in the decision making process regarding their health care, regardless of their benefit coverage. Physicians should encourage and provide active member communication and participation in their treatment planning and course of care. This includes the member's right to withhold resuscitative services or to forgo or withdraw life-sustaining treatment in compliance with federal and state laws.

Each member has the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law, as applicable. Physicians must communication information, regarding the risks, benefits, and consequences of treatment or non-treatment, at a level the member can understand to decide among the treatment options.

Competent members have the right to refuse a recommended treatment, counsel or procedure. The physician may regard such refusal as incompatible with the continuance of the physician/patient relationship and the provision of proper medical care. If this occurs, and the physician believes that no professionally acceptable alternatives exist, the physician must so inform the member in writing, via certified mail. The physician must give the member 30 calendar days to find another care provider. During this time, the physician is responsible for providing continuity of care to the member. For more information, refer to *Chapter 7: Quality Management Programs*.

Advance Directives

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

This law states that members' rights and personal wishes must be respected even when the member is too sick to make decisions on their own.

To help ensure a person's choices about health care will still be respected, even when they are no longer able to make such decisions, the Florida legislature enacted Chapter 765, Florida Statutes. Care providers, hospitals, nursing homes, home health agencies, hospices, and HMOs are required to provide their patients with written information regarding advance directives and their treatment options.

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

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

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

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

Member Financial Responsibility

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

If you prefer to collect payment at the time of service, you must make a good faith effort to estimate the member's responsibility using the tool we make available and collect no more than that amount at the time of services. The Claims & Payments tool is available on our website at medicaplans.com > Physicians and Providers, to help you determine member and health plan responsibility.

Chapter 6: Medical Records

A well-documented medical record reflects the quality and completeness of care delivered to patients. You are required to keep accurate and complete medical records of our members for at least ten years. Medical record review is a tool we use to evaluate the quality, timeliness, and appropriateness of the services rendered.

Documentation and Confidentiality of Medical Records

You are required to maintain records, correspondence and discussions regarding the member in the strictest of confidence and protection.

You must keep a medical records system that:

> Follows professional standards

> Allows quick access of information

> Provides legible information that is accurately documented and available to appropriate healthcare providers

> Maintains confidentiality

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

The following guidelines are applicable:

> Records that contain medical / clinical, social, financial or other data on a patient is treated as confidential and is protected against loss, tampering, alteration, destruction, or inadvertent disclosure;

> Release of information from your office requires that you have the patient sign a *Medical Record Release Form* 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 abuse, or potential chronic medical conditions that may affect the member's plan benefits are subject to additional specific waivers for release and confidentiality.

Exemption from Release Requirements

HIPAA regulation 45 CFR § 164.512 (d) specifically permits disclosure of protected health information to government benefit programs for which health information is relevant to beneficiary eligibility, without patient authorization.

Medical Records Requirements

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

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

Advance Directives: For detailed information on advance directives, refer to *Chapter 5: Member Rights & Responsibilities*. 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. This discussion should be documented at least once in the member's medical record.

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, all entries should be 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: As part of the past medical history, family history should be documented 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, vaccination history must be recorded.

Medication List: The member's current medications should be listed, with start and end dates, if applicable and re-conciliated within 30 days post inpatient admissions.

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

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

Preventive Screenings: Participating care providers will promote the appropriate use of age/gender specific preventive health services for members in order to achieve a positive impact on the member's health and better medical outcomes.

Required Encounter Documentation: Every visit must include the following documentation:

> The date;

> Chief complaint or purpose;

> Objective findings;

> Diagnosis or medical impression;

> Studies ordered (lab, x-ray, etc.);

> Therapies administered or ordered;

> Education provided;

> Disposition, recommendations, instructions to the member and evidence of whether there was follow-up; and

> Outcome of services.

Documentation that a written policy regarding follow-up care and written procedures for recording results of studies and therapies and appropriate follow-up has been adopted must be available.

As a part of their medical record, members should sign a *Medical Record Release Form*, as well as a *Refusal Form* when declining a preventative screening referral.

We also recommend that medical records include copies of care plans whenever home health or skilled nursing services are being provided.

Medical Record Reviews

As a part of our recredentialing requirements, and for HEDIS reporting, we perform reviews of care providers' medical records. Our review criteria incorporate applicable federal, state and regulatory requirements for medical record documentation.

The purpose of periodic medical record reviews is to determine compliance with standards for documentation, coordination of care and outcome of such services; to evaluate the quality and appropriateness of the care provider's office medical records documentation; and to promote continuous improvements. These reviews evaluate medical records and do not define standards of care or replace a physician's judgment.

We conduct pre-contractual medical record reviews; thereafter, reviews are done every three years for re-credentialing purposes. All primary care providers and high volume specialists are subject to medical record reviews.

At the conclusion of the review, the reviewer will notify you of any deficiencies identified during the review. You must achieve a score of at least 80% in order to meet our quality standard. Care providers who do not meet the standard have up to 30 days to address the items noted and provide a written response, signed by you. If applicable, we will issue a Corrective Action Plan, or provide guidance and other tools to assist providers in improving documentation of care. Any care provider not meeting the Corrective Action Plan will be reported to the Credentialing Committee for further action.

Chapter 7: Quality Management Programs

Medica is a health care delivery organization that provides comprehensive medical care and services for Medicare Advantage members through a network of physicians, facilities and other health care professionals. Medica operates under the UnitedHealthcare, Medicare Advantage Quality Management (QM) Program (hereafter referred to as the Program) which is designed to objectively monitor, systematically evaluate, and effectively improve the quality and safety of clinical care and services provided to all Medicare Advantage members and to provide oversight and guidance for all Medicare Advantage plans. The Program is universal and is implemented by all of the UnitedHealthcare Medicare Advantage health plans, both National and Regional. At the individual Plan Benefit Package (PBP) level these activities may have unique metrics and systematic improvements that are designed to fit the population of each PBP.

Health promotion, health management, and patient safety activities are an integral part of the Program and are specialized according to regulatory requirement, population needs, and available delivery models. The QM program identifies planned activities related to program priorities that address the quality and safety of clinical care and services, including special attention to high volume and high risk areas of care and service. These QM activities include:

> Promote and incorporate quality into the health plan's organizational structure and processes.

> Provide effective monitoring and evaluation of patient care and services provided by practitioners and care providers for compatibility with evidence based medicine guidelines.

> Identify and analyze opportunities for improvement and implement actions and follow-up.

> Coordinate quality improvement, risk management, patient safety and operational activities.

> Maintain compliance with local, state and federal regulatory requirements and accreditation standards.

> Serve culturally and linguistically diverse populations.

> Monitor and improve quality indicators.

> Serve members with complex health needs.

Quality Management Committees

The Medical Advisory Committee (MAC) oversees, reviews, and provides recommendations on QM activities. Reviews may include, but are not limited to, clinical practice guidelines, medical policies, pharmacy updates, service standards, over-under utilization of services by physicians and other health care professionals. This committee also makes recommendations regarding the selection of QM studies (based on identified high-volume, high-risk and problem-prone areas in their regions) and develops and implements regional components of the QM work plan.

The UnitedHealthcare Board of Directors has delegated responsibility for the oversight of health plan quality improvement activities to the Regional Quality Oversight Committee (RQOC).

The Regional Peer Review Committee (RPRC) provides a forum for qualified physicians to investigate, discuss and take action on member cases involving significant concerns about quality of care. The RPRC has been delegated decision-making authority by the National Peer Review Committee (NPRC).

The NPRC provides a forum for qualified physicians to discuss and take disciplinary action on member cases involving significant concerns about quality of care that were unresolved through Improvement Action Plan mechanism administered by the RPRC.

The National Provider Sanctions Committee (NPSC) provides a forum for qualified physicians to discuss and take action on sanction reports involving participating practitioners that raise issues regarding compliance with our credentialing plan, and/or patient safety concerns. Sanctions are monitored from government agencies and authorities including but not limited to CMS, Medicaid agencies, state licensing boards, and the Office of the Inspector General (OIG) that relate to Licensed Independent Practitioners (LIP).

Quality Management Program Activities

Scope of QM Program Activities

This involves a variety of mechanisms to measure and evaluate the total scope of services and care provided to health plan members. The three primary types of activities are Quality of Care (QOC), Patient Safety, and Quality of Service (QOS).

QOC measures are used to monitor and evaluate performance on important dimensions of care. monitoring

> QOC monitoring activities come from a variety of sources including, but not limited to, Star Ratings, HEDIS, Health Outcome Surveys (HOS), Chronic Care Improvement Programs (CCIP) and Quality Improvement Projects (QIP), patient safety, peer review, and Member Engagement.

> The commitment to patient safety is demonstrated throughout the QM programs and activities which are available to support our members.

> Members' satisfaction with their experiences with a health plan are influenced by customer service interactions, costs, ease of using plan services, accessibility to care and experience with practitioners/providers in the course of receiving care. The CAHPS

survey results are used to provide information on the members' satisfaction with these key drivers. The plan augments the CAHPS survey with additional survey data such as the UnitedHealthcare Experience Survey (UES), Net Promoter Score (NPS) and satisfaction data from OptumHealth programs such as Disease Management and Case Management.

Medicare Advantage and Prescription Drug Plans

Several industry quality programs, including the programs for CMS Star Ratings, provide external validation of our Medicare Advantage and Part D plan performance and quality progress. Quality scores are provided on a 1 to 5-star scale, with 1 star representing the lowest quality and 5 stars representing the highest quality. Star ratings scores are derived from four sources:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or patient satisfaction data;
2. Healthcare Effectiveness Data and Information Set (HEDIS) or medical record and claims data;
3. Health Outcomes Survey (HOS) or patient health outcomes data; and
4. CMS administrative data on plan quality and Customer satisfaction.

To learn more about Star Ratings and view current Star Ratings for Medicare Advantage and Part D plans, go to the CMS consumer website at cms.gov.

Clinical and Preventive Health Guidelines

MEDICA uses evidence-based clinical and preventive health guidelines from nationally recognized sources to guide the quality and health management programs. We hope you consider this information and use it when it is appropriate for our members who are your patients. A complete list of the current guidelines is available at medicaplans.com > Physicians and Providers > Clinical and Preventive Health Guidelines.

Credentialing and Recredentialing

We are dedicated to providing our members with access to effective health care and, as such, we credential physicians and other health care professionals who seek to participate in our network and get listed in our provider directory, and then recredential them at least every 36 months thereafter, in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are more extensive than (though, fully compliant with) the NCQA, CMS, and State of Florida requirements.

You must notify Network Management Services at **877-670-8432** if you add a new physician, physician assistant, or advanced nurse practitioner to your staff. New health care professionals may not see our members until a credentialing approval letter has been received.

We accept the Council for Affordable Quality Healthcare (CAQH) credentialing application. We use the CAQH Universal Provider Data Source to obtain credentialing and credentialing documentation for care providers that participate with CAQH. If the care provider is not a CAQH participant, or if the CAQH file is not updated, we will fax a request to for current documentation to your office. Care providers must maintain an active, Florida Medical License, DEA license and current malpractice insurance. Current documentation must be maintained in the CAQH system or sent directly to us.

A site audit and medical record review must be conducted at the time of recredentialing. Physicians are expected to cooperate and facilitate scheduling of these activities. Results will be made available to the physician, including any Corrective Action Plan, if needed.

Rights Related to the Credentialing Process

Physicians and other health care providers applying for network participation have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or recredentialing application, upon request.

Delegation Oversight

Some functions or activities that we would normally perform, under regulatory and accreditation standards and requirements, may be delegated to another organization. These delegated activities are described in a written, mutually agreed upon contract. The agreement outlines the delegated activities, reporting responsibilities, and remedies for inadequate performance, including revocation of the delegation agreement. Oversight of these delegated activities is required by CMS and the NCQA. We will conduct ongoing oversight. Opportunities for improvement are identified and addressed, as applicable.

Case Management and Disease Management Program Information

Optum provides Case Management (CM) and Disease Management (DM) services for Medica HealthCare.

Here are the criteria for referrals to Optum CM and DM Programs:

> **Complex Case Management—*(Special Needs Plan (SNP) members only)***
- Three or more unplanned admissions and/or Emergency Room (ER) visits in the last six months or
- Multiple, complex co-morbid conditions and/or
- Coordination of multiple community resources/ financial supports to cover basic services

> **Heart Failure (HF) Disease Management Program**
- Diagnosis of HF and
- Has CHF on an inpatient claim or
- HF admission in last three months

> **Diabetes Disease Management Program**
- Diabetic with A1C 9% or greater or
- An inpatient admission related to diabetes in the past 12 months or
- Two or more ER visits related to diabetes

> **Advanced Illness Case Management—**Primary goal is to facilitate and support end of life wishes and services
- Life expectancy of 12 - 18 months
- Chronic, irreversible disease or conditions and declining health
- Reduce disease and symptom burden

> **Transplant Case Management and Network Services** Bone marrow/stem cell, kidney and kidney/pancreas, heart, liver, intestinal, multi-organs and lung transplants
- Case management for one year post-transplant

> **End Stage Renal Disease Case Management—**The member is diagnosed with end stage renal disease and is undergoing outpatient dialysis including in-center or home hemodialysis, home peritoneal dialysis, etc.

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

NOTE: South Florida Medica no longer provides Social Worker evaluations without skilled services. Please direct your patient to their local social services department or The Florida State Department of Elder Affairs Help Line at 800-963-5337.

To request CM or DM services for one of your patients, select only **one** program that your member meets the criteria for, and email the CM/DM referral form, available on medicaplans.com > Physicians and Providers > Provider Forms, to southfl@optum.com.

When appropriate, we provide referrals to other internal programs such as disease management, complex condition management, mental health, employee assistance and disability. Case management services are voluntary and a member can opt out at any time.

Behavioral Healthcare Programs

Beacon Health Options, LLC is the Managed Behavioral Healthcare Organization (MBHO) we have contracted with to provide behavioral healthcare services for our members. Beacon Health Options is accredited by the National Committee for Quality Assurance (NCQA) and submits regular reports to Medica for oversight and monitoring. As much as possible and as permitted by law, behavioral health and general medical management is combined for the best possible health outcomes.
For more information on how to access the Behavioral Healthcare programs, see the *How to Contact Us* table in Chapter 1, or you or our members may contact a representative through the phone number listed on the back of their health care ID card.

Special Needs Plans

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

The MOC is a framework for providing healthcare and healthcare plans designed by theory, evidence-based protocols and accepted standards. The MOC contains specific elements that delineate implementation, analysis and improvement of care.

These elements include description of SNP population (including health conditions), Care Coordination, Provider Network and Quality Measurement and Performance Improvement.

Structure and Process

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

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

Chapter 8: Healthcare Risk Management

Risk management addresses liability, both proactively and reactively. Proactive is avoiding or preventing risk. Reactive is minimizing loss or damage after an adverse or bad event. Risk management in health care considers patient safety, quality assurance and patients' rights. The potential for risk is present in all aspects of health care, including medical mistakes, electronic record keeping, provider organizations and facility management.

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

Agency for Healthcare Administration (AHCA)

The Florida Agency for Healthcare Administration (AHCA), as directed under F.S. 641 Parts I, II, III and other applicable state laws, provides oversight and monitoring of health plans operating in the State of Florida as an HMO and their compliance to applicable regulations. This includes implementation of a Risk Management Program (RMP) with the purpose of identifying, investigating, analyzing and evaluating actual or potential risk exposures by a state licensed risk manager. The RMP also corrects, reduces and eliminates identifiable risks through instruction and training to staff and care providers.

Examples of adverse and serious incidents as defined by AHCA include:

- > Death of a patient;
- > Severe brain or spinal damage to a patient;
- > Performance of a surgical procedure on the wrong patient;
- > Performance of a wrong site surgical procedure; or
- > Performance of a wrong surgical procedure.

For more information, go to the AHCA website at ahca.myflorida.com

CMS 2016 Hospital Acquired Conditions (HACs) and Codes

A hospital-acquired condition (HAC) is an undesirable situation or condition that affects a patient arising during a time spent in a hospital or medical facility. It is a designation used by CMS for determining MS-DRG reimbursement. For more information go to cms.gov > Medicare > Hospital Acquired Conditions.

HACs as of 2016:

- > Foreign Object Retained After Surgery
- > Air Embolism
- > Blood Incompatibility
- > Stage III and IV Pressure Ulcers
- > Falls and Trauma:
  - Fracture
  - Dislocation
  - Intracranial Injury
  - Crushing Injury
  - Burn
  - Other Injuries
- > Manifestations of Poor Glycemic Control
- > Catheter-Associated Urinary Tract Infection (UTI)
- > Vascular Catheter-Associated Infection
- > Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
- > Surgical Site Infection Following Certain Orthopedic Procedures of Spine, Shoulder & Elbow
- > Surgical Site Infection following Bariatric Surgery
- > Surgical site Infection following Cardiac Implantable Electronic Device (CIED) Procedure
- > Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
- > Iatrogenic Pneumothorax with Venous Catheterization

Provider Reporting Responsibilities

As outlined in our provider contracts, network providers are required to report to our Risk Manager all adverse events identified above, whether actual or potential. To report such incidents, please call **952-406-4806**.

Serious incidents must be reported to AHCA within 24 hours of occurrence. Consequently, all serious incidents, such as those listed below, must be reported immediately. This allows us to quickly access the risk and address liability. Examples of serious incidents include:

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

Our provider contracts include the obligation to participate in Quality Management inquiries upon request from the Clinical Quality Analyst. For more information, refer to *Chapter 7: Quality Management Programs*.

Chapter 9: Risk Adjustment & Coding

We are committed to providing the resources necessary to assist plan care providers in meeting the guidelines for the CMS compliant documentation and coding. Our team of certified coders can meet with care providers, by request, to help ensure success in the CMS Medical Risk Adjustment (MRA) model.

What is the Purpose of Risk Adjustment?
Risk adjustment strengthens the Medicare Advantage program by ensuring that accurate payments are made to Medicare Advantage organizations based on the health status of their enrolled beneficiaries. Accurate payments to Medicare Advantage organizations help ensure that care providers are paid appropriately for the services they provide to Medicare beneficiaries. The process adjusts payments to help ensure all eligible Medicare beneficiaries maintain robust access to Medicare Advantage plans, regardless of medical history.

Why is Risk Adjustment Important to Physicians and Providers?
The risk adjustment model relies on the ICD-10-CM diagnosis codes to prospectively reimburse MA organizations based on the health status of their enrolled beneficiaries. You must focus attention on complete and accurate diagnosis reporting according to the official ICD-10-CM coding guidelines.

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

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

CPT and HCPCS Codes

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

If 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 access CPT, HCPCS and ICD-10 coding resources and materials at the American Medical Association's website at ama-assn.org, or from another vendor.

Chapter 10: Claim Processes

You can learn more about the many tools available to help you prepare, submit and manage your UnitedHealthcare claims at UnitedHealthcareOnline.com > Help > Claims & Payments, including: Claim Estimator with bundling logic and Real-Time Adjudication, training tools and resources including Frequently Asked Questions (FAQs), Quick References, Step-by-Step instructions and tutorials.

Prompt Claims Processing

We know that you want your claims to be processed promptly for the covered services you provide to our members. We work hard to process your claims timely and accurately. This is what you can do to help us:

1. Make sure you submit the claim to the correct payer by reviewing the member's eligibility.

   Note: Eligibility and benefit information provided is not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date(s) of services rendered, and benefit plan terms and conditions. For Medicare Advantage benefit plans, reimbursement is also dependent on CMS guidance and claims processing requirements.

2. When applicable, notify us in accordance with the *How to Submit Advance or Admission Notifications/ Prior Authorizations* section in this guide.
3. Prepare complete and accurate claims (use our reference guides found on UnitedHealthcareOnline.com > Help > Claims and Payments).
4. Submit claims electronically for fast delivery and confirmation of receipt.

   a. EDI and Clearinghouse Connections –Participating and non-participating physician, health care professional, facility and ancillary care provider claims are accepted electronically. Medica HealthCare's payer ID is 78857.

   b. UnitedHealthcare contracts generally require you to conduct business with us electronically and contain requirements regarding electronic claim submission specifically. Please review your agreement with us and abide by its requirements. While some claims may require supporting information for initial review, we have reduced the need for paper attachments for referrals/notifications, progress notes, ER visits and more. We will request additional information when needed.

   c. For more information and tips for submitting claims electronically, visit UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions > Electronic Claims.

   d. If you need additional information on EDI, contact the EDI Support Line at 800-842-1109, Option 3. Issues can also be submitted online at UnitedHealthcareOnline.com > Contact Us > Electronic Data Interchange (EDI) Claims > EDI Transaction Support Form

Electronic Payments and Statements (EPS)

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

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

You may make electronic payments by direct deposit/ EFT into an organization's bank account or by Virtual Card Payment (VCP). With VCP, your bank account information is not needed as you process payments like a credit card transaction.

EPS with Direct Deposit: No Credit Card Processing Fees

While funds are deposited to your account, UnitedHealthcare will not debit or deduct claim adjustments from your checking or savings account. You may also contact your bank to help ensure you have appropriately placed controls over the electronic funds transfers to and from your account.

Posting and Balancing With EPS with Direct Deposit:

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

You should enroll with your clearinghouse if you would like to receive the 835 file from them.

EPS with Virtual Card Payments:

> Process Virtual Card Payments using the same method used by your organization to process credit card transactions. Your current credit card processing fees will apply. Please confirm those rates with merchant processor directly.

> Banking information is not shared outside your organization.

Posting and Balancing with Virtual Card Payment:

1. Your practice will receive one or more virtual card numbers (a card number is issued for each payer ID) in the mail and should be retained in a secure location as you will need it for future payments.
2. You will be notified of new claim payments by email
3. Log on to EPS and view, save or print remittance advice to post payments manually to your practice management system, or auto-post using the free electronic remittance advice 835/ERA.

Note: you should enroll with your clearinghouse if you would like to receive the 835 file from them.

EPS Registration

To learn more about EPS and to register, visit WelcometoEPS.com. If you have questions about EPS, direct deposit, Virtual Card Payments or enrollment, call us at **877-620-6194**, to speak with an EPS representative.

Claims and Encounter Data Submissions

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

It is particularly important to accurately code because a member's level of coverage under their benefit plan may vary for different services. To assist you in correctly coding your claims, the Claim Estimator on UnitedHealthcareOnline.com includes a feature called Professional Claim Bundling Logic, which helps you determine allowable bundling logic and other commercial claims processing edits for a variety of CPT (CPT is a registered trademark of the American Medical Association) and HCPCS procedure codes.

Only bundling logic and other claims processing edits are available under this option. Pricing and payment calculations for professional commercial claims are available under the Pre-Determination of Benefits option. Allow enough time for your claims to process and check the status in the claims management application on Link before sending second submissions or tracers. If you do need to submit a second submission or a tracer, please submit it electronically no sooner than 45 days after original submission.

Complete claims include the information listed under the *Requirements for Complete Claims and Encounter Data Submission* in the following section. Our preferred method to receive claims is electronically, but they can also be submitted on paper. If submitted electronically and required information is not provided or invalid codes used, the claim/encounter may be rejected or not processed or submitted to CMS for consideration in the risk adjustment calculation. If submitted using the paper form, the claim may be pended in order to obtain the correct information. In addition, we may require additional information for particular types of services, or based on particular circumstances or state requirements.

To order Form 1500 and CMS-1450 (also known as UB-04) forms, contact the U.S. Government Printing Office at **202-512-0455**, or visit the Medicare website.

Requirements for Complete Claims and Encounter Data Submission

Your claim may be pended or not processed if you omit any of the following:

> Member's name, address, gender, date of birth (dd/mm/yyyy), relationship to subscriber (policy owner)

> Subscriber's name (enter exactly as it appears on the member's health care ID card), ID number, employer group name and employer group number

> Rendering care provider's name, their signature or representative's signature, address where service was rendered, "Remit to" address, phone number, NPI and federal TIN

> Referring physician's name and TIN (if applicable)

> Complete service information, including date of service(s), place of service(s), number of services (day/units) rendered, current CPT and HCPCS procedure codes, with modifiers where appropriate, current ICDCM diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)

> Charge per service and total charges

> Detailed information about other insurance coverage

> Information regarding job-related, auto or accident information, if available

> Retail purchase cost (or a cumulative retail rental cost) greater than $1,000 for DME

Risk Adjustment Data

Risk adjustment is required by the U.S. Department of Health and Human Services (HHS) for commercial small group and individual benefit plans. Similar to the CMS risk adjustment program for Medicare Advantage benefit plans, HHS utilizes Hierarchical Condition Categories (HCCs) to calculate an annual patient risk score that represents the individual patient's disease burden. In order to perform the calculation, CMS and HHS require information from us annually about the demographic

and health status of our members. Therefore, the clinical documentation and diagnosis code information you submit to us must be accurate and complete. Because patient diagnoses do not carry forward from one year to the next under the commercial risk adjustment program, all existing and chronic conditions much be evaluated and documented at least once each calendar year in the patient's medical record and claims or encounters you submit.

The risk adjustment data you submit to us must be accurate and complete. It is critical for your office to refer to the ICD-10-coding guide and code accurately, specifically and completely when submitting claims and/or encounters to us. To comply with risk adjustment guidelines, specific ICD-10-CM codes are required. Some unspecified ICD-9 codes that were acceptable for risk adjustment are not acceptable for risk adjustment when submitted as an ICD-10-CM.

For example:

The former ICD-9 diagnosis 366.41 - Diabetic cataract maps to several more specific ICD-10 codes:

ICD-10 Risk Adjustable Code	ICD-10 Description
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract
E10.36	Type 1 diabetes mellitus with diabetic cataract
E11.36	Type 2 diabetes mellitus with diabetic cataract

> Remember, risk adjustment is based on ICD-10-CM diagnosis codes and CPT codes. Use the correct CPT codes and the ICD-10-CM coding guide and code accurately, specifically, and completely when submitting claims and/or encounters to us.

> Medical records must support the diagnosis codes. Therefore, medical records must be clear, complete and support all conditions coded on claims or encounters you submit.

> 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. Instead, code only to the highest degree of certainty.

> Distinguish between acute and chronic conditions 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 previously treated and no longer exist.

> Always carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the member's condition.

> Check the diagnosis code against the member's gender.

> Sign chart entries with credentials.

> All claims and/or encounters submitted to UnitedHealthcare for risk adjustment consideration are subject to federal and/or internal audit. Audits may come from CMS, HHS, or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner and provide all available medical documentation for the services rendered to the member.

National Provider Identification (NPI)

The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations, and many state Medicaid agencies mandate the adoption and use of a standardized NPI for all health care professionals. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPI for identification purposes in standard electronic transactions.

In addition, based on state-specific regulations, you may be required to submit your NPI on paper claims.

HIPAA defines a covered health care provider as any health care provider who transmits health information, such as claims, electronically. You must obtain an NPI and use this number in all HIPAA transactions, in accordance with the instructions in the HIPAA electronic transaction x12N Implementation Guides.

> To avoid payment delays or denials, we require you to submit a valid Billing NPI, Rendering NPI and relevant Taxonomy code(s) on both paper and electronic claims and encounters. In addition, we strongly encourage you to submit all other NPIs as defined below.

> It is important that, in addition to the NPI, you continue to submit your TIN.

The NPI information you report to us now and on all future claims and encounters is essential in allowing us to efficiently process claims and encounters and to avoid delays or denials.

We will continue to accept NPIs submitted through any of the following methods:

> Link: If you have received the upgraded My Practice Profile app and your ID administrator has granted you editing rights, you may update your NPI here for fastest service.

- > UnitedHealthcareOnline.com: To update your NPI and related information online, login and go to "Practice/ Facility Profile" and select the TIN. Click "Continue", select the "View/Update NPI Information" tab.
- > **Fax:** For all UnitedHealthcare business, you may fax your NPI to the appropriate fax number based on your geographic location/state. Find the form at Medicaplans.com > Physician and Providers > Participating Provider Forms.
- > **Phone:** 877-670-8432.
- > Credentialing/Contracting: NPI and National Uniform Claim Committee (NUCC) taxonomy indicator(s) are collected as part of credentialing, recredentialing, new provider contracting and re-contracting efforts.

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

Information is provided for the location of NPI, TIN and Taxonomy on paper and electronic claims on UnitedHealthcareOnline.com > Tools & Resources > National Provider Identifier.

Claim Submission Tips

Submit your claims and encounters as an 837 EDI Transaction

- > The payer ID for Medica HealthCare is 78857.

Claims that were either denied or pended for additional information should not be resubmitted by EDI or paper claim. Please use the claim management application on Link.

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 UnitedHealthcareOnline.com may be different from the number issued by your clearinghouse. Validate any discrepant Payer IDs with your clearinghouse to avoid processing delays.

Submit professional and institutional claims and/or encounters electronically, including secondary claims. The HIPAA ANSI X1 25010 837 format is the only acceptable format for submitting claims and encounter data.

We accept primary and secondary claims electronically and support other HIPAA EDI transactions to assist you with your revenue cycle process. Locate specific claims using either your provider ID or a specific member's ID and obtain a claim summary or line-item detail about claims status, including whether we have received the claims and whether they have been paid, pended or denied.

Estimating Treatment Costs

To facilitate the discussions you may have with your patients about treatment costs, we encourage you to take advantage of the Claim Estimator on UnitedHealthcareOnline.com.

The Claim Estimator tool provides a fast and simple way to obtain your commercial professional claim predeterminations through UnitedHealthcareOnline.com > Claims & Payments > Claim Estimator. With Claim Estimator, you can receive an estimate on whether a procedure will be covered, at what percentage, if any, and what the claim payment will be. Claim Estimator enables you to share this information with your patient before treatment.

Pass-through Billing/CLIA Requirements/Reimbursement Policy

If you are a healthcare care provider, you must only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

For laboratory services, you will only be reimbursed for the services you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services for which you lack the applicable CLIA certification.

Claim payment is subject to our payment policies (reimbursement policies) and medical policies, which are available to you online or upon request to your Network Management contact.

Special Reporting Requirements for Certain Claim Types

Anesthesia Services

- > Use one of the CMS-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) for anesthesia services reporting.
- > For electronic claims and/or encounters, report the actual number of anesthesia minutes in loop 2400 SV104 with an "MJ" qualifier in loop 2400 SV103. For Form 1500 paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H.
- > When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

Laboratory Claims

Many UnitedHealthcare benefit plan designs exclude outpatient laboratory services from coverage if they were not ordered by a participating care provider. Our benefit plans may also cover such services differently

when a portion of the service (e.g., the draw) occurs in the care provider's office, but the analysis is performed by a laboratory care provider. In addition, many state laws require that most, if not all, laboratory services are ordered by a licensed care provider.

Therefore, all laboratory claims and/or encounters must include the name of the referring care provider and NPI number of the referring care provider, in addition to the other elements of a complete claim and/or encounter described in this guide. Laboratory claims that do not include the identity of the referring care provider will be rejected or denied.

This requirement applies to claims and/or encounters for both anatomic and clinical laboratory services. This requirement also applies to claims and/or encounters received from both participating and non-participating laboratories, unless otherwise provided under applicable law. This requirement does not apply to claims for laboratory services provided by care providers in their offices. Please also refer to the *Laboratory Services Protocol*, in Chapter 7: Specific Protocols.

Physical Medicine and Rehabilitation Services

Physical Medicine and Rehabilitation (PM&R) services are eligible for reimbursement only if provided by a physician or therapy care provider duly licensed to perform those services as described in the applicable benefit plan. PM&R services rendered by individuals who are not duly licensed to perform those services are not eligible for reimbursement, regardless of whether they are supervised by, or billed by, a physician or licensed therapy care provider.

Assistant Surgeons or Surgical Assistants Claim Submission Requirements

The practice of directing or using non-participating care providers significantly increases the costs of services for our members, we require our participating care providers to use reasonable commercial efforts to use the services of network care providers, including network surgical assistants or assistant surgeons to render services to our members. Payment is subject to our payment policies (reimbursement policies).

Submission of Claims for Services Subject to Medical Claim Review

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

In these cases, a letter will be sent explaining additional information is needed.

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

For more information about our Medical and Drug Policies, please see UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > w

Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and Coordination of Benefits (COB) rules.

1. **Subrogation —** To the extent permitted under applicable state and federal law and the applicable benefit plan, we reserve the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness.
2. **Coordination of Benefits (COB) —** COB is administered according to the member's benefit plan and in accordance with applicable law. We accept secondary claims electronically. To learn more, go to UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions > Quick Tips for Electronic Claims > Secondary/COB or Tertiary Claims. You can also contact EDI Support at 800-842-1109 or UnitedHealthcareOnline.com > Contact Us > Electronic Data Interchange (EDI) Claims > EDI Transaction Support Form.
   When coordinating benefits with Medicare, if Medicare is the primary payer, we will process up to the Medicare allowed amount when you are a Medicare participating care provider. CMS determines the rules for when Medicare processes claims as the primary or secondary payer.
3. **Workers' Compensation —** In cases where an illness or injury is employment-related, workers' compensation is primary. If notification is received that the workers' compensation carrier has denied a claim for services rendered to one of our commercial or Medicare Advantage members, you should submit the claim to UnitedHealthcare, regardless of whether the case is disputed. It is also helpful to send us the worker's compensation carrier's denial statement with the claim.

Claim Correction and Resubmission

Electronic Process:

- Use the claims reconsideration application on Link to resubmit corrected claims that have been paid or denied.
- If you received a letter asking for additional information, submit it using the claims management application on Link.

> When correcting or submitting late charges on 837 institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim.

Paper Process:

> Submit a new Form 1500 or UB-04 CMS-1450 indicating the correction made. Please attach the Claim Reconsideration Request Form located on UnitedHealthcareOnline.com > Tools & Resources > Forms. Check box number 4 for resubmission of a corrected claim.

> Current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. You must enter the NDC number in the 24D field of the Form 1500, or the LIN03 segment of the HIPAA 837 Professional electronic form.

> Method of Administration (Self or Assisted) for Hemophilia Claims – note the method of administration and submit with the claim form with applicable J-CODES and hemophilia factor, in order to enable accurate reimbursement. Method of administration is either noted as self or assisted.

Additional Information Needed for a Complete UB-04 (or CMS-1450) Form:

Your claim may be pended or not processed if you omit any of the following:

> Date and hour of admission

> Date and hour of discharge

> Member status-at-discharge code

> Type of bill code (three digits)

> Type of admission (e.g., emergency, urgent, elective, newborn)

> Current four digit revenue code(s)

> Attending physician ID

> For outpatient services/procedures, the specific CPT or HCPCS codes, line item date of service, and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)

> Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)

> Submit claims according to any special billing instructions that may be indicated in your agreement with us

> On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the member was admitted to inpatient status

> If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, report a nominal monetary amount ($01 or $100) on all other surgical revenue code lines to assure appropriate adjudication

> Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within three calendar days of an inpatient admission and are not related to the admission.

Reimbursement Policies

UnitedHealthcare reimbursement policies are available online at:

> UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Reimbursement Policies - Commercial

> UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Reimbursement Policies

The term “reimbursement policies” may be referred to in your agreement with us as “payment policies.”

Charging Members

Additional Fees for Covered Services

You may not charge our members fees for covered services beyond copayments, coinsurance, or deductibles as described in their benefit plans. You may not charge our members retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees, as well as fees to cover increases in malpractice insurance and office overhead, any taxes, or fees for services you provide denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or otherwise comply with our protocols as required by your agreement with us, or based on our reimbursement policies and methodologies. This does not prevent you from charging our commercial members nominal fees for missed appointments or completion of camp/school forms. However, for Medicare Advantage members, CMS does not allow you to charge for “missed appointments” unless you have previously disclosed that policy to the member.

Charging Members for Non-covered Services

You may seek and collect payment from our commercial members for services not covered under the applicable benefit plan, provided you first obtain the member’s written consent. The consent must be signed and dated by the member prior to rendering the specific service(s) in question. Retain a copy of this consent in the member’s medical record. If you know, or have reason to suspect, the service may not be covered (as described below), the written consent also must include: (a) an

estimate of the charges for that service; (b) a statement of reason for your belief the service may not be covered; and (c) in the case of a determination by us planned services are not covered services, a statement that we have determined the service is not covered and that the member, with knowledge of our determination, agrees to be responsible for those charges.

For Medicare Advantage members, in addition to first obtaining the member's written consent as indicated, the following must also occur in order for you to seek and collect payment from our member for a non-covered service or item.

> If you know or have reason to believe that a service or item you are providing or referring may not be covered (as described below), you must request a pre-service organization determination from UnitedHealthcare prior to providing or referring for the service or item and UnitedHealthcare must issue a determination before you render or refer for the non-covered service or item.

> If after you request a pre-service determination, UnitedHealthcare determines that the service or item is not covered, UnitedHealthcare will issue an Integrated Denial Notice (IDN) to the member and you. The IDN informs the member of their liability for the non-covered service or item and appeal rights. You must make sure the member has received the IDN prior to rendering or referring for non-covered services or items in order to collect payment. Please be aware that when a Medicare Advantage member wishes to receive a non- covered service or item, CMS requires that the member be provided an IDN in order for the them to be held financially liable for the non-covered service or item unless the service or item is clearly excluded in the EOC or other related materials.

> A pre-service organization determination is not required in order to seek and collect payment from the member where the Medicare Advantage Member's Evidence of Coverage (EOC) or other related materials is clear that a service or item is never covered.

A pre-service organization determination must be requested by submitting an advance notification request on UnitedHealthcareOnline.com > Notifications/Prior Authorizations.

You should know or have reason to believe that a service or item may not be covered if:

> We have provided general notice through an article in a newsletter or bulletin, or information provided on UnitedHealthcareOnline.com, (including clinical protocols, medical and drug policies) either that we will not cover a particular service or item, or that a particular service or item will be covered only under certain circumstances not present with the member; or

> We have made a determination that the planned service or item is not covered and have communicated that determination to you on this or a previous occasion.

> For Medicare Advantage benefit plans, CMS has published guidance, through National Coverage Determinations, Local Coverage Determinations, or other CMS guidance, indicating that the service or item may not be covered in certain circumstances. You are required to review the Medicare Coverage Center available at cms.gov. You must not bill our member for a non-covered service or item in cases in which you do not comply with this protocol.

If, in accordance with the terms of this protocol, you requested a pre-service organization determination and an IDN was issued before the non-covered service was rendered, you must include the –GA modifier on your claim for the non-covered service. Including the –GA modifier on your claim helps ensure your claim for the non-covered service is appropriately adjudicated as member liability.

You must not bill a member for non-covered services in cases in which you do not comply with the terms of this protocol. Failure to comply with the terms of this protocol, including but not limited to failure to request a pre-service organization determination for a Medicare Advantage member or rendering the service to a Medicare Advantage member before we issue the pre-service organization determination, results in an administrative claim denial. You cannot bill the member for administratively denied claims.

Balance Billing

You may not balance bill the member for additional payment of covered services beyond their normal cost share amounts (copayments, deductibles, or coinsurance) associated with their benefit plan.

For Medicare Advantage members who are eligible for Medicaid, you may not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage member, or their representative, or against the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, and coinsurance). You must either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

Member Financial Responsibility

Members are responsible for the copayments, deductibles, and coinsurance associated with their benefit plans.

You should collect copayments at the time of service.

To determine the exact member responsibility related to benefit plan deductibles and coinsurance, we

recommend that you submit claims first and refer to the appropriate Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) when billing patients who are our members.

However, if you prefer to collect payment at time of service, you must make a good faith effort to estimate the member's responsibility using the tools we make available, and collect no more than that amount at the time of services. Several tools on our website can help you determine member and health benefit plan responsibility, including Claim Estimator (UnitedHealthcareOnline.com > Claims & Payments > Claim Estimator) and the Patient Eligibility & Benefits function. Claim Estimator is available only for professional commercial claims.

Some claims may be adjudicated in real time while the member is still in your office. After services have been rendered, you can use the claim submission feature on UnitedHealthcareOnline.com. Within seconds you receive a fully adjudicated claim that shows the benefit plan's responsibility and the member's responsibility, based on contracted discounts and plan benefits. This helps promote accurate collections and avoid overpayment or underpayment situations.

In the event the member pays you more than the amount indicated on the medical claim EOB/remittance advice, you are responsible for promptly refunding the difference to the member.

Preventive Care

The Department of Health and Human Services has released regulations that require most benefit plans to include preventive care without any cost-sharing (copayments, coinsurance or deductible) requirements as long as services are rendered by participating physicians and other health care professionals.

UnitedHealthcare has updated its Preventive Care Services Coverage Determination Guideline (CDG) to help physicians identify and correctly code preventive services they deliver to members.

The CDG is updated when new guidance is received about services that should be covered as preventive services and whenever the applicable codes are revised. The United States Preventive Services Task Force is one of the primary references driving changes to the CDG. Items that have an "A" or "B" rating must be covered without cost-share by non-grandfathered benefit plans.

This preventive services provision 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 provision does not apply to members enrolled in government health benefit plans (Medicare/Medicaid). For information on Medicare coverage of preventive services, please go to UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries > Preventive Health Services and Procedures. For more information please visit:

> Benefit Verification: You can verify the benefits and coverage of UnitedHealthcare members in the eligibility application on Link. Health care Reform: UnitedHealthcareOnline.com > Quick Links > Health Reform Resources > Providers > Health Reform for Providers > Preventive Services.

> Coverage Determination Guideline: UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines - Commercial > Preventive Care Services.

Provider Audits - Extrapolation

As part of our payment integrity responsibility to evaluate the appropriateness of paid claims, we may conduct a systematic review of paid claims. In cases where reviewing all medical records for a particular code would be burdensome on you, we may select and audit a statistically valid random sample (SVRS) of claims, or a smaller subset of the SVRS, in order to obtain an estimate of the proportion of claims that were, in fact, paid in error. The estimated proportion— referred to as the error rate—may then be projected across the relevant universe of claims to determine any overpayment, as permitted by law or regulation. You may appeal the initial overpayment findings or alternatively, if only a subset of the SVRS sample was reviewed, cooperate by supplying the full sample of medical records represented in the SVRS. Should you request a more comprehensive audit, we will select a larger sample of claims, re-estimate the error rate based on the payments made in that sample, and extrapolate our findings across the relevant universe of claims to determine the amount of overpayment, if any. Any overpayment disputes are handled as outlined in this guide and in your agreement with us.

Notice of Medicare Non-Coverage (NOMNC)

You must deliver required notice to members at least two calendar days prior to termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If the member's services are expected to be fewer than two calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non- institutional setting. In a non-institutional setting, if the span of time between

services exceeds two calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or their authorized representative, if the member is incompetent. You must use the most current version of the standard CMS approved notice entitled, "Notice of Medicare Non- coverage" (NOMNC).

The standardized form and instructions regarding the NOMC may be found on the CMS website at cms.gov > Medicare > Beneficiary Notices Initiative (BNI) > MA ED Notices or contact your Quality Improvement Organization (QIO) for information. There can be no modification of this text and all required elements must be present, including but not limited to instructions on how to contact the QIO and the member's Medicare Advantage benefit plan.

Any appeals of such service terminations are called "fast track" appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of calendar day of the day that you are notified by us or the QIO if the member has requested a fast track appeal (this includes, but is not limited to, weekends and holidays).

Hospital Audit Services

We use appropriate nationally recognized billing or coding guidelines as the criteria for audits performed by our internal auditors and/or external contracted vendors.

These coding guidelines are produced by the American Association of Medical Audit Specialists, in partnership with CMS, and other nationally recognized regulatory agencies and can be located at: aamas.org > Resources> Nat'l Audit Guidelines. Facility audits are designed to identify billing and coding inaccuracy, and audits are developed in response to identified contract risk. Facility audits include a thorough review of critical claim elements not submitted on the UB-92 or UB-04, such as medical record, itemized bill, manufacturer invoices, etc. Audits may be conducted on a pre-payment or post-payment basis, depending on the federal and state regulations, national guidelines and the terms of your agreement with us. These audits may be conducted either onsite at the hospital/care provider's location, or offsite in cooperation with a designated representative. In accordance with the National Hospital Billing Audit Guidelines, UnitedHealthcare may conduct other audits, or make other records requests, in addition to the audits described in this guide.

Standard Percent of Charge Hospital Bill Audit

The scope of audit for our Standard Percent of Charge Hospital Bill Audit includes review of medical records to substantiate charges billed by the hospital. The process below provides details on handling of inappropriate charges identified during the course of an audit. Generally, the auditor is expected to report their written findings to the hospital representative upon completion of the audit. Inappropriate charges may include, but are not limited to an individual charge that appears to have been unbundled from the more general charge in which it is commonly included or a charge not supported by the medical record. Post-audit claim reconsideration reconciles any overpayments or underpayments identified as a result of the audit process, in accordance with applicable law and your agreement with us.

Hospital Requirements and Access

UnitedHealthcare's internal auditors and/or external contracted vendor notifies the hospital of the intent to audit a claim by sending a communication to the appropriate hospital representative.

The hospital provides the following:

> A copy of the itemized bill to our auditor and/or contracted vendor, within 30 calendar days of the date requested, and/or

> A copy of the bill breakdown to the auditor and/or contracted vendor at the time of the audit. The hospital notifies the auditor and/or contracted vendor if a bill breakdown will be provided within 30 calendar days after we notify the hospital of our intent to audit.

> The hospital must cooperate in a timely manner, so the auditor and/or contracted vendor can complete the audit scheduling process within 30 calendar days of the scheduling request.

> If there is a requirement for a valid authorization to release medical information, it is the hospital's responsibility to obtain this release from the member, or to waive the requirement if permitted under applicable law. In many cases, such authorizations are signed at the time of admission and may already be on file.

> If there is a hospital-imposed fee to audit the medical record, or a copy fee, such fee is waived unless specified in the hospital's agreement with us.

> Audits are conducted either offsite or at the hospital in cooperation with the hospital representative.

> At the time of the audit, the hospital provides the auditor and/or contracted vendor with access to the medical record, all applicable department charge sheets and, if requested, any applicable hospital policy and procedures.

> The hospital gives our audit vendors the same level of access as our employee auditors, when those vendors are acting at our direction and on our behalf. Any vendor authorized by us to conduct an audit on our behalf is bound by our obligations under the hospital's agreement with us. This includes any confidentiality requirements regarding the hospital audit, and

compliance with HIPAA requirements and use of Protected Health Information.

> The hospital may not impose any time limitation on our right or ability to audit, unless stated in the hospital's agreement with us or permitted by applicable state or federal law.

Audit findings

At the completion of each audit, the auditor and/or contracted vendor may notify the hospital of our audit findings, which include overcharges, undercharges, unbilled charges and disallowed unbundled charges for the claims reviewed. Upon request, we provide the hospital representative with a copy of the audit findings. If the audit occurs at a location other than the hospital, a copy of the findings are supplied promptly.

Post-audit procedures

> Refund Remittance – In the event there is an undisputed overpayment, the hospital remits the amount of the overpayment within 30 calendar days of receipt of the refund request, or as required by state or federal law.

> Disputed Audit Findings – In the event the hospital wishes to dispute any audit findings, the hospital submits notification of its intent to dispute the audit findings to our auditor and/or contracted vendor within 30 calendar days of receipt of the audit findings per the terms outlined in our overpayment notification letter. The notification of dispute of audit findings must clearly identify the items in dispute, citing relevant authority and attaching relevant documentation specific to the disputed items.

> Dispute Resolution – We respond to notification of disputed audit findings in writing within 60 calendar days of receipt.

> Escalated Dispute Resolution – In the event that the dispute remains unresolved, the hospital may request a conference call to include representatives of UnitedHealthcare as well as our Network Management staff. Escalated Dispute Resolution causes suspension of recovery efforts associated with the disputed audit findings for the duration of ongoing discussion between parties.

> Unresolved Dispute – Either party may further pursue dispute resolution as outlined in this guide and in your agreement with us.

> Offsets – When a refund request has been issued in connection with an audit, we recoup or offset the identified overpayment, and/or disallowed charge amounts after the expiration of 35 calendar days from the date of the refund request provided by our auditor and/or contracted vendor, except under the following circumstances: (1) the hospital has remitted the amount due within the 35 calendar day repayment period; or (2) the hospital has provided written notification of its dispute of the audit findings, in accordance with the process outlined above, within the 35 calendar day repayment period; or (3) your agreement or state law indicates otherwise.

Technical Denials

In accordance with the audit findings and post-audit procedures listed above, the hospital is required to submit, or provide access to, medical records upon UnitedHealthcare or UnitedHealthcare representative request. Failure to do so in a timely manner may result in a technical denial, resulting in an overpayment. In addition to the initial medical record request notification sent with all audited claims, technical denial claims include additional information, notifying care providers of the technical denial process, overpayment, and future actions.

Overpayment Recovery & Audit

Whenever possible, we work with you to eliminate incorrect or duplicate claims. You are contractually obligated to return any overpayments.

The following are examples of overpayments:

> Payment based on a charge that exceeds the fee schedule

> Duplicate processing of the same charges or claims (for example, duplicate billing)

> Payment made to incorrect payee

> Payment for non-covered services or medically unnecessary services

> Payment for services provided during a period of member non-entitlement

> Claims processed incorrectly by us as the primary payer

> Payment for unauthorized services

If You Discover an Overpayment

If you discover an overpayment, duplicate payment, or other payment in excess of the member's benefits payable according to the member's benefit plan, remit payment promptly to us.

Send us a refund check including the following information:

> Claim number or reference number
> Member name
> Your patient account number
> Date of service, if available

Send the letter to:

UnitedHealthcare
PO Box 101760
Atlanta, GA 30392

If We Discover an Overpayment

If we discover an overpayment, we will send you a letter asking for a refund of the overpaid amount.

For questions related to overpayments, call the Provider Customer Service department at **800-348-5548**.

Claim Reconsideration, Appeals Process and Resolving Disputes

Step 1 of a Two Step Process: Claim Reconsideration

A processed claim in which you do not agree with the outcome of the original payment/corrected claim.

Timeframe

You must submit your Claim Reconsideration within 12 months (or as required by law or your participation agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law, together with a completed *UnitedHealthcare Claim Reconsideration Request* form.

How to submit your Reconsideration:

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

1. **Online:** In the claim reconsideration application on Link. More information is available at UnitedHealthcareOnline.com > Quick Links > Link: Learn More.
2. **Paper:** Find the form on UnitedHealthcareOnline.com > Tools & Resources > Forms > Claim > Paper Claim Reconsideration Form. Mail the form to the applicable address listed on the form instructions.
3. **Phone:** You can call the number on the member's health care ID card to request an adjustment for a claim that does not require written documentation.

If you have a request involving 20 or more paid or denied claims and attachments are not required, aggregate these claims online. Go to UnitedHealthcareOnline.com > Claims & Payments > Claim Research Project.

If you are submitting medical documentation required for a denied claim:

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

If you are submitting a *Claim Reconsideration Request* for a claim denied because filing was not timely:

1. **Electronic claims -** include confirmation we or one of our affiliates received and accepted your claim.
2. **Paper claims -** include a copy of a screen print from your accounting software to show the date you submitted the claim.

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

Step 2 of a Two Step Process: Claim Appeal (Post-Service)

If you do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may use the following Claim Appeal process.

Timeframe

You must submit your appeal to us within 12 months (or as required by law or your participation agreement), from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). The two step process described in the Claim Reconsideration and Appeal Process allows for a total of 12 months for timely submission and not 12 months for Step 1 and 12 months for Step 2.

Medical Records Request Submission Timeframe

(Which may include providing a copy of the denial notice) – if medical records are requested to process an appeal, the following timeframes are when the information is due:

> Expedited appeals – within two hours of receipt of the request

> Standard appeals – within 24 hours of receipt of the request.

Timeframes may change based on applicable law, or your participation agreement.

What to Submit

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

Our decision will be rendered based on the materials available at the time of formal appeal review. If you are appealing a claim denied because filing was not timely:

> Electronic claims - include confirmation we or one of our affiliates received and accepted your claim.

> Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.

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

Where To Send Your Appeal

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

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

Retroactive Eligibility Changes

Eligibility under a benefit contract may change retroactively if:

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

If you have submitted a claim(s) affected by a retroactive eligibility change, a claim reconsideration may be necessary, except as otherwise required by state and/or federal law. The reason for the claim reconsideration will be reflected on the EOB or PRA. If you are enrolled in Electronic Payment System (EPS), you will not receive an EOB; however, you will be able to view the transaction online or in the electronic file you receive from us. If we implement a claim reconsideration and a refund is requested, you will be notified at least 30 business days prior to any adjustment, or as provided by applicable law or your agreement with us.

Chapter 11: Fraud, Waste and Abuse (FWA)

The purpose of our Fraud, Waste and Abuse (FWA) Program is to protect the ethical and fiscal integrity of our health care benefit plans and programs. The program is comprised of two principle functions:

> The Payment Integrity functions are performed by UnitedHealthcare Payment Integrity, Optum entities and others. They help ensure reimbursement accuracy, keep up to date on new and emerging FWA schemes as well as new methodologies and technologies to combat FWA.

> Special Investigations Units (SIUs) perform retrospective investigations of suspected of fraud committed against UnitedHealthcare health care benefit plans and programs.

This program is part of the UnitedHealthcare Compliance Program led by the UnitedHealthcare Chief Compliance Officer. Our Compliance Department works closely with internal business partners in developing, implementing and maintaining the program.

For CMS definitions of fraud, waste, or abuse, please refer to the Glossary at the back of this guide.

If you identify compliance issues and/or potential fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond appropriately. UnitedHealthcare expressly prohibits retaliation if a report is made in good faith.

Medicare Compliance Expectations and Training

CMS requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including UnitedHealthcare, to annually communicate specific Compliance and FWA requirements to their "first tier, downstream, and related entities" (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties. FDRs working on Medicare Advantage and Part D programs – including contracted care providers – must complete the two requirements below within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services. The required education, training, and screening requirements include the following:

Standards of Conduct Awareness

Provide a copy of your own code of conduct, or the UnitedHealth Group's Code of Conduct (at unitedhealthgroup.com > About > Ethics & Integrity > UnitedHealth Group's Code of Conduct).

What You Need to Do

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

Fraud, Waste, and Abuse and General Compliance Training

Provide FWA and general compliance training.

As of Jan. 1, 2016, CMS no longer required the use of CMS published training materials to meet compliance training requirements. You have met CMS training and education requirements if you complete FWA certification through a fee-for-service Medicare program, or if as a DMEPOS provider you meet accreditation requirements through a fee-for-services Medicare program. FDRs must still complete the General Compliance Training available on the CMS Medicare Learning Network® at cms.gov.

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

What You Need to Do

> Administer FWA and General Compliance training as outlined above.

> Maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), attestations or electronic certifications that include the date of the training) for 10 years. UnitedHealthcare or CMS may request documentation from you to verify compliance with this requirement.

Exclusion Checks

Prior to hiring or contracting employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA and Part D benefits or services.

What You Need to Do

> Make sure that potential employees are not excluded from participating in federal health care programs as outlined above. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov.
- General Services Administration (GSA) System for Award Management at SAM.gov

> Review the federal and state exclusion lists on a monthly basis thereafter.

> Maintain a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by UnitedHealthcare or CMS to verify that checks were completed.

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 services not rendered: Billing for services or supplies that were not provided to the member.

Billing for unauthorized services or equipment: Billing for ancillary, therapeutic or other services without a required physician's order.

Billing while ineligible: Billing for services after care provider's license has been revoked/restricted or after debarred from a government benefits program for fraud or abuse.

Double billing: Billing more than once for the same service.

Falsified documents: Submitting falsified or altered claims or supporting claims with falsified or altered medical records and/or supporting documentation.

Looping: Claims are submitted for various family members when only one member is receiving services.

Misrepresentation: Misrepresenting the diagnoses and/or services provided for which they were based in order to obtain higher payment or payment for non-covered services.

Patient brokering: Care provider has "brokers" who offer money to subscribers for the use of their ID cards.

Phantom billing: Billing by a "phantom" or non-existent care provider for services not rendered.

Unbundling: Billing each component of a service when one comprehensive code is available.

Up-coding: Billing at a higher level of service than was actually provided.

Waiver of copay: Failure to collect copayments or deductibles as part of the payment agreement.

*This is not an inclusive list.

Prevention and Detection

Potential FWA is prevented and detected through various internal and external sources, which include but are not limited to 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 Web Sites: oig.hhs.gov/oei/reports
oig.hhs.gov/exclusions

In addition, prevention and detection is monitored and audited through such mechanisms as:

> Prospective Detection:

- Pre-Payment Data Analytics
- Data Mining Queries
- Abnormal Billing Patterns
- Other activities to determine if additional prospective activities are needed.

> Retrospective Detection:

- Post-Payment Data Analytics
- Payment Error Analytics
- Industry Trend Analysis
- Care Provider Audits

Corrective Action Plans

As an additional part of our payment integrity responsibility to evaluate the appropriateness of paid claims, we may initiate and implement a formal corrective action plan if a care provider fails to comply with our billing guidelines or performance standards. We monitor the corrective action plan to confirm it is implemented effectively, and to help ensure any billing or performance problems are addressed and not repeated.

Beneficiary Inducement Law

The Beneficiary Inducement Law is a federal health care program, created in 1996 as part of HIPAA. The law makes it illegal to offer money, or services that a person knows or should know are likely to influence a member to select a particular care provider, practitioner, or supplier. Examples include offering gifts to induce members to come in for a consultation or treatment, or waiving copayments and deductibles to motivate members to receive services from a care provider. Care providers who violate this law are fined – up to $10,000 for each wrongful act. Fines may be assessed for up to three times the amount claimed. Violators may also be excluded from participating in Medicare and Medicaid programs.

Chapter 12: Provider Communications & Outreach

Network Bulletin

UnitedHealthcare publishes the *"Network Bulletin"* monthly. This publication is a user-friendly newsletter resource, which includes notice to our network physicians and facilities of any protocol, policy, or program updates and changes, as well as an array of other useful and interesting items. It includes information relevant to our Medicare Advantage products.

The Network Bulletins are available on our website at unitedhealthcareonline.com > Tools and Resources > News and Network Bulletin, or you may call **800-348-5548** to receive a copy.

Please read the Network Bulletin to view important information on protocol and policy changes, administrative information and clinical resources.

Provider Website

Our provider website, UnitedHealthcareOnline.com, is an information resource to help you meet the healthcare needs of our members efficiently and effectively. The website has services that are available to the public and members and secure services accessible by participating care providers. Some public services include:

Find a Pharmacy: Search the most current list of our in-network pharmacies by pharmacy name, location or zip code. You may also view, download, and print the entire list.

Find a Provider: Search for a care provider by name, specialty, language, or location. You may also view, download and print the complete Provider Directory.

Provider Forms: The latest versions of all forms referenced in the manual are available on our website at medicaplans.com > Physicians and Providers > Provider Forms or contact Network Management Services at **877-670-8432**. We recommend that you check our website frequently to ensure that you are using the latest version of any form.

Provider Portal

Some online services available 24 hours a day, seven days a week, only to registered care providers on UnitedHealthcareOnline.com, and include the following:

- Member information: Verify a member's eligibility, including plan benefits, deductibles, and information on the member's primary care provider, as applicable.
- Authorizations: Submit, search for, and print authorizations for outpatient services or inpatient stays.
- Claims: Search for, view, and check the status of claims.

You must register prior to using secure services. Go to UnitedHealthcareOnline.com to register. Should you need help with registration, contact **866-842-3278**.

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contract: The policy is a contract between the insurer and the insured, known as the policyholder, which determines the claims which the insurer is legally required to pay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fee for Service: 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 in order to receive benefits, or to make a financial profit. (18 U.S.C.§1347).

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

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

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

Home Health Care (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:

1. 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.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

Medically Necessary: Medically necessary health care services or supplies are medically appropriate and:

- Necessary to meet the basic health needs of the client;
- Rendered in the most cost-effective manner and type of setting appropriate for the delivery of the covered service;
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies;
- Consistent with the diagnosis of the condition;
- Required for means other than convenience of the client or their physician;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency of demonstrated value; and
- No more intense level of service than can be safely provided.

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

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

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

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

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

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

Optum: A UnitedHealth Group company that designs and implements custom information technology systems, and offers management consulting, in the health care industry nationwide.

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

Physician Assistant: A health care professional licensed to practice medicine with physician

supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subscriber: Person who owns an insurance policy.

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

Therapeutic Interchange: The practice of replacing, with the prescribing physician's approval, a prescription medication originally prescribed for a patient with a chemically different medication.

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

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

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

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

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

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

UnitedHealthcare Nursing Home Plan Member: A Medicare member who for 90 calendar days or longer has had or is receiving an institutional level of care is enrolled in a UnitedHealthcare Nursing Home Plan.

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

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

Waste: The over-utilization 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.

Network Management Services

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