

2017
UHC West Capitated Care Provider
Administrative Guide

Welcome

Welcome, to the UHC West Capitated Care Provider Administrative Guide. This comprehensive up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This guide also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and additional electronic tools are available on our website at UHCWest.com.

- If you are looking for Medicare Advantage member information, click [here](#) to access the UnitedHealthcare Administrative guide.
- If you are looking for a Community and State manual, click [here](#) or go to uhcommunityplan.com > For Health Care Professionals, then select the correct state.

You may easily find information in this guide by using the following steps:

1. CTRL+F
2. Type in the key word
3. Press Enter.

Note: UHC West Capitated Admin Guide Retirement — Effective Jan. 1, 2018—the United Healthcare West Capitated Administrative Guide will be retired. You may find information for capitated care providers in the UnitedHealthcare Care Provider Administrative Guide as a supplement.

UnitedHealthcare West Capitated Care Provider Administrative Guide

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Chapter 1: Introduction

Important Information Regarding Use of This Guide

The 2017 UnitedHealthcare West Capitated Care Provider Administrative Guide (“guide”) applies to all covered services for your UnitedHealthcare West capitated members, unless otherwise noted.

Except when indicated this guide is effective on July 1, 2017 for capitated network care providers, health care professionals, facilities and ancillary care providers and their respective staff and is effective immediately for capitated network care providers, health care professionals, facilities and ancillary care providers joining on or after April 1, 2017.

In the event of a conflict or inconsistency between your agreement, as amended, and this guide, the provisions of your agreement with us, as amended, will apply. If your agreement indicates that additional protocols or guides are applicable to members covered under certain benefit plans, those other protocols and guides will control, with respect to such members as described in your agreement. This entire guide is subject to change.

Unless otherwise specified in this guide, any references to UnitedHealthcare West in this guide is intended to apply to any or all of the entities and benefit plans listed below. This information is subject to change. This guide replaces all previous versions of the UnitedHealthcare West Capitated Administrative Guide.

Note: Each employer’s group benefit structure is different. Services covered when they are a part of the applicable benefit plan and are medically necessary. The codes and code ranges listed in this guide were current at the time this guide published. Codes and coding requirements, as established by the organizations that create the codes, may periodically change. Please refer to the applicable coding guide at UnitedHealthcareOnline.com for further information. The following affiliated companies provide administrative services: United HealthCare Services, Inc. OptumRx or OptumHealth CareSolutions, Inc. Behavioral health products provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Except as otherwise noted, this guide is effective July 1, 2017, for capitated care providers currently participating in the UnitedHealthcare West networks and effective immediately for capitated care providers who join the West networks, on or after April 1, 2017.

UHC West Cap Admin Guide Retirement—Effective Jan. 1, 2018—the United Healthcare West Capitated Administrative Guide will be retired. At that time, you will find information for capitated care providers in the UnitedHealthcare Care Provider Administrative Guide as a supplement.

Important News and Updates

Our preferred method to communicate with you is electronically; any news or updates regarding policy, product or reimbursement changes posted in the Spotlight section of UnitedHealthcareOnline.com. We use multiple channels (mail, internet, email, phone, and fax). In the event a protocol changes or is modified, we notify you prior to implementation in accordance with your agreement with us, and in accordance with state and federal law.

To the extent that some protocols are applicable only in certain states at the time of printing, we have indicated that in this guide. If your agreement with us is effective after the date of printing, please reference UnitedHealthcareOnline.com to view a complete list of states to which such protocols are applicable. To register on UnitedHealthcareOnline.com, simply select the “New User” [Link](#) in the upper-right corner of the UnitedHealthcareOnline.com home page, and follow the prompts.

Health Reform

The Patient Protection and Affordable Care Act (PPACA) implemented to expand coverage, control health care costs, and improve the health care delivery system. Our goal is simple: to help you understand what health reform means for you. To find out about these changes, visit the United for Reform Resource Center at uhc.com.

Free Medicare Education for Your Staff and Patients

Medicare Made Clear (MMC) is a public service campaign that educates, equips and empowers consumers with the information they need to select the right Medicare plan for their needs. We created this award-winning campaign to help consumers easily access important information on topics such as the parts of Medicare, enrollment timing, what is covered (and what is not) and what they need to know to make good choices.

Whether your patients are new to their Medicare coverage or are experiencing changes that affect coverage such as moving, delaying retirement or managing a chronic illness, they can find answers on our easy-to-use reference website MedicareMadeClear.com.

Connect with us on social media:



The Network Bulletin

UnitedHealthcare publishes monthly editions of the “Network Bulletin”, a user-friendly resource that is available online to our network care providers and includes notifications of any protocol, policy, or program updates and changes as well as an array of other useful information. The information applies to Commercial, Medicaid, and Medicare products. The Network Bulletin is posted and

accessible online at UnitedHealthcareOnline.com. The email distribution is not limited to only one person in your office—anyone in your office location can sign up! Read the Network Bulletin throughout the year to view important information on protocol and policy changes, administrative information and clinical resources.

Postcard announcements regarding the availability of the Network Bulletin for the upcoming year mailed to all: network care providers participating every Jan. 1, and where required by applicable law, mailed out to network care providers, each publication date of the Network Bulletin throughout the year, as set forth below.

In 2017, the Network Bulletin will be available on UnitedHealthcareOnline.com and through email on the following dates:

Network Bulletin Edition	Publication Date
January	Jan. 2
February	Feb. 1
March	March 1
April	April 3
May	May 1
June	June 1
July	July 3
August	Aug. 1
September	Sept 1
October	Oct. 2
November	Nov. 1
December	Dec. 1

Supplements to the Network Bulletin published on an as needed basis.

General Information about Protocol Updates

Where required by law or your agreement, we will provide prior notification of any protocol updates in writing by mail or fax. We may also use additional channels (such as internet, email, and phone) to communicate with you in the event a protocol is modified.

Information Regarding Our Care Provider Website Transition

Our goal is to streamline and simplify the care provider administrative experience by consolidating all UnitedHealthcare transaction capabilities into one location.

UHCWest.com is moving to UnitedHealthcareOnline.com and Link

In 2017, UnitedHealthcare will be retiring the UHCWest.com address is transitioning to UnitedHealthcareOnline.com and [Link](#), the gateway to UnitedHealthcare's online tools. Users will continue to have access to the content and transaction tools they need, and notified when these are moving. [Link](#) apps allow users to check eligibility and benefits, view claim status and submit claim reconsideration requests.

Available plan information on [Link](#) varies for each of the apps, but at this time, you can access most information for UnitedHealthcare Commercial, UnitedHealthcare Medicare Solutions, UnitedHealthcare Community Plan (as contracted by state), UnitedHealthcare West, and UnitedHealthcare of the River Valley and UnitedHealthcare Oxford members. We are working to update [Link](#) with enhanced features and new apps, so watch for the most current information by email, or in the Network Bulletin or on UnitedHealthcareOnline.com.

You can access [Link](#) by logging on to UnitedHealthcareOnline.com with your Optum ID.

How to Contact Us

RESOURCE	WHERE TO GO
Helpful Health Plan Service Phone Numbers	Online: UHCWest.com > Contact Us > Select the appropriate state > Phone numbers will display.
UnitedHealthcare West Care Provider Portals	Online: UnitedHealthcareOnline.com and Link or UHCWest.com
Prior Authorization (Non-delegated)	To view the most current and complete Notification/Prior Authorization List, including procedure codes and associated services, go to: Online: UHCWest.com AZ: Medicare Advantage Phone: Phone: 800-746-7405 CA/OR/WA: SignatureValue, Medicare Advantage, Direct contract network care provider and medical group/IPA carve-out Phone: 800-762-8456 CO: Medicare Advantage Phone: 800-746-7405 NV: Medicare Advantage Phone: 888-866-8297 TX/OK: Medicare Advantage, SignatureValue Inpatient Notification/Utilization Management Phone: 800-668-8139
Radiology-Advanced Outpatient Imaging Procedures (Non-delegated): CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology	Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Radiology Notification & Authorization—Submission & Status Phone: 866-889-8054 For more information related to radiology prior authorization, refer to: UnitedHealthcareOnline.com > Clinician Resources > Radiology
Cardiology: (Non-delegated): Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram	Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Cardiology Notification & Authorization—Submission & Status Phone: 866-889-8054 For more information related to cardiology prior authorization, refer to: UnitedHealthcareOnline.com > Clinician Resources > Cardiology
Facility Inpatient Notification (Non- delegated)	Inpatient & Observation Phone: 800-799-5252 Fax: 800-274-0569 Mental Health Medicare Advantage Phone: 800-508-0088 Transplant Phone: 866-300-7736 Fax: 888-361-0502
EDI Support Encounter Collection, Submission & Controls	Online: UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions Phone: 800-842-1109 Email: supportedi@uhc.com
United Voice Portal— Follow prompts to access information.	Commercial & Medicare Advantage HMO/ MCO: CA Phone: 800-542-8789 AZ/CO/NV Phone: 888-866-8297 OK Phone: 877-847-2862 OR Phone: 800-920-9202 TX Phone: 877-847-2862 WA MCO Phone: 800- 213-7356

RESOURCE	WHERE TO GO
Standard Member Appeals (Applies to Commercial UnitedHealthcare West Signature Value HMO/MCO)	California, Oklahoma, Oregon, Texas, Washington Mailstop CA124-0160 P.O. Box 6107 Cypress, CA 90630 Fax: 866-704-3420 CA Phone: 800-624-8822 OK/TX Phone: 800-825-9355 OR/WA Phone: 800-932-3004
Medicare Advantage Member Appeals	Mailstop CA124-0157 P.O. Box 6106 Cypress, CA 90630 Phone: 877-699-5710 Fax: 888-517-7113 Online: AARPMedicareComplete.com
Expedited Appeals (Applies to Commercial UnitedHealthcare West SignatureValue HMO/MCO)	California Oklahoma, Oregon, Texas, Washington Phone: 888-277-4232 Fax: 800-346-0930
Pharmacy Services	Commercial products: UHCWest.com Medicare products: UHCMedicareSolutions.com > Our Plans > Medicare Prescription Drug Plans Phone: 800-711-4555 Fax: 800-527-0531 and 800-853-3844 Website: OptumRx.com Medicare Advantage Part D Medication Therapy Mgmt. Phone: 866-798-8780, Option 2
Mental Health, Substance Abuse/ Substance Use, Vision or Transplant Services	See member's health care ID card for carrier information and contact numbers. Note: The health care ID card can be viewed on Link in the eligibilityLink app.
California Language Assistance Program (Applies to Commercial products in California)	Online: UHCWest.com > Provider > Library > Publications > California Language Assistance Program Information Phone: 800-752-6096
Health Management and Disease Management Programs	UnitedHealthcareOnline.com > Tools & Resources > Health Resources for Patients> Health Management Program Phone: 877-840-4085 Fax: completed referral form to: 877-406-8212

CHAPTER 2: Products

Policies, Guidelines, & Coverage Summaries

Access to Policies

A complete library of Commercial Benefit Interpretation Policies and Medical Management Guidelines is available at UHCWest.com.

A complete library of UnitedHealthcare Medicare Advantage Coverage Summaries is available at UnitedHealthcareOnline.com.

Policy Updates

We publish monthly editions of the “Medical Policy Update Bulletin”, a user-friendly online resource that provides notice to our network care providers of any changes to our Benefit Interpretation Policies, Medical Management Guidelines, and Medicare Advantage Coverage Summaries. The Medical Policy Update Bulletins posted on the first calendar day of every month and are accessible online:

- **Commercial Products:** UHCWest.com
- **Medicare Advantage Products:** UnitedHealthcareOnline.com

As a supplemental reminder to the detailed policy update summaries announced in the Medical Policy Update Bulletins, a list of recently approved, revised and/or retired Benefit Interpretation Policies, Medical Management Guidelines, and Medicare Advantage Coverage Summaries is also provided in the monthly [Network Bulletin](#).

State	Legal Entities	Products Offered	Benefits Plans
Arizona	PacifiCare Colorado, Inc.	Medicare Advantage	<ul style="list-style-type: none"> • AARP® MedicareComplete® • UnitedHealthcare® Group Medicare Advantage
California	UnitedHealthcare California	Commercial and Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue® family of products including, but not limited to: <ul style="list-style-type: none"> › UnitedHealthcare SignatureValue › UnitedHealthcare SignatureValue Advantage › UnitedHealthcare SignatureValue VEBA › UnitedHealthcare SignatureValue Alliance › UnitedHealthcare SignatureValue Flex › UnitedHealthcare SignatureValue Focus <p>Medicare:</p> <ul style="list-style-type: none"> • AARP® MedicareComplete® SecureHorizons® • Sharp® SecureHorizons® Plan by UnitedHealthcare® • UnitedHealthcare® Group Medicare Advantage
Colorado	PacifiCare Colorado, Inc.	Medicare Advantage	<ul style="list-style-type: none"> • AARP® MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
Nevada	PacifiCare Colorado, Inc.	Medicare Advantage	<ul style="list-style-type: none"> • AARP® MedicareComplete® • UnitedHealthcare® Group Medicare Advantage
Oklahoma	UnitedHealthcare Oklahoma, Inc.	Commercial and Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue® <p>Medicare:</p> <ul style="list-style-type: none"> • AARP® MedicareComplete® SecureHorizons® • UnitedHealthcare® Group Medicare Advantage
Oregon	UnitedHealthcare Oregon, Inc.	Commercial and Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue® <p>Medicare:</p> <ul style="list-style-type: none"> • AARP® MedicareComplete® • UnitedHealthcare® Group Medicare Advantage

State	Legal Entities	Products Offered	Benefits Plans
Texas	UnitedHealthcare Benefits of Texas, Inc.	Commercial and Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue® <p>Medicare:</p> <ul style="list-style-type: none"> • AARP® MedicareComplete® SecureHorizons® • UnitedHealthcare® Chronic Complete • UnitedHealthcare Dual Complete® • UnitedHealthcare® Group Medicare Advantage
Washington	UnitedHealthcare Washington, Inc. UnitedHealthcare Oregon, Inc.	Commercial Medicare Advantage	<p>Commercial:</p> <ul style="list-style-type: none"> • UnitedHealthcare SignatureValue® <p>Medicare:</p> <ul style="list-style-type: none"> • AARP® MedicareComplete® • UnitedHealthcare® Group Medicare Advantage

Our Products

We offer a wide range of products and services for employer groups, families and individual members. Plan availability may vary by state and county. Contact your care provider advocate for more information about plan availability and service areas where each of these products and supplemental benefits may be available.

Commercial Products

UnitedHealthcare West SignatureValue

This plan is a Health Maintenance Organization (HMO) and/or Managed Care Organization plan (MCO), which focuses on the quality of care provided to members, with prevention and wellness as key components of care. Health services are accessed through contracted PCPs who know the member's medical history and individual needs; thus, a partnership is formed among the member, the care provider and UnitedHealthcare. HMOs/MCOs offer minimal paperwork and predictable out-of-pocket costs. Members pay a small, predetermined copayment each time they receive health care services.

Medicare Advantage Products

AARP® MedicareComplete® (HMO)

These health plans are Medicare Advantage plans that provide all of the benefits covered under original Medicare and more. Our plans do not have limitations for pre-existing conditions for enrollment, and they do not require a physical exam. However, the member may not be eligible to enroll in a plan if the member diagnosed with end-stage renal disease (ESRD). Depending on where the member lives, the member may have several health plans available to them.

While the exact benefits vary depending on the member's specific plan, these plans provide:

- Access to medical care through a trusted network of contracted doctors, specialists and facilities
- Coverage for many preventive services with a zero dollar copayment, including an annual routine physical exam
- Help with financial protection through annual limits on out-of-pocket health expenses.
- Worldwide coverage for emergency care
- Many plans also offer the following benefits.
- Medicare Part D prescription drug coverage
- Coverage for additional benefits such as routine vision and hearing exams

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

Note: UnitedHealthcare Insurance Company, a Medicare Advantage Organization with a Medicare contract, insures The AARP® MedicareComplete® plans. AARP

MedicareComplete plans carry the AARP name, and UnitedHealthcare pays a royalty fee to AARP for use of the AARP intellectual property. AARP is not the insurer. Members do not need to be an AARP member to enroll.

UnitedHealthcare Group Medicare Advantage (HMO)

UnitedHealthcare Group Medicare Advantage plans offered to employer groups for their retired employees eligible for Medicare. These plans have similar benefits to the individual benefit plans noted above.

The member's health care ID card will list the employer group name and number for reference.

Medicare Advantage Special Needs Plans (SNP)

Special Needs Plans (SNPs) are part of the Medicare Advantage program. These plans offer benefits in addition to those covered under Original Medicare (including Part D prescription drug coverage) and intended to keep the member healthy and as independent as possible. UnitedHealthcare offers two types of Medicare Advantage SNPs within the plans covered by this guide. These SNPs are currently only available in specific counties in the state of Texas:

UnitedHealthcare Dual Complete

Medicare Advantage Dual SNP designed around the needs of individuals enrolled in Medicare and who are eligible for Medicaid benefits (or "dual eligible"). This plan provides access to coordinated, personalized care to and enhanced benefits by combining those available through Medicare and Medicaid.

UnitedHealthcare Chronic Complete

This Medicare Advantage Chronic SNP helps members who have one or more severe or disabling chronic conditions including diabetes, chronic heart failure, and/or cardiovascular disorders. UnitedHealthcare helps members manage not only their condition, but also their overall health and well-being.

Chapter 3: General Care Provider Requirements

Delegate Performance Management Program

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

Together we can get a clearer picture of measures that may provide opportunities for improving quality and care experiences for our members, taking into account standards of care, evidence-based guidelines and Choosing Wisely® recommendations from the American Board of Internal Medicine Foundation, supported through partnerships with more than 70 national medical specialty societies.

Performance Domains

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

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

- Clinical utilization management
- Clinical quality including STARS, HEDIS and member satisfaction
- Encounter data performance management
- Credentialing performance management
- Financial performance management
- Compliance with UnitedHealthcare, Federal and State requirements

Performance domains evaluated on a regular basis compared to peers benchmarks, and communicated to the delegate in the form of performance reports.

Improvement Action Plans

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

Delegates who do not achieve compliance within the established timeframes may require continued oversight until they achieve compliance.

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

Physician Incentive Plan Disclosure Requirements

Federal regulations govern Physician Incentive Plans (PIP) and require our network care providers and us to disclose PIP arrangements annually. The PIP regulation requirements designed to govern and regulate arrangements under which payment made directly or indirectly to a care provider that might create an inducement to reduce or limit medically necessary services furnished to our member. On an annual basis, we send a questionnaire to each medical group/IPA. The medical group/IPA should complete the questionnaire and return it to us. This annual process includes the member panel size and the amount and type of stop-loss protection.

Hospital Incentive Program (HIP) Professional Capitation

In a professional capitation agreement, the medical group/IPA receives capitation for the provision of medical services, and selected facility services paid out of the Hospital Incentive Program (HIP). The HIP designed to provide an incentive for the medical group/IPA efficiently utilize facility services. These services may include, but are not limited to, inpatient activity, in-area emergency services and other selected outpatient services provided to our members. The HIP calculates surpluses and deficits based on an annual comparison of accumulated actual expenses in accordance with the terms of the UnitedHealthcare West medical group/IPA agreement.

This section provides general information for a professional capitation arrangement on the following:

- How HIP results are calculated;
- What services are included in the HIP;
- What information is available to assess HIP performance?

Budget

The Commercial Hospital Incentive Program (CHIP) replaced with the Integrated Healthcare Association (IHA) P4P Value Based Incentive Program effective Jan. 1, 2017 for new agreements or renewal dates of Jan. 1, 2017. The new incentive program will not be a component of this capitation agreement, but a separate letter of agreement sent to the medical group/IPA by July 1, 2017.

The Medicare Advantage Hospital Incentive Program (MAHIP), formerly known as Secure Horizons Hospital Incentive Program (SHIP), budget is based on a percent

of premium, less the reinsurance premium. Aside from the budget, all other aspects of the HIP apply to the MAHIP.

Reinsurance

Reinsurance is required to protect the HIP budget and medical group/IPA against catastrophic cases.

Actual Costs

HIP actual costs defined in the DOFR section of the participation agreement and typically include, but are not limited to, the following:

- Inpatient costs for facility services rendered to our members by network care providers valued at the actual costs incurred by us; plus,
- Other facility services rendered to our members by network care providers other than inpatient services, valued at actual costs incurred by us; plus,
- The actual amount paid for facility services, which are rendered by non-network care providers; plus,
- A percentage of all facility services incurred during the period but not yet processed (for the interim calculation), less:
 - › Reinsurance recoveries; and
 - › Third party recoveries received during the period of calculation.

Monitoring Performance

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

- Records of authorized services;
- Claims paid/denied reports;
- HIP financial report for the settlement period, the HIP financial report details:
 - › Total number of member months;
 - › Total budget allocation for the member months;
 - › Total expenses paid during the period;
 - › A description of each amount of expense allocated to the risk arrangement by member ID number, date of service, description of service by claim codes, net payment, and date of payment.

Settlement Calculations

UnitedHealthcare West, as defined in the agreement, will perform interim settlements and the final settlement and reconciliation of the HIP.

We shall provide a quarterly incentive program report to the medical group/IPA on a quarterly basis, within 45 calendar days of the close of each calendar quarter. The incentive program report shall contain the information stated above.

Split Capitation

In a split capitation agreement, the medical group/IPA receives capitation for the provision of medical services

and the facility receives capitation for facility services and selected outpatient services. The medical group/IPA and facility can create and administer their own facility incentive program under a split capitation agreement.

Institutional Encounter Data

We require institutional encounter data submissions, via hard copy claims or electronically, from all capitated facilities. Refer to [Requirements for Submission of Encounter Data \(Commercial\)](#) section of this guide for details.

Rider Contracts

A “rider contract” defined as a contract obtained by the medical group/IPA for services covered under capitation or paid for out of the facility incentive program. The medical group/IPA is required to submit copies of rider contracts to us.

The most common examples of services for which rider contracts are established include, but are not limited to specialist services, ancillary services and outpatient facility services.

Contract Criteria

The contract needs signatures by all parties to be valid. The medical group/IPA must submit the following required information, along with an original, signed letter stipulating that the “care provider” is granting us permission to access rates as described in the agreement to pay claims for our members assigned to the medical group/IPA, even if the agreement includes assignability language:

- Address;
- TIN, IRS number;
- NPI;
- Phone number;
- Name and title of contact person at care provider’s office; and
- Care provider specialty.

The following contractual documentation needs submission:

- Cover page of the contract;
- Definition section;
- Rate pages, including any withholds, exclusions or special arrangements;
- Effective date of rates;
- Signature page (signed by both parties);
- Payment terms (e.g., due in 45 or 60 calendar days);
- Rate renewal terms (e.g., automatically or renegotiated);
- Late penalty terms; and
- Claims timely filing language

Contract Entry

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

If the rider contract qualifies for data, entry entered with an effective date beginning, the first of the month following a 60-day load and review period. We will not retroactively adjust claims paid prior to receipt, data entry of the contract, or the effective date that used in our claims payment system.

Note: You must notify us if you terminate a rider contract or change the terms of the contract relative to reimbursement or claims payment turnaround time. In addition, you must confirm annually that those rates and provisions previously submitted have not changed.

Monthly Reporting

We either posts online, or distributes to each medical group/IPA, a monthly-shared risk claims report that lists the actual costs incurred and denied during the previous month for services included in the HIP. The medical group/IPA should review this report each month to make sure the claims were processed and/or paid correctly.

The following tools will assist the medical group/IPA in analyzing the Shared Risk Claims Report:

- NICE Claims Code Sheet.
- Place of Service Mapping—this document cross-references the CMS place of service codes to UnitedHealthcare West's internal place of service codes.

Discrepancy Report

The Discrepancy Report used to request research of the payment or denial of a claim that we processed. After reviewing the Monthly Shared Risk Claims Report, the medical group/IPA should complete the Discrepancy Report by completing all required fields. Submit the completed Discrepancy Report via electronic means to our Network Care Provider Management department. Returned files sent to the medical group/IPA as incomplete, if the required fields are not completed, the required fields include:

- Member ID number (seven-digit number)
- Member ID number suffix (two-digits) (i.e., 01, 02, etc.)
- Claim number
- Expected care provider reimbursement
- Care provider comments—the rationale as to why the medical group/IPA is disputing the payment

Discrepancy Report Timely Filing

The medical group/IPA must submit Discrepancy Reports on at least a quarterly basis. However, our preference is to receive monthly submissions. We will not pursue recoveries of overpayments that submitted late and not in a timely

manner, as dictated by your agreement with us, or by state law.

We reserve the right to deny/reject any request for review that are submitted beyond the timely filing limit.

Individual Stop Loss and Reinsurance Programs (Stop Loss Protection)

Individual Stop Loss (ISL)/Reinsurance (REI) is protection in order to limit the medical group's/IPA's/facility's financial risk for medical and facility services beyond a specified dollar amount per-member, per calendar year. This program applies to services for which we capitated the medical group/IPA/facility.

The ISL program updated annually and given the option for each medical group/IPA/facilities to elect to participate or not participate in the program each year.

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

The premium for ISL offered by us is determined based on an analysis of our previous experience. The calculated premium for stop loss is converted to either a percentage of premium or flat PMPM rate based upon the medical group's/IPA's participation agreement, and is subtracted from the total capitation on a monthly basis.

A medical group/IPA that purchases ISL through UnitedHealthcare West reimbursed for services that exceed the ISL deductible at the ISL program rates specified in the participation agreement or the ISL election letter for the applicable contract year, less the medical group's ISL coinsurance amount.

A facility that purchases reinsurance through UnitedHealthcare West, we will reimburse the facility for services that exceed the reinsurance deductible at the reinsurance program rates specified in the participation agreement or the reinsurance election letter for the applicable contract year, less the facility's reinsurance coinsurance. The facility must clearly identify all reinsurance claims prior to submission. The facility reinsurance program, are updated annually.

The medical group/IPA or facility may elect to opt-out of the UnitedHealthcare West ISL/reinsurance program by purchasing ISL/reinsurance coverage through a third party insurance carrier. Such coverage must be through an entity acceptable to us and in the amounts required by UnitedHealthcare West and state and federal law. Refer to your agreement for details.

Notification of ISL/Reinsurance Claims

The medical group/IPA or facility will provide written notification to us when services for a member equal 50% of the ISL/reinsurance deductible. The written notification submission needs to be to us no later than the 15th day of the month following the month in which the claim amounts reach the 50% threshold.

ISL/Reinsurance Claims Submission Procedure

All ISL/reinsurance claims having met the ISL/reinsurance deductible must be submitted to us yearly, but no later than 90 calendar days after the end of the calendar year.

In order to obtain reimbursement under the ISL/reinsurance program, follow these steps:

- Submit the ISL/reinsurance claims by spreadsheet to email address Individual_stoploss@uhc.com. Please scan and email all hard-copy images. The format below should be included on the submission spreadsheet:
 - › Service care provider name;
 - › Date of service;
 - › Service description;
 - › Correct RBRVS or CPT codes and description of services if required;
 - › Billed charges;
 - › Place of service;
 - › Medical group/IPA paid amount;
 - › Other insurance information;
 - › Discount adjustments;
 - › ICD-10-CM diagnosis codes; and
 - › Proof of payment (copies of cancelled checks)
- Each spreadsheet submission sheet must be for one member only. Combined submissions for an entire family or for more than one member are not acceptable.
- For capitated services rendered outside the medical group/IPA/facility, copies of cancelled checks showing actual amounts paid will be required. Upon request, submission of copies of all referral bills and/or copies of consultation and operative reports may be required.
- Upon request, submit a brief member history (copy of a consultant report and/or history dictation). Lab results, X-ray results or records of this nature are not required.
- The following are excluded from the calculation of ISL/reinsurance claims:
 - › Member copayment amounts;
 - › Non-covered services;
 - › Services paid by Workers' Compensation;
 - › Services paid by other health plans; and
 - › Services paid through third party reimbursement.

Our Claims Production Unit will review the claim for completeness and will notify medical group/IPA/facility if any additional information is necessary. Supporting records for ISL/reinsurance claim verification may be required. After review, if the claim is accepted, a payment made within 60

calendar days. Please submit ISL/Reinsurance claims to Individual_stoploss@uhc.com.

Privacy

You must make reasonable efforts to limit Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, to the minimum necessary when using or disclosing PHI. The minimum necessary standard not intended to impede activities related to treatment, payment or health care operations (TPO). The Privacy Rule requires written member authorization for uses and disclosure that fall outside of the TPO.

CMS Risk Adjustment and Medical Records

Medical records are an important data source that contributes to CMS reimbursement for our Medicare Advantage members. Medical records must reflect all conditions evaluated during a face-to-face care provider visit in order to translate the conditions into diagnosis codes utilizing the ICD-10-CM coding system. It is important to evaluate all chronic conditions at least annually. You may code all documented conditions that coexist at the time of the encounter/visit and require or affect member care treatment or management.

For accurate reporting on ICD-10-CM diagnosis codes, the documentation must describe the member's condition, using terminology including specific diagnosis as well as symptoms, problems, or reasons for the encounter. You are responsible for making sure that ICD-10-CM coding adheres to ethical standards.

Our Medicare Advantage member charts are subject to chart reviews and/or data validation. We may assess member charts in order to identify chronic diseases not coded on claims. CMS conducts periodic data validation assessments to confirm that the Hierarchical Condition Categories (HCCs) triggered for payment, based on ICD-10-CM coding might support by chart documentation during the reporting period. CMS works through us to obtain these records, and care provider cooperation with this process is required.

Availability of Medical Records

In addition to assuring medical records are maintained in a confidential manner, member's medical records must also be available at the time of an appointment. Medical record documentation facilitates communication, coordination, and continuity of care to promote the most efficient and effective treatment of the member. All medical groups/IPAs must have systems for retrieving, archiving, purging and disposing of records, and making sure of their availability and confidentiality. Medical records of our Medicare Advantage members must be available to

our representatives upon request, for chart review, quality improvement and peer review purposes.

Medical Records Duplication

Medical Record Copies for Specialist Referrals—The PCP office shall bear the cost of duplicating and shipping the member's medical records when referring the member to a specialist. The care provider office shall not charge the member for the cost of copying medical records that utilized during the member's course of treatment with a referral care provider.

Member Transfer to Another PCP—If a member is requesting copies of medical records sent to another medical professional due to a transfer to another PCP, there is no charge to the member.

Member Request for Medical Records—A member, or the member's representative, presents a written request to the care provider office. The request is for copies of medical records for reasons other than stated above, the care provider office may charge a fee not to exceed \$.25 cents per page, and any additional reasonable clerical costs incurred in making the records available, unless state law indicates otherwise.

Part C Reporting Requirements

Medicare Advantage organizations are subject to additional reporting requirements. Periodically, we request data from our contracted care providers. Such data is due by 11:59 p.m. Pacific Time on the date of the reporting deadline established by us and communicated to the care provider. Some measures reported annually, while others reported quarterly or semi-annually. This includes, but is not limited to, the following measures:

- Benefit Utilizations;
- Procedure Frequency;
- Serious Reportable Adverse Events;
- Network care provider Adequacy;
- Grievances;
- Organization Determinations/Reconsiderations including source data for all determinations and reopenings
- Special Needs Plans Care Management.

Chapter 4: Care Provider Office Procedures

Member Enrollment & Eligibility

Commercial Enrollment

To enroll for membership, an applicant must complete a UnitedHealthcare enrollment form or an employer enrollment form approved by us. Some larger member accounts may provide open enrollment through electronic means rather than enrollment forms.

Newly eligible members may present in a care provider's office or facility with a copy of the enrollment form as proof of eligibility. Care providers should make a copy of the enrollment form. If the member not yet reflected online at or through our voice response systems as eligible, you should follow up with member service the next business day. The capitated medical group/IPA is responsible for making sure the contracted network of care providers accepts the enrollment form as temporary proof of eligibility.

We may receive enrollment/eligibility information from employer groups electronically or within the guide. Regardless, we will use this information to update member records.

Medicare Advantage Enrollment

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

- Complete and sign an *Individual Enrollment Request Form and Statement of Understanding*;
- Call UnitedHealthcare Medicare Solutions, as applicable and complete a telephonic enrollment;
- Meet with a licensed sales representative;
- Log on to [UHC Medicare Solutions.com](https://www.uhcmedicare.com), or [AARP Medicare Plans.com](https://www.aarpmedicare.com), as applicable for online enrollment;
- Log on to [medicare.gov](https://www.medicare.gov) to enroll online (may not apply for all SNPs); or
- Call 800-MEDICARE or 800-633-4227 to enroll (may not apply for all SNPs).

Enrollment Periods (Commercial and Group Retiree)

Each employer group typically has an annual open enrollment period where current employees elect their health insurance choices for the following benefit year. The employer group selects the annual benefit year. Jan. 1 is a commonly used benefit start date, but many employers select different dates throughout the year. Plan codes change throughout the year on your eligibility reports.

Enrollment Periods (Medicare Advantage)

The Centers for Medicare & Medicaid Services (CMS) has defined specific enrollment periods during which individual plan members may enroll in a health plan, change to another health plan, change benefit plans, or return to

Medicare. Details on the different types of enrollment periods and the requirements of each type outlined, on the CMS website at [cms.hhs.gov](https://www.cms.hhs.gov).

Enrollment periods for UnitedHealthcare Group Medicare Advantage Members dictated, by the employer group's annual renewal date with us. A group retiree annual enrollment period will coincide with the employer's annual enrollment cycle.

Effective Date

The [Link](#) website or Enterprise Voice Portal used to verify eligibility whenever a member receives services.

Commercial

Coverage begins at 12:01 a.m. on the effective date.

Medicare Advantage

UnitedHealthcare Group Medicare Advantage processes eligible *Individual Enrollment Request Forms and Statement of Understanding Forms*. Forms received by the end of the month processed for eligibility on the first of the following month.

Coverage begins at 12:01 a.m. on the effective date, provided the enrollment request form received as complete. The effective date resulting in delay if the enrollment request form is incomplete, needs additional information, or lacks documentation of proof of entitlement to Medicare Parts A and B. We will try to resolve any outstanding issues with the enrollment request form to complete the enrollment process.

We may process a group retiree member's enrollment into UnitedHealthcare Group Medicare Advantage plan with a retroactive effective date. The retroactive window allows the group retiree member to enroll with an effective date up to 90 calendar days retroactive. The effective date can never be earlier than the signature date on the enrollment request form.

We will notify the member of the effective date in writing in an enrollment confirmation letter.

Selection of PCP or Medical Group/IPA (Commercial)

UnitedHealthcare SignatureValue™ (HMO/MCO) members and any enrolled dependents must designate a PCP or primary medical group/IPA. The member and enrolled dependent(s) may choose their own PCP or medical group/IPA, as long as the doctor/group selected from the appropriate list of participating PCPs or medical group/IPAs for that product. The PCPs or medical group/IPAs designated by the member and enrolled dependent(s) do not need to be the same person, or affiliated with the same group; however, if the member is on a tiered network care provider plan, the selected PCP or medical group/

IPA must also be within the same tier. The member and enrolled dependent(s) may select a PCP or medical group/IPA within 30 miles of their primary residence or the member's work location.

If a member or any enrolled dependent does not designate a PCP or medical group/IPA on the enrollment form, we assign them to a PCP or medical group/IPA within the member's service area. We notify the member and enrolled dependent(s) of the assignment. The member may contact our Customer Service Department to make an alternate selection.

Selection of PCP or Medical Group/IPA (Medicare Advantage)

For most plans, the member will be required to select a PCP or medical group/IPA when the member completes the enrollment request form, telephonic enrollment, online enrollment or EDI. The PCP or medical group/IPA enrollment cannot be restricted to a pre-determined mile radius. However, we encourage the member to select a PCP or medical group/IPA within a 30-mile radius of the member's residence.

If a member fails to select a PCP or medical group/IPA on the enrollment request form, telephonic enrollment, online enrollment or EDI, we will assist the member to select a PCP or medical group/IPA nearest the member's residence. If we cannot reach the member, the members assigned to a PCP or medical group/IPA nearest the member's residence.

Eligibility (Commercial)

Eligibility Requirements

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

Qualified Medical Child Support Order (QMCSO)

A member (or person otherwise eligible to enroll in a UnitedHealthcare West product) may enroll an eligible child upon presentation of appropriate documentation.

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

Full Time Student Eligibility

A dependent under the age of 26 and enrolled full-time as a student in a college may continue to remain eligible when temporarily located outside our service area.

To receive coverage, all care, except for emergency and urgently needed services, provided or arranged in our service area by the designated PCP or medical group/IPA.

Enrollment in Rural Areas

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

Dependent Definition

Dependents of the subscriber are eligible for coverage, based on the subscriber's benefit plan, and may include, but are not limited to, the following:

- Spouse or Common Law Spouse
- Domestic partner
- Unmarried child under the limiting age, including, but not limited to:
 - › Stepchildren
 - › Children placed for adoption or legally adopted children
 - › Grandchildren (only if subscriber has legal guardianship or the employer has purchased additional eligibility coverage)
 - › Full-time students—proof of student status is required on a periodic basis if the child remains under the age of 26.
 - › Dependents with a physical or mental handicap, which have been identified as permanently disabled, and where the disabling condition occurred prior to reaching the limiting age

Newborn Dependents Coverage

Coverage of the subscriber's newborn children begins at birth. The subscriber must submit an enrollment application to the employer group or UnitedHealthcare West, as applicable, within 30 calendar days from the date of birth to continue coverage, unless the subscriber's benefit plan dictates otherwise.

If the mother of the newborn is a dependent of the subscriber, other than the spouse, domestic partner or common law spouse of the subscriber, coverage for the newborn grandchild not provided which includes any services beginning upon delivery of the newborn; unless it is specifically stated in the subscriber's benefit plan.

California Commercial: State Knox-Keene regulations dictate eligible newborns coverage for the first 30 days beginning on date of birth. Should the newborn not be enrolled as a dependent on the subscriber's plan (mother's or father's), temporary 30 day eligibility stays with the subscriber's medical group/IPA throughout the 30 day period following birth. Notwithstanding the above, coordination of benefits may be applied as determined by the birthday rule.

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

Newborn Enrollment Policy

Unless the subscriber's benefit plan dictates otherwise:

If the mother (Subscriber, Spouse or Domestic Partner) is our member, she selects the newborn's PCP medical group/IPA, the (Subscriber, Spouse or Domestic Partner) will remain with the mother's medical group/IPA an alternative PCP or medical group/IPA is selected following the 15/30 rules.

If the mother is not our member, we assign the newborn to the father's PCP or medical group/IPA for the first 30 days following birth.

Note: The enrollment or eligibility of a newborn under the health coverage of a child's parent with no denial based on the following:

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

In cases where the baby's coverage under both the mother's insurance plan and the father's insurance plan, once the mothers discharge from the facility, general coordination of benefits rules apply. The medical group/IPA must make sure that care coordination handled appropriately.

If both the mother and father of a dependent newborn are eligible under separate UnitedHealthcare benefit plans, the dependent newborn added to both plans as determined by the subscribers.

Any subsequent PCP or medical group/IPA transfer of a dependent newborn will follow the 15/30 rules.

Adopted Dependents Coverage

Typically, coverage begins on the first day of physical custody if the subscriber submits an enrollment application to the employer group within 30 calendar days of physical custody of the child, unless the subscriber's benefit plan dictates otherwise.

Surrogate (Newborn Coverage)

We may provide coverage for a surrogate when the surrogate is the subscriber or eligible dependent; please refer to the UnitedHealthcare benefit plan. However, the newborn dependent(s) may not have coverage upon birth. Surrogate cases need review on a case-by-case basis, and newborn coverage denials, issuance to the facility in advance of the newborn's birth. Please contact your care provider relations representative if a surrogate case comes to your attention. Under California rescission rules, if UnitedHealthcare West or the member's care provider or medical group/IPA authorizes surrogate newborn care (beyond 30 days from birth), and the facility relies upon

such authorization to render treatment, those claims must be paid.

Additionally, we may seek recovery of actual costs incurred by us from a member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.

Certain Disabled Dependents Coverage

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

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

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

Domestic Partners

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

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

Eligibility (Medicare Advantage)

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

- Beneficiaries must be entitled to Medicare Part A and enrolled in Medicare Part B;
- Beneficiaries must reside in the UnitedHealthcare Medicare Advantage service area;
- In order to maintain permanent residence, the beneficiary must not continuously reside outside the applicable service area for more than six months (nine months if utilizing the UnitedHealth Passport® benefit);
- Beneficiaries must not have End Stage Renal Disease (ESRD), unless they meet one of the following exceptions:
 - › Beneficiary with ESRD, whose enrollment with another Medicare Advantage plan was impacted by the plan's termination or service area reduction, is allowed to enroll in UnitedHealthcare Medicare Advantage;
 - › Customer who developed ESRD after enrollment may remain on the program;
 - › Beneficiary with ESRD covered under a UnitedHealthcare Commercial contract is eligible to join UnitedHealthcare Medicare Advantage, as long as there is no lapse in coverage. The beneficiary with ESRD must be a member of the Commercial contract at the time he/she developed ESRD in order to be considered a true rollover and become eligible for benefits. A beneficiary who developed ESRD prior to their enrollment on the Commercial contract would not meet the eligibility criteria.
- Exceptions have been granted for a UnitedHealthcare group retiree member with ESRD:
 - › If an employer or union group offers a Medicare Advantage plan as a new option to its employees and retirees, a retiree with ESRD may select this new Medicare Advantage plan (regardless of whether it has been an option in the past) option as the employer's or union's open enrollment rules allow;
 - › If an employer or union group that has been offering a variety of coverage options consolidates its employee/retiree offerings (i.e., it terminates one or more plans), current members of the dropped plans may be accepted into a Medicare Advantage plan that is offered by the group;
 - › If an employer or union group has contracted locally with a Medicare Advantage organization in more than one geographic area (for example, in two or more states), an ESRD retiree who relocates permanently from one geographic location to another may remain with the Medicare Advantage organization in the local employer or union Medicare Advantage plan.

ESRD information is accessible at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com).

- Beneficiaries receiving Medicare hospice benefits are eligible to join UnitedHealthcare Medicare Advantage.

- › We are financially responsible for covered additional and optional supplemental benefits not covered under original Medicare.
 - › All services related to the member's terminal illness and not all Medicare-covered services related to the terminal illness coverage through original Medicare.
- Beneficiaries must maintain monthly premiums in geographic areas, where applicable.

Change of Membership Status (Medicare Advantage)

If a Medicare beneficiary is an inpatient at any of the following facilities at the time the beneficiary's membership becomes effective with us, the previous carrier is financially responsible for Part A services (inpatient facility care) until the day after the member is discharged to a lower level of care:

- An acute facility,
- A psychiatric facility,
- A long-term care facility, or
- A rehabilitation facility;

The member's assigned medical group/IPA assumes financial responsibility for Part B services (medical care) on the member's membership effective date.

If the member is an inpatient at a skilled nursing facility at the time of their effective date, the medical group/IPA and capitated facility become financially responsible for Part A and Part B services on the member's effective date. Conversely, if a member's coverage terminates while the member is an inpatient at any of the facilities identified above, the medical group/IPA is no longer financially responsible for Part B (medical care) services. The capitated facility, however, remains financially responsible for Part A (inpatient facility care) services until the day after the member's discharge to a lower level of care (e.g., home health or skilled nursing facility).

Refer to the Medicare Advantage Coverage Summary titled "Change of Membership Status while Hospitalized (Acute, LTC and SNF) or receiving Home Health" for more information on this subject, see [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com).

Eligibility Lists

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

- Member ID number, Name, Date of birth, Plan code, Employer group number (if applicable), Care provider effective date, Plan effective date, Care provider name and group number, Gender, Eligibility status (currently eligible, newly eligible), Effective dates of terminations and transfers, Benefits, including copayments and

deductible; Address (including ZIP code); Managed Care Plan selected, Identity of third party coverage (if known), Enrollment/Disenrollment date, Type of change to coverage, Primary Care Provider (PCP), Member copay total, Member copay max date, Member deductible total, Member deductible max date;

The most common eligibility report used is the EL915. This report is available electronically, and sent to the capitated care provider through a file transfer protocol and viewed on UnitedHealthcareOnline.com. Eligibility information generally provided once per month, and or provided on a weekly basis. Initiation of electronic eligibility requires coordination with your software vendor and us. If you are not currently receiving these files in this format today, please contact your provider advocate for further assistance.

Welcome Letter

We recommend that the medical group/IPA send a welcome letter to all new members in order to promote the appropriate utilization of medical group/IPA services. Although we stress to our members that they must follow the normal, established procedures of the medical group/IPA in order to receive services, direct contact by the medical group/ IPA will reinforce this point.

The welcome letter should provide the following important information:

- Hours and days of operation, including information on after-hours coverage
- How to schedule an appointment
- How to select a care provider
- Copayment policies
- Specialty referral procedures
- Hospitalization/primary facility
- Emergency services procedures
- Availability of urgent care

Member Communication (Medicare Advantage)

All member communications from any of our contracted entities are required to receive CMS approval prior to distribution, including all marketing activities and correspondence that:

- Include Medicare Advantage, and/or the AARP name or logo, or
- Describe benefits, including copayments, or
- Are used for marketing purposes

This requirement does not pertain to correspondence between care providers and their members regarding the member's medical condition, treatment plan or options,

or other communication that is necessary to manage the member's care.

In addition to making sure prior approval received by the governing regulatory body, we will direct the letter to the appropriate audience. For example, it is necessary to differentiate a mailing to Medicare Advantage plan individual members versus Medicare group retiree members, as their benefits are distinctly different.

State-Specific Requirements for Eligibility/Authorization Guarantee

Eligibility/Authorization Guarantee Procedure (CA Commercial)

Eligibility/Authorization Guarantee provides an opportunity for reimbursement to the medical group/IPA for covered services provided to:

- An individual who is identified as eligible on or two business days prior to the date of service through UnitedHealthcare West's eligibility determination and verification processes and who is later determined to be ineligible for benefits on the date of service, but no authorization has been provided ("Eligibility Guarantee") and;
- An individual for whom an authorization provided and who confirmed as eligible on or two business days prior to the date of service but who is later determined to have been ineligible on the date of service ("Authorization guarantee").

The Eligibility Guarantee and Authorization Guarantee procedures are designed to limit the medical group/IPA's risk of rendering care or incurring financial risk for services provided to ineligible members where the individual's lack of eligibility is only determined after the services are rendered.

Medical Group/IPA's Responsibility to Monitor Eligibility (CA Commercial)

We periodically sends to each medical group/IPA an eligibility list of all its assigned members and makes available current eligibility information through the Enterprise Voice website, care provider portal, and member service center. Medical group/IPA and/or its network of care providers is/are responsible for checking eligibility within two business days prior to the date of service for individuals for who/whom services are provided or authorized through the Enterprise Voice Portal, care provider website or toll-free phone number. Medical group/IPA shall be eligible for reimbursement under the Eligibility Guarantee and Authorization Guarantee programs. This program described herein for services authorized by the medical group/IPA or UnitedHealthcare West or provided by the medical group/IPA prior to the receipt of updated eligibility, showing individual no longer eligible. This occurs if medical group/IPA or the care provider of service has

checked and confirmed eligibility within two business days prior to the date of service through the Enterprise Voice Portal, care provider website or toll-free phone number.

Eligibility Guarantee Billing Procedures (No Authorization Provided) (CA Commercial)

Medical group/IPA provides or arranges for health care services for an individual identified as an eligible member through our eligibility determination and verification processes. No authorization is required or provided, and it is later determined that the individual was not a member at the time the health care services were provided, medical group/IPA may seek reimbursement for such services by following the procedure set forth below.

- Submit the claim to the member or the responsible payor for fee-for-service reimbursement in two consecutive billing cycles, no less than 30 calendar days apart. The responsible payor may be another health plan or insurer or it may be a government payor, such as Medicare when determined primary.
- If neither the member nor the responsible payor pays the claim within 30 business days following the submission of the second bill, the medical group/IPA must submit the following information to the UnitedHealthcare West care provider Dispute Team for reimbursement consideration using the address included in the [UnitedHealthcare West Care Providers Rework or Dispute Process Reference Table](#), set forth in the [Appeals](#) section of this guide:

- Cover sheet;
- Copy of the itemized bill for services rendered;
- Proof of eligibility verification within two business days prior to the date of service through the Enterprise Voice Portal, online care provider portal or toll-free phone number or care provider attestation letter;
- Proof of billing the member or responsible payor twice—no less than 30 calendar days apart;
- A record of any payment received from any other responsible payor; and
- Amount due based on medical group/IPA's cost of care rate, less any payment received from any other responsible payor.

Eligibility Guarantee Reimbursement (CA Commercial)

Verification of the medical group/IPA's compliance with the eligibility guarantee billing procedures with reimbursement to the medical group/IPA for services which are eligible under the eligibility guarantee policy, within 45 business days of receipt of the information stated above at the cost of care rates defined in the contract but no greater than 100% of the uncollected balance. Medical group/IPA shall be responsible for reimbursing the care provider of service if it is financially responsible for issuing payment for the applicable service under its contract with us.

Authorization Guarantee Billing Process (CA Commercial)

For services rendered in accordance with a valid authorization to a person identified as a member of UnitedHealthcare West, but later determined to have been ineligible, the Medical group/IPA must submit the following information to UnitedHealthcare West care provider Dispute Team for reimbursement consideration using the address included and set forth in this guide:

- Cover sheet;
- Copy of the itemized bill for services rendered;
- Proof of eligibility verification within two business days prior to the date of service through the Enterprise Voice Portal, care provider portal or toll-free phone number or care provider attestation letter;
- A record of any payment received from any other responsible payor;
- A copy of the authorization for the service rendered; and
- Amount due based on medical group/IPA contracted rate, less any payment received from any other responsible payor.

Authorization Guarantee Reimbursement (CA Commercial)

For medical group/IPA authorized services, medical group/IPA shall be responsible for reimbursing the care provider of service if it is financially responsible for issuing payment for the applicable service under its contract with us. We will reimburse medical group/IPA 100% of the amount payable to the care provider pursuant to medical group/IPA's contractual or other arrangements with such care provider. We will reimburse the medical group/IPA directly within 45 business days following receipt of the information stated above and provided medical group/IPA has followed the billing procedures described. For UnitedHealthcare West authorized services medical group/IPA shall submit the bill to us for reimbursement, and we shall reimburse the Care provider of service directly.

If we make a payment under the Eligibility Guarantee or Authorization Guarantee, the medical group/IPA receives payment for the same services from another source; the medical group/IPA agrees to refund to us, the amount received, not to exceed the amount paid by UnitedHealthcare West, within 45 business days.

Eligibility Verification Guarantee (TX Commercial)

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

We will guarantee payment for proposed medical care or health care services if the services rendered within the required timeframe to the member for whom the services

proposed. The payment reduced by any applicable copayments, coinsurance and/or deductibles.

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

You must request eligibility prior to rendering a service. Otherwise, we will not be responsible for payment of services provided to the member. The care provider is entitled to collect the payment directly from the member to the extent permitted by law or from any other source of payment.

Submit service verification requests to;

Phone: 877-847-2862

Or

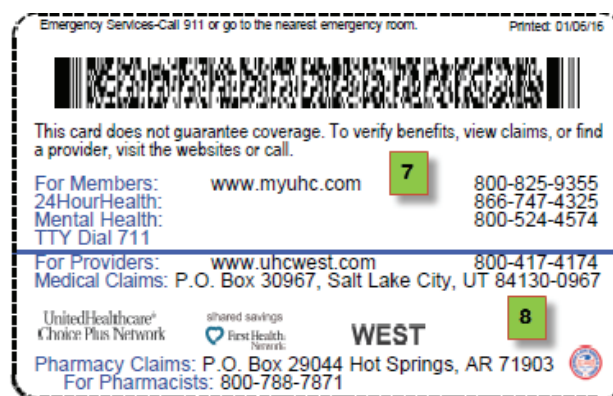
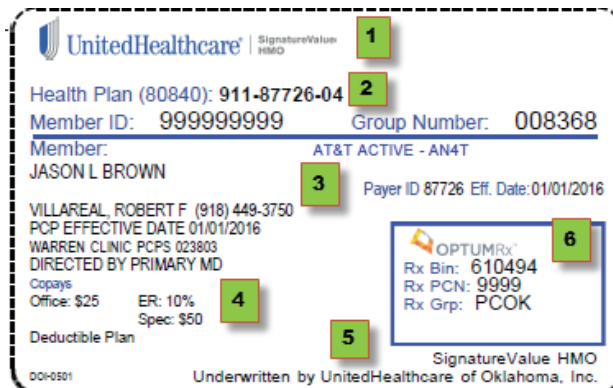
Care Provider Correspondence
P.O. Box 30975
Salt Lake City, UT 84130-0975

Health Care Identification (ID) Cards

Each member receives a health care identification (ID) card containing information that helps you submit claims accurately. Information may vary in appearance or location on the card due to payer or other unique requirements. It is important to check the member's health care ID card at each visit and to keep a copy of both sides of the card for your records. Member ID cards are viewable in the eligibilityLink app on [Link](#).

UnitedHealthcare West Commercial

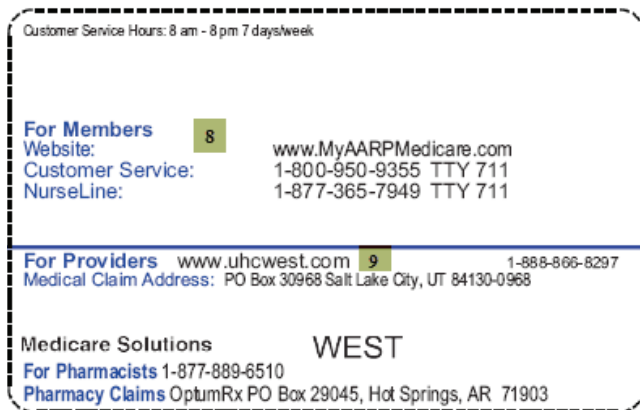
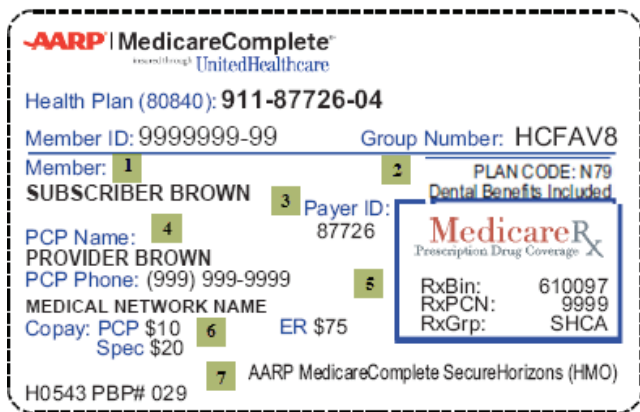
Note: Sample health care ID cards are for illustration only; information on health care ID cards may vary



1. UnitedHealthcare commercial logo
2. Member Plan Identifier: This is a customized field to capture more specific details about a member's plan as needed
3. PCP name and phone number: Please note the PCP address information found in the eligibilityLink app on [Link](#). For Individual Exchange members, 'PCP required' noted in place of the PCP name and number in most states. This section may also include 'Laboratory' (LAB) and 'Radiology' (RAD) member codes.
4. Copay information; if this area is blank, no copayment is required at the time of service.
5. The Benefit Plan Name
6. Prescription information: This will include the prescription plan name, prescription bin, and PCN and Group code.
7. For members/Insureds benefit plan contact information (website, phone numbers) for the member/Insured, and if applicable may include critical information on referrals and notifications.
8. For care providers; benefit plan and pharmacy contact information for care providers (websites, phone numbers). May also include critical information regarding referrals and may point to some customized benefit plans participation.

Sample Health Care ID Cards—Medicare Advantage Products

To see specific Medicare Advantage plan ID cards go to UnitedHealthcareOnline.com



1. Member Name
2. Dental Benefits: Included if routine dental benefits are part of the plan and/or if the member purchased an optional supplemental dental benefit (rider)
3. Payer ID: Indicates claim submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.
4. PCP name and phone number: Please note the PCP address information found in the Eligibility and Benefits Center application on [Link](#).
5. Prescription information: If the plan includes Part D prescription drug coverage, the Rx Bin, Rx PCN and Rx Group code will show. If Part D coverage is not included, this area will show information for Medicare Part B Drugs.
6. Copay information: Including PCP, Specialist, and ER copays. Some Special Needs Plans do not list the copay information.
7. The Benefit Plan Name: Identifies the applicable benefit plan name.
8. For Members: Section contains benefit plan contact information for the member.

9. For Providers: Section contains benefit plan contact information for the care provider.

Member Transfer/Disenrollment

Transfer of Members (Commercial)

A member may select a new medical group/IPA or PCP by calling Customer Service or by accessing UnitedHealthcareOnline.com.

Effective Date

Customers will be allowed to change their PCP within the same medical group/IPA and the change will be effective the first of the following month when the member calls to make the request, unless the subscriber’s benefit plan dictates otherwise.

If a member requests a transfer out of the member’s medical group/IPA entirely, and the change request is received prior to or on the 15th of the month, we will change the member’s medical group/IPA effective the 1st day of the following month. If the request to transfer to another medical group/IPA received after the 15th of the month, UnitedHealthcare West will change the member’s medical group/IPA effective the first day of the 2nd month following receipt of the request.

If the member Primary Care Provider Change Request, our contract with requested network care provider allows for a “retroactive” transfer. Per the contract, the network care provider may have the right to refuse to accept the member until the first day of the second month following receipt of request. Additionally, some care provider groups may only accept new members during an open enrollment period. If the member meets all eligibility requirements, the member will become effective the 1st day of the following month, even though the change request was received after the 15th of the month. If the 15th of the month falls on a weekend or holiday, we will allow transfer requests received on the first business day after the 15th to become effective the 1st day of the following month.

Transfers from one participating medical group/IPA to another, or PCP transfers initiated outside of member’s open enrollment period, will not be effective until the 1st day of the 2nd month following the member’s discharge from care, if at the time of the request for transfer or upon the effective date of transfer, the member is currently:

- Inpatient at an acute care facility;
- Inpatient at a skilled nursing facility, at a skilled level;
- Receiving other acute institutional care;
- In the 3rd trimester of her pregnancy (defined as when the member reaches the 27th week of pregnancy); or
- Experiencing a high-risk pregnancy (not applicable to California members)

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

Retroactive Member Transfers

Members allowed to retroactively changing their medical group/IPA or PCP within the same month, in the following instances:

- The member calls to request a change within 30 calendar days of the member's effective date and has not received services with the originally assigned care provider; or
- The member calls to request a change within 30 calendar days due to a household move over 30 miles, and the member has not received services with the originally assigned care provider.

If the member received services during the current month from you, other than the month requested, there will be no remittance to the current month's change.

Transfer Due to Termination of Medical Group/ IPA, Facility or Care Provider (Commercial)

We will provide prior written notice to members of any termination of the member's medical group/IPA, PCP, or facility, as applicable or when required by state or federal law. In such event, the member may be eligible for continuation of care. For individual physician terminations, the medical group/IPA shall be responsible for providing the above-mentioned notice in the following circumstances:

- PCP terminations in medical group/IPAs where medical group/IPA assigns members to the PCPs; and
- All specialist terminations

Each Commercial member will be provided with at least 30 calendar days (exception: 60 calendar days in California) to select another medical group, IPA, PCP or facility. Each Medicare member will be provided with at least 14 calendar days (exception: 60 calendar days in California) to select another medical group, IPA, PCP or facility. If the member fails to designate a new medical group/IPA or PCP within the period as specified in the notice, UnitedHealthcare West shall designate a medical group/IPA or PCP on the member's behalf within 15 miles or 30 minutes of member's residence. Members may select a new medical group/IPA or PCP within 30 miles of their residence or workplace. In the event of an individual physician termination, we shall designate a PCP within the member's current medical group/IPA. The member will receive a new health care ID card prior to the first of the month in which the transfer is effective.

When a member is in need of care and it is determined the member's PCP has terminated without proper notice, we will transfer the member to another PCP, within the same medical group/IPA with an effective date retroactive to the first of the current month.

Transfer of Members (Medicare Advantage)

In accordance with CMS, a member may change medical groups/IPAs or PCPs for any reason, including, but not limited to, the following:

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

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

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

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

- An acute care facility
- A critical access facility
- A long-term care facility
- A psychiatric facility
- An inpatient rehabilitation facility
- A skilled nursing facility when the member is at a skilled level of care

Refer to [UnitedHealthcareOnline.com](https://www.uhcare.com) and look to UnitedHealthcare Medicare Advantage Coverage Summaries for additional information about coverage of ambulance transfers due to a medical group/IPA change while the member is an inpatient.

Removal of Members (Commercial)

The medical group/IPA acknowledges and agrees that UnitedHealthcare West, in its discretion, and upon request

by the medical group/IPA, due to a material detrimental change in the medical group/IPA member relationship, has the right to transfer a member to another specified medical group/IPA or care provider, if necessary and the member is medically able.

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

The medical group/IPA may request us to change a member to a different medical group/IPA if the care provider-member relationships materially damaged by the member's refusal to accept recommended treatment, counsel or procedure. We will evaluate such request considering the member's best interests and the geographic accessibility of another medical group/IPA. If we grant the request for transfer, we shall request the member to select another medical group/IPA within 30 calendar days. If the member fails to select another medical group/IPA, we shall designate another medical group/IPA on the member's behalf. If the member continues to refuse to accept the medical group/IPA's recommended treatment, counsel or procedures and no professionally acceptable alternatives exist, neither UnitedHealthcare West nor the medical group/IPA shall be responsible to provide or arrange for the medical care or pay for the condition under treatment.

Potential areas of concern for requesting removal of a member from the medical group/IPA include:

- Repeated disruptive behavior or dangerous behavior exhibited in the course of seeking/receiving care;
- Failure to pay required copayments (minimum dollar amount of \$200 outstanding); or
- Fraudulently applying for any UnitedHealthcare benefits

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

Copies of all notification letters, request for removal and supporting documentation sent directly to your provider advocate.

Upon receipt of a completed "Incident Report for Removal of members" and related documentation, we will respond to the member and copy the PCP or medical group/IPA on all correspondence.

Criteria and Procedure for Removal of Commercial Members from the Medical Group/IPA

LEVEL I	LEVEL II	LEVEL III
Criteria:		
Demanding a payment from medical group/IPA for non-authorized services; Minor disruptive behavior* Failure to pay required copayments* * Three or more missed appointments, within six consecutive-months without 24-hour prior notice;	Refusal to follow recommended treatment, or procedures by care provider resulting in deterioration of member's medical condition; Disruptive behavior, verbal threats of bodily harm towards medical group/IPA personnel and/or other members, provided the conduct is not a direct result of the member's medical condition or prescribed medication.+	Member fraudulently applies for any UnitedHealthcare benefits; Dangerous behaviors exhibited in the course of seeking or receiving care provided the conduct is not a direct result of the member's medical condition or prescribed medication. Need an eyewitness who is willing, to formally document the incident in writing.
1st Occurrence:		
Medical group/IPA must counsel with and write to member in certified letter expressing such behavior is unacceptable; Discussions need documentation. Send copies to UnitedHealthcare West, which will send warning letter outlining behavior and possible consequences.	Medical group/IPA must counsel with and write to member in certified letter expressing such behavior is unacceptable; Discussions will need documenting. Send copies to UnitedHealthcare West, which will send warning letter outlining behavior and possible consequences.	Medical group/IPA requests immediate removal of Subscriber/member from medical group/IPA. Incident must be, formally documented by medical group/IPA; Send written notification to member in a certified letter, Mail copies of documentation and member letter to UnitedHealthcare West for review.
2nd Occurrence:		
Medical group/IPA must counsel with and send second letter to member expressing concern regarding their unacceptable behavior; Send copies to UnitedHealthcare West, which will send warning letter outlining continued behavior and possible consequences.	Send UnitedHealthcare West a request to immediately remove subscriber/member from the Medical group/IPA UnitedHealthcare West will review the medical group/IPA documentation outlining continued unacceptable behavior.	
3rd Occurrence:		
Send UnitedHealthcare West request to immediately removal of subscriber/member from the medical group/IPA. We will review the medical group/IPA documentation, which outlines continued unacceptable behavior.		

*Minor disruptive behavior: unruly behavior, use of abusive and/or profane language directed towards medical group/IPA and/or other members.

**UnitedHealthcare West will not consider the removal of a member unless the unpaid copayment balance exceeds \$200.00.

+ Disruptive behavior: physical or verbal threat of bodily harm towards medical group/IPA personnel and/or other members or property, and/or use of unacceptable behavior relative to drug and/or alcohol misuse.

Dangerous behavior such as; attempted physical abuse, display of weapon or damage to property, use of unacceptable behavior relative to drug and/or alcohol misuse, and/or chronic demands for unreasonable services.

Benefit Plan Changes (Medicare Advantage)

When a Medicare Advantage member has a benefit plan change, the member is required to complete and submit an *Individual Enrollment Request Form and Statement of Understanding*. Customer Service contacted to complete the form verbally over the phone allowing plan changes made the first of the following month, without the need to return any paperwork. A benefit plan change occurs when the member:

- If the member moves, from one service area to another, within the same state, the household then requires the member to complete the form and return it within 30 calendar days. If the form is not returned within 30 calendar days, the member is considered to be out of the service area and will be disenrolled on the 1st of the month following the 30 calendar days;

- Changes from one benefit plan to another. If the member does not return a completed form, the member will remain on the existing plan. Members may only change benefit plans using their annual election period or during the Medicare Advantage Disenrollment Period defined by CMS. If the member has exhausted these elections, and does not qualify for a Special Election Period, the members locked in to the current benefit plan for the remainder of the calendar year and may not change benefit plans.

CMS requires that we treat a member who experiences a benefit plan change as a new member, rather than as an existing member. Therefore, the member's enrollment to another PCP or medical group/IPA is effective the first of the month following receipt of the completed form.

The 15/30 rule does not apply to members who fall into this category. The following policies apply to *Individual Enrollment Request Form and Statement of Understanding* processing:

- When a form change will be effective the 1st of the upcoming month and the member subsequently requests a medical group/IPA or PCP change prior to the effective date of the form, the requested care provider change will have the same effective date as the original form;
- When a medical group/IPA or PCP change request received after the effective date of the original form, the member's effective date with the new care provider will follow the 15/30 rule for processing. The transfer will not be effective until the 1st of the following month;
- On an exception basis, a member may be re-assigned retroactively to the 1st of the month in which a medical group/IPA or PCP change request is made, based on the following criteria:
 - If the member was auto-assigned to the medical group/IPA or PCP by UnitedHealthcare West and member needs services.

Note: The Individual Enrollment Request Form and Statement of Understanding process does not apply to Medicare Advantage Group Retiree members.

Member Elected Disenrollment (Medicare Advantage)

If a member requests disenrollment through the care provider, the member referred to the UnitedHealthcare Medicare Solutions Customer Service Department. Once the disenrollment is processed, a letter with the effective date of disenrollment sent to the member. If the member submits a request for disenrollment during the month, the disenrollment will be effective the 1st day of the following month.

Criteria and Procedure for Involuntary Transfer of Medicare Advantage Members from the Current PCP/Medical Group/IPA to an Alternative PCP/Medical Group/IPA

If the member/care provider relationship has been seriously impaired, by the following the guidelines:

First Occurrence

At the first occurrence, you should send the member a certified/return receipt-warning letter advising him/ her of the issue and potential consequences of dismissal. Document the specific information including the care provider's name, date of occurrence, and issue. Letter must notify the member that PCP/medical group/IPA is notifying us regarding the matter and offer the member the right to

grieve the allegations PCP/Medical group/ IPA is required to maintain full documentation. Send a copy of the letter directly to your provider advocate.

Second Occurrence

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

Third Occurrence

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

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

Disenrollment for Cause (Medicare Advantage)

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

- Failure by the member to pay plan premiums, subject to the 90 calendar day grace period and appropriate notification;
- Disruptive, unruly, abusive or uncooperative behavior that seriously impairs the organization's ability to furnish services to either the member or other members;
- The member provides fraudulent information when enrolling or permits others to use the member's health care ID card to obtain services;
- The member resides outside the service area for over six months (or nine months if using the UnitedHealth Passport® benefit);
- The beneficiary loses entitlement to Medicare Part A or dis-enrolls from Part B.

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

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

Filing of a Lawsuit by a Member

Lawsuits against Care Provider

The filing of a lawsuit by a member against a physician does not by itself; automatically provide sufficient cause to transfer the member to another medical group/IPA. We will apply the following Guidelines in determining whether to grant a request by a medical group/IPA to transfer a member to another medical group/IPA when the member has filed a lawsuit:

- When a lawsuit alleges quality of care deficiencies or inappropriate professional conduct against a care provider and the care provider requests that the member discharged from the care provider's care, we will consider the immediate transfer of the member to another care provider within the medical group/IPA at a different location.
- If the member is in active care and treatment, the treating care provider must take steps to confirm that continuity of care provided and the member's care not delayed, impeded as resulted of the transfer. The treating care provider will also cooperate in the transfer of medical records and information to the new care provider. If previously sued by member, permission to member for selection of new care provider if care provider is located within the same office as the treating care provider is not granted. However, the member has permission, to select another care provider who is part of the same medical group/IPA but located in a different office.

Lawsuits against Medical Group/IPA

The filing of a lawsuit against a medical group/IPA is not, by itself, sufficient cause to deny the member access to all care providers within the medical group/IPA. A request for the transfer of a member from the medical group/IPA will not be considered unless the member's complaint alleges deficiencies in the general practices and procedures of the medical group/IPA. Lawsuits not involving allegations related to the general practices and procedures of the medical group/IPA will not be considered sufficient grounds to transfer the member from the entire medical group.

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

Referrals & Referral Contracting

PCP and Provider Responsibilities

The assignment of a PCP, will be given to each member at the time of enrollment.

PCPs and specialty care providers not affiliated with a medical group/IPA delegation for medical management must follow our Medical Management processes for referrals. Refer to the [Medical Management](#) section of this guide.

Referral Authorization Procedure

The delegated medical group/IPA may be responsible to initiate the referral authorization process when a request made to refer a member for services. (Please refer to the delegated group's Notification/Prior Authorization list, as applicable). The following capitated medical services are examples where a referral authorization may be necessary:

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA's facility)
- Specialty consultation/treatment

The medical group/IPA, PCP and/or other referring care provider is responsible for verifying eligibility and network care provider network care provider listings on all referral authorization requests, so that the referral is to the appropriate network care provider. The medical group/IPA must comply with the following procedure:

- When a member requests specific services, treatment or referral to a care provider, the PCP or treating care provider shall review the request for medical necessity.
- If there is no medical indication for the requested treatment, the care provider shall discuss an alternative treatment plan with the member.
- If the treatment option selected by the member requires referral or prior authorization, the PCP or treating care provider must submit the member's request to the medical group/IPA Utilization Management Committee or its designee for determination. The PCP or treating care provider should include appropriate medical information and commentary on the referral. This referral is regarding why they believe the requested treatments of no indication of alternative treatments as appropriate.
- If the request is not approved in whole, the medical group/IPA (or if not delegated, UnitedHealthcare West) must issue a denial letter to the member, specific to the requested services, treatment or referral and which complies with the applicable state and federal requirements.

CA:

Out-of-Network Provider Referrals (HMO)

When covered services are not available within a delegated medical group's/IPA's network, the member's PCP shall submit a request for an out-of-network provider review to the delegated medical group/IPA for accessibility. If approved, the member's financial responsibility for services rendered by the out-of-network provider, shall not exceed the member's applicable in-network copayment, deductible, and coinsurance associated with their benefit plan.

Requests for Services (Medicare Advantage)

CMS regulations 42 CFR 422.568(a) allow a member to request services from the MA Plan or the entity responsible for making the determination which is the utilization management/Medical Management delegated medical group/IPA. This requirement applies to both standard and expedited pre-service Initial Organization Determinations (IODs). The established requirements for pre-service standard and expedited IODs apply. The medical group/IPA must have explicit policies and procedures for the following:

- Starting the referral or authorization processes when a member contacts the delegate to request services. The medical group/IPA must use the date and time the member first called as the received date and time of the request in order to comply with required turn-around times. The member's request may have happened before the date and time the request reached the department that processes referrals and authorizations.
- Working with UnitedHealthcare West, on requests for referrals or authorizations of services, for a member contacted UnitedHealthcare to request services. The medical group/IPA must use the date and time of the member's request to UnitedHealthcare as the received date and time of the request for compliance with turn-around times.

Requests for Services (Commercial CA)

CA:

California Language Assistance Program, possible authorization determinations include:

- Approved as requested—No changes;
- Approved as modified—Services were approved, but the original requested care provider or treatment plan was modified; Denial letter for the originally requested service, including rationale for denial, must be sent if requested care provider is changed or specific treatment modality is changed (e.g., requested chiropractic services, approved physical therapy);
- Extension—Delay of decision for a specific service (e.g., need additional documentation or information, or require consultation by an expert reviewer);
- Delay in Delivery—The authorizing entity requires a postponement of an approved service for a specified period of time or until a specified date. To facilitate timely processing of claims, the medical group/IPA referral authorization process should include claims processing guidelines for the referral care provider.

Referral Authorization Form

The medical group/IPA may design its own request for authorization form, without approval by us; however, the font of the form must be at least 12-point, with "Times New Roman" being the preferred style. In addition, the form at a minimum, include all of the following components:

- Member identification (e.g., member ID number and birth date)
- Services requested for authorization (including appropriate ICD-10-CM and/or CPT codes)
- Authorized services (including appropriate ICD-10-CM and/or CPT codes)
- Proper billing procedures (including the medical group/IPA address)
- Verification of member eligibility

Within two business days of the decision, the medical group/IPA shall provide copies of the referral authorization form to the following:

- Referral care provider
- Member
- Member's medical record
- Managed care administrative office
 - › If UnitedHealthcare West is financially responsible for the service, or responsible for processing the claim for such services, the group shall consult with UnitedHealthcare to determine if UnitedHealthcare authorization is required prior to rendering any authorization decision.

Chapter 5: Virtual Visits

Virtual Visits to Commercial HMO Plans CA only

UnitedHealthcare of California will be adding a new benefit for Virtual Visits to members benefit plan starting in Jan 2017. Virtual Visits defined as primary care services that include the diagnosis and treatment of low acuity medical conditions for members with interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual Visits provide communication of medical information in real-time between the member and a care provider or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work). When covered by member's benefit plan, the Virtual Visit benefit will have separate defined copayment that will generally be equal to or less than the member's PCP office visit copayment.

The Commercial HMO members with the new benefit may access Virtual Visits from a Designated Virtual Network Care Provider. UnitedHealthcare prefers members to access Virtual Visits through their selected PCP or medical group/IPA, if available. In the event the member's medical group/IPA or PCP does not offer the Virtual Visit services, UnitedHealthcare will make available a nationally contracted Virtual Visit care provider. The network care provider groups intending to offer Virtual Visit services, must comply with the service standards in the [Service Expectations Exhibit](#) section below.

Service Expectations Exhibit

Access—When the care provider group develops Virtual Visit technology, services offered to assigned members benefit plan. Virtual Visit primary care services delivered by the care provider groups covered under professional capitation. Not all UHC West members benefit plan will have the Virtual Visit benefit option, the care provider group will validate member eligibility for Virtual Visit service and member cost share. Applies only if medical group/IPA chooses to develop its own virtual visit technology.

24 Hour/7 Day Availability—Virtual Visit technology services are available 24 hours a day, seven days a week.

Staffing Credentials—All professional staff are certified or licensed in their applicable specialty or have a level of certification, licensure, education and/or experience in accordance with state and federal laws.

Staff Orientation and Ongoing Training—The network care provider group must participate in a written orientation plan with documented skill demonstrations as well as initial and ongoing training programs including review of policies and procedures. The care provider group will pursue accreditation of its Virtual Visit program with the [American Telemedicine Association](#).

Service Response Time—The care provider group will contact a member within 30 minutes after a member requests a visit to either schedule or initiate a Virtual Visit.

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

Professional Accreditation—The care provider group will pursue applicable accreditation by the American Telemedicine Association (or other mutually agreed upon accreditation body) with the objective of, accreditation within one year after the accreditation program release date.

Continuous Quality Improvement (CQI)—There is a documented CQI program for identifying through data opportunities for real, time measured improvement in areas of core competencies. There are demonstrated ties between CQI findings and staff orientation, training and policies and procedures.

Member Complaints—Logged by category and type, member complaints with specific improvement action plans for any patterns. There are complaints registered on < 2 percentage of member cases.

Regulatory Assessment Results—Upon UnitedHealthcare's request, the care provider will have available and permit access to any applicable regulatory reviewed results.

Utilization—The care provider group will submit Virtual Visit encounters with proper coding as part of existing encounter submission process.

Electronic Billing/Encounter Coding—The care provider group will submit Virtual Visit encounters or claims with proper coding as part of existing encounter submission process.

Eligibility Verification—The care provider group will use existing eligibility validation methods to confirm Virtual Visit benefits. Options include real time EDI eligibility request (270) and response (271) and use of the care provider website.

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

Joint Operating Committee—The care provider will meet with UnitedHealthcare up to quarterly upon

UnitedHealthcare's request to review data reports, quality issues, and address any administration issues.

Professional Environment—The care provider group will help ensure that rendering care provider's conduct Virtual Visits in a professional appearing, private location when conducting Virtual Visits with members. Virtual encounters will occur in private space. The care provider group (rendering care providers) will not conduct member Virtual Visits in vehicles or public location.

Medical Director—The care provider will employ or engage a licensed care provider as Medical Director. The Medical Director will be responsible for clinical direction and oversight of services provided to members.

Chapter 6: Medical Management

Delegated medical groups/IPAs should follow the information listed below.

The purpose of the Medical Management Program is to determine if the medical services proposed or rendered are:

- Medically necessary;
- Covered under the member's UnitedHealthcare West benefit plan; and
- Performed at both the appropriate place and level of care

With limited exceptions, care providers will not be reimbursed for services that are not a covered benefit, not medically necessary, or for which correct procedures have not been followed (e.g., notification requirements, prior authorization, or verification guarantee process).

NCQA Accreditation standards require that all health care organizations, health plan and medical group/IPAs, delegated for utilization/medical management, distribute a statement to all members, care providers and employees who make UM decisions affirming the following:

- UM decision-making based only on appropriateness of care and service, and existence of coverage;
- Care providers or other individuals, are not specifically rewarded for issuing denials of coverage or service;
- Financial incentives for UM decision-makers, do not encourage decisions that result in under-utilization;

Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and the attending care provider. If the care provider and member decide to go forward with the medical services once UnitedHealthcare West or the delegated medical group/IPA has denied prior authorization, UnitedHealthcare West or the delegated medical group/IPA will reimburse no care provider, facility, or ancillary services. UnitedHealthcare medical directors are available to discuss their decisions and our criteria with you. Benefit Interpretation Policies, Medical Management Guidelines, and Coverage Summaries are available online or from the delegated medical group/IPA as applicable.

Criteria for Determining Medical Necessity

UnitedHealthcare West and medical group/IPAs delegated for utilization/medical management review nationally-recognized criteria to determine medical necessity and appropriate level of care for services whenever possible.

UnitedHealthcare West and delegated medical group/IPAs will utilize multiple resources and guidelines to determine medical necessity and appropriate level of care. For Medicare Advantage members, Medicare coverage guidelines, including National Coverage Determinations and Local Coverage Determinations used to determine medical necessity of services requested. For services not

addressed in Medicare coverage guidelines, the delegate should use UnitedHealthcare's Medicare Advantage Coverage Summaries. If other nationally-recognized criteria contradict Medicare coverage guidelines, UnitedHealthcare and delegated medical group/IPAs will follow Medicare coverage guidelines for Medicare Advantage members. Individual criteria provided to you upon request.

Medical Management Pre Service Coverage Determinations

For some commercial benefit plans, and all Medicare Advantage plans, services on the Notification/ Prior Authorization List will require prior authorization through a pre-service clinical coverage review that will result in either a coverage approval or an adverse determination.

- Once you inform us of a planned service listed on the Notification/Prior Authorization List, we will inform you if prior authorization is required. We will advise you of the required information necessary to complete the review and you will be notified of the coverage determination within the time required by law.
- It is important that you and your patient who is our member are fully aware of coverage decisions before services are rendered. If you provide the service before a coverage decision is made, and we ultimately determine that the service was not covered, we may deny the claim and you must not bill the member. If you begin providing services prior to the final coverage determination, it is not possible for the member to make an informed decision about whether to pay for and receive non-covered services.
- No updates can be made to an existing advance notification or prior authorization AFTER the service has been delivered. If during the service, you performed an additional or different service than was originally approved, you must submit the supporting clinical information for the service at the time of claim submission.

Care Provider Requirements

Care providers are required to participate, cooperate and comply with UnitedHealthcare West Medical Management policies. All care providers and care providers must render covered services at the most appropriate level of care, based on nationally recognized criteria.

UnitedHealthcare West may delegate medical management functions to a medical group/IPA that demonstrates compliance with UnitedHealthcare West's established standards. Care providers associated with these delegated medical groups/IPA must use the medical group/IPA's medical management office and protocols. In addition, we may retain responsibility for some medical management functions, such as inpatient admissions and outpatient surgeries. When the care provider is not associated

with a delegate or where UnitedHealthcare West retains responsibility for the specific medical management function, the care provider is required to comply with the UnitedHealthcare West Medical Management procedures.

Care Provider Responsibilities under UnitedHealthcare's Medical Management Program

Care providers are required to confirm a request for services has been authorized prior to rendering services for a specified member. If a prior authorization has not been requested, the care provider must request prior authorization for services within three business days prior to providing or ordering the covered service except in the case of emergent or urgent services.

In order to confirm a Prior Authorization approval for a particular date of service, care providers may check UHCWest.com. If the member assigned is to a delegated medical group/IPA, a care provider may check with this medical group/IPA for confirmation.

UnitedHealthcare West notifies urgent or emergent cases, within 24-hours of services rendered, or an admission.

Failure to obtain prior authorization when required or to notify us within the appropriate timeframe may result in a denial of payment. The delegated medical group/IPA sets its own policies regarding the responsibilities of care providers. In no event, shall UnitedHealthcare West or the member, be held responsible to reimburse care providers and care providers for medical services, admissions, inappropriate facility days, and/or not medically necessary services if required prior authorization was not obtained. Receipt of an authorization does not affect the application of any applicable payment policies in determining reimbursement.

Inpatient Concurrent Review: Clinical Information

Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, we ask you to provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information or documents required within four hours of receipt of our request. If it is received before 1 p.m. local time or make best efforts to provide requested

information within the same business day if the request is received after 1 p.m. local time, but, no later than 12 p.m. local time the next business day.

UnitedHealthcare uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, and home health care and ambulatory facilities.

Direct Access Services

Women's Health Specialist

Female members may receive obstetrical and gynecological (OB/GYN) care provider services directly from a participating OB/GYN, family practice care provider, or surgeon identified by the medical group/IPA or UnitedHealthcare West as providing OB/GYN care provider services. This means the member may receive these services without prior authorization or a referral from her PCP. In all cases, however, the care provider must be affiliated with the member's assigned medical group/IPA and participating with UnitedHealthcare West.

Flu Vaccine

Each Commercial and Medicare Advantage member has direct access to a network care provider for an annual flu vaccine. The medical group/IPA shall educate each Medicare Advantage member about annual flu vaccine, care providers and the availability of flu vaccines through the member's PCP.

Access to Participating Eye Care Providers (CA and CO)

If the medical group/IPA is delegated for vision services, the medical group/IPA must allow the member direct access to any eye care provider participating and available under the plan. An eye care provider defined as a network care provider who is an optometrist or ophthalmologist who is appropriately licensed. The medical group/IPA may subsequently require the eye care provider to submit requests for approval of surgical vision-related procedures.

Access to Participating Chiropractor (WA)

If the medical group/IPA is delegated for chiropractic services, the medical group/IPA must allow the member direct access to any participating chiropractor and available under the plan. The medical group/IPA may utilize managed care cost and containment techniques.

Second Opinion

An appropriately qualified health care professional shall provide a member, who meets specific criteria, a second medical opinion consultation.

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

PCP Second Opinions

When the PCP affiliates himself with a delegated medical group/IPA, the medical group/IPA is responsible for authorization and claims payment for a second opinion when the member requests a second opinion based on care received from the member's PCP.

- Member requests for a second opinion regarding primary care is provided by an appropriately qualified health professional of the member's choice within the medical group/IPA group of network care providers.
- If denial of the request for a second medical opinion occurs, the medical group/IPA will notify the member in writing and provide the reasons for the denial. The member may appeal the denial. If the member obtains a second medical opinion without prior authorization from the participating medical group/IPA and/or UnitedHealthcare West, the member will be financially responsible for the cost of the opinion.

The member may request a second opinion from a care provider or specialist listed in our care provider directory at UHCWest.com when the PCP is not affiliated, with any participating medical group/IPA, but is instead, independently contracted with UnitedHealthcare West. The approved provider will document the second medical opinion in a consultation report, which the approved provider will make available to the member and the treating participating provider. The second opinion provider will include in the report any recommended procedures or tests that the provider giving the second opinion believes are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by UnitedHealthcare West and the

recommendation is determined to be medically necessary by both participating medical group/IPA and either the participating medical group/IPA or UnitedHealthcare West will arrange UnitedHealthcare West, the treatment, diagnostic test or service.

Note: An appropriately qualified care provider gives a second medical opinion and recommends a particular treatment diagnostic test or service does not necessarily mean that the recommended action will be determined to be medically necessary or is a covered service. The member will also remain responsible for paying any applicable cost-sharing amount to the care provider who gives the second medical opinion.

Specialist Care Second Opinions

- If the member requests a second opinion consultation based on care received through an authorized referral to a specialist within the medical group/IPA in-network, the second opinion provided by any practitioner of the member's choice from any medical group/IPA within the UnitedHealthcare West network care provider of the same or equivalent specialty.
- If the healthcare professional is participating with the member's assigned medical group/IPA, the medical group/IPA is responsible for authorization and claims payment for the second opinion consultation.
- Second opinion requests for care providers or care providers not participating with the member's assigned medical group/IPA processed by the medical group/IPA as a request for services that are carved out, following the appropriate UM guidelines, and be referred to UnitedHealthcare West's Medical Management department. If approved, we are responsible for claims payment of the second opinion consultation by the nonparticipating health care professional.
- A second opinion consists of one office visit for a consultation or evaluation only. Upon completing the examination, the care provider's opinion is included in a consultation report. The member must return to the member's assigned medical group/IPA for all follow-up care.
- If a second opinion consultation differs from the initial opinion, coverage for a third opinion provided upon member or care provider request, following the same process as for second opinions.

Turnaround Time

Requests for second opinion processed in a timely manner to accommodate the clinical urgency of the member's condition and in accordance with established utilization management procedures and applicable regulatory requirements. When there is an imminent and serious threat to the member's health, the second opinion determination made within 72 hours after receipt of the request by the medical group/IPA or UnitedHealthcare

West. An imminent and serious threat includes the potential loss of life, limb, or other major bodily function. It can also be existent where a lack of timeliness would be detrimental to the member's ability to regain maximum function.

Refer to the Medicare Advantage Coverage Summary titled Second and Third Opinions located at UnitedHealthcareOnline.com for more detailed information and benefit exclusions.

Standing Referral/Extended Referral for Care by a Specialist

The delegated medical group/IPA is required to develop procedures by which a member may receive a standing referral/ extended referral for specialty care. Procedures shall provide for a standing referral or extended referral to a specialist, or specialty care center. If the member and PCP, in consultation with the specialist, determine if the member requires: (i) continuing care from a specialist or specialty care center over a prolonged period of time; and/or (ii) extended access to a specialist for a life-threatening, degenerative or disabling condition that requires coordination of care for the member by such specialist. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visit be authorized and/or require that the specialist provide the PCP with regular reports on the health care provided to the member.

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

HIV/AIDS Extended Referrals (CA Commercial)

The delegated medical group/IPA must have a written process for extended referrals to HIV/AIDS specialists when the PCP and medical group/IPA Medical Director agree that diagnosis and/or treatment of the member's condition requires the expertise of an HIV/AIDS specialist. To comply with the state laws and regulations, the delegated medical group/IPA must identify care providers within their group who qualify as HIV/AIDS specialists. If there are no such care providers within the medical group/IPA, then the medical group/IPA must have available a mechanism to refer members to a qualified HIV/AIDS specialist outside of the group. The State regulations contain the qualification of an HIV/AIDS specialist California Health and Safety Code (Ca H&SC 1300.67.60).

Referral Contracts (Medicare Advantage)

The medical group/IPA is encouraged to establish contracts with care providers to whom members referred for specialty services. Each contract must have specific components as described in this section.

The medical group/IPA may establish written contracts with referral care providers who will provide services to Medicare Advantage members or may utilize existing UnitedHealthcare contracts unless the medical group/IPA delegated for claims processing. In that situation, they medical group/IPA must negotiate their own contracts. Such contracts must comply with the requirements of this guide.

- No contractual arrangement between the medical group/IPA and any subcontracting care provider may violate any provision of applicable law.
- The medical group/IPA must make sure that all provisions of its agreement with any care provider who provides services to Medicare Advantage members includes all provisions required under the medical group/IPA's Medicare Advantage participation agreement and CMS rules and regulations.
- If a care provider has opted out of the Medicare program, the medical group/IPA will not contract with such care provider to provide services to Medicare Advantage members.

Establishing Contracts

Any medical group/IPA delegated for claims processing must negotiate contracts with individual specialists or group practices to facilitate the availability of appropriate services to members. All contracts must be in writing and comply with state and federal law, accreditation standards and the Medicare Advantage agreement.

Reciprocity Agreement

A reciprocity agreement between network care providers encourages the exchange of services within the Medicare Advantage network. This arrangement is advantageous in that care providers within the Medicare Advantage network already have an established history of working with Medicare Advantage members and managing health care.

Situations in which reciprocity agreements may be useful include:

- When a needed specialty service is not available within the member, assigned network care provider but is available with another Medicare Advantage network care provider.
- If a member is hospitalized in a facility in which the member's care provider, or referral specialist does not routinely use; in such a case, the primary care provider/specialist services referred to a network care provider who routinely uses that particular facility.

Subcontract Review

In order to be compliant with CMS regulatory requirements, we are required to make sure that the applicable provisions are contained in the written agreements the medical group/IPA has in place with its care providers. On an

annual basis, we recommend that the medical group/IPA complete a review of the most current model subcontracts it uses to help ensure that all are fully compliant with state and federal law. Annually, at a minimum, we will conduct a review of each delegated medical groups/IPA's downstream contracts to determine compliance with CMS regulations and guidance.

Improvement Action Plans (IAP) will be required of any medical group/IPA with non-compliant contracts. The IAP will identify specific findings, actions and expected timeframe for compliance.

Continuity of Care

Continuity of care intended to be a short-term transition period, which allows members temporarily continue to receive services from a non-network care provider the timeframes and conditions vary according to state regulations. In general, continuity of care is available to:

- New members who are experiencing an acute episode of care while making the transition to UnitedHealthcare West; and
- Existing members who are experiencing an acute episode of care when:
 - › A care provider participating with UnitedHealthcare terminates its agreement to provide services for UnitedHealthcare West members; or
 - › A care provider contracted with a participating medical group/IPA terminates its agreement to provide services for UnitedHealthcare West members. This occurs when the medical group/IPA holds the contract with its care providers.

Typically, a condition that would initiate a request for continuity of care requires prompt medical attention and is of limited duration.

It is not enough prefer receiving treatment from a former care provider or other non-network care provider, even for a chronic condition. A member should not continue care with a non-network care provider without formal approval by UnitedHealthcare West or the delegated medical group/IPA. Except for emergent or urgent out-of-area (OOA) care, if the member does not receive prior authorization from UnitedHealthcare West or the delegated medical group/IPA, payment for services performed by a non-network care provider will be the member's responsibility.

UnitedHealthcare West (or the medical group/IPA delegated for continuity of care) shall review all requests for continuity of care on a case-by-case basis. Reasonable consideration, must be given to the severity of the member's condition and the potential clinical effect on the member's treatment and outcome of the condition under treatment, which may result from a change of care provider.

A member may request to continue covered services with a care provider for continuity of care under the following circumstances:

- Care provider terminating from UnitedHealthcare, other than for cause or disciplinary action;
- Care provider agrees in writing to be subject to the same contractual terms and conditions that are imposed upon network care providers, including, but not limited to: credentialing, facility privileging, utilization review, peer review and quality assurance requirements; and
- Care provider agrees in writing compensation rates and methods of payment similar to those used by UnitedHealthcare West and current network care providers providing similar services, who are not capitated and who are practicing in the same or a similar geographic area.

In order for a member's request for continuity of care, considering a member must be undergoing an active course of treatment.

Examples of an Active Course of Treatment Considered for Continuity of Care (CA)

- **An Acute Condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services provided for the duration of the acute condition.
- **A Serious Chronic Condition** is a medical condition due to disease, illness, medical problem, mental health problem, or medical or mental health disorder that is serious in nature and that persists without full cure or worsens over an extended period, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services provided for the period necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a network care provider. Active course of treatment determined by a UnitedHealthcare West or medical group/IPA Medical Director in consultation with the member, the terminated care provider or the non-network care provider and as applicable, the receiving network care provider, consistent with good professional practice. Completion of covered services for this condition will not exceed 12 months from the participation agreement's termination date, or 12 months after the effective date of coverage for a newly enrolled member.
- **A Terminal Illness** is an incurable or irreversible condition that has a high probability of causing death within one year. Completion of covered services may be provided for the duration of the terminal illness, which could exceed 12 months, provided that the prognosis of death was made by the: (i) terminated care provider prior to the participation agreement termination date, or (ii) non-network care provider prior to the newly enrolled member's effective date of coverage with UnitedHealthcare West.

- **A Pregnancy** diagnosed and documented by the: (i) terminated care provider prior to termination of the participation agreement, or (ii) by the non-network care provider prior to the newly enrolled member's effective date of coverage with UnitedHealthcare West. Completion of covered services provided for the duration of the pregnancy and immediate postpartum period.
- **The Care of a Newborn** service provided to a child between birth and age 36 months. Completion of covered services will not exceed (i) 12 months from participation agreement, termination date (ii) 12 months from the newly enrolled member's effective date of coverage with UnitedHealthcare West, or (iii) the child's 3rd birthday.
- **Surgery or Other Procedure** Performance of a surgery or other procedure that authorized by UnitedHealthcare West or the members assigned network care provider. Parts of a documented course of treatment and has been recommended and documented by (i) the terminating care provider to occur within 180 calendar days of the participation agreement's termination date, or (ii) the non-network care provider to occur within 180 calendar days of the newly enrolled member's effective date of coverage with UnitedHealthcare West.

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

Coordination of Care between Medical and Behavioral Healthcare

Some medical group/IPAs are capitated for providing and paying for behavioral healthcare services. These medical group/IPAs are required to at least annually, collect information about opportunities for collaboration between medical and behavioral healthcare. Based on that data, the medical group/IPA then collaborates with its behavioral healthcare specialists to identify, analyze and take collaborative action on identified opportunities for improvement. The medical group/IPA must have a documented process that describe how it will collect and analyze the data, identify opportunities, and collaborate with its behavioral healthcare specialists. The medical group/IPA submits this report at least annually to its quality improvement committee or the appropriate committee, as determined by the medical group/IPA's structure. UnitedHealthcare will assess the process and report during its annual assessment of the capitated medical group/IPA.

The medical group/IPA that is capitated for providing and paying for behavioral healthcare services is also

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

Emergency Services and/or Direct Urgent Facility Admissions under UnitedHealthcare's Medical Management Program

Scheduling of some admissions will not occur. In these cases, care provider is required to notify UnitedHealthcare West of admissions as soon as possible on the same day (but no later than 24 hours from admission). The care provider must work with our Medical Management Department to obtain authorization. Admission notification sent to the Medical Management Department at:

Phone: 800-799-5252

Fax: 800- 274-0569

24 hours/day, seven days/week

Eligibility determination should occur before the admission of any after-hours or weekend admission whenever possible. The UVR confirmation eligibility system is available 24 hours per day, seven days per week.

The delegated medical group/IPA sets its own policies regarding notification and authorization for the above services.

Emergency Services

Emergency Services are Covered Services provided in a hospital emergency facility or comparable facility to evaluate, treat, and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including, without limitation, severe pain). Such that would lead the member to reasonably believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could reasonably be expected to result in: (i) placing the member's health in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; (iv) serious disfigurement; or (v) in the case of a pregnant woman, serious jeopardy to the health of the fetus. The final determination of whether services rendered

constitute Emergency Services shall be made by the UnitedHealthcare medical director or designee, subject to appeal under the applicable Member appeals procedure or pursuant to the Dispute Resolution Procedure and Arbitration proceedings of Section 7.4 of this Agreement.

Post Stabilization Care (Commercial)

Post stabilization care is medically necessary, non-emergency services needed to make sure the member remains stabilized from the time the treating facility requests authorization from the plan or its delegate until the member is:

- Discharged;
- A network care provider arrives and assumes responsibility for the member's care; or
- The treating care provider and the organization, defined as the plan or its delegate, agree to another arrangement.

A member is "stabilized" or "stabilization" has occurred when, in the opinion of the treating care provider, the member's medical condition is such that, within reasonable medical probability, no material deterioration of the member's condition is likely to result from, or occur during, a transfer of the member.

UnitedHealthcare and any of its delegates must:

- Have a process to respond to requests for post-stabilization care;
- Respond to requests for authorization of post-stabilization services within 30 minutes;
- If UnitedHealthcare or delegate does not respond within 30 minutes, care is deemed authorized until:
 - › Member is discharged;
 - › A network care provider arrives and assumes responsibility for the member's care; or
 - › Treating care provider and the organization, defined as the plan or its delegate, agree to another arrangement.

Based on the contract, the Delegated Entity may be financially responsible for

- ER and post-stabilization services in area;
- Out of Area Services (OOA);
- Post stabilization care (Medicare Advantage); CMS defines post-stabilization care as services that are:
 - Related to an emergency medical condition;
 - Provided after a member is stabilized; and
 - Provided to maintain the stabilized condition, or under certain circumstances to improve or resolve the member's condition.

UnitedHealthcare West or its delegates must:

- Have a process to respond to requests for post-stabilization care;
- Respond to requests for authorization of post-stabilization services within one hour.

If UnitedHealthcare or delegated entity does not respond within one hour, care deemed authorized until;

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

Based on the participation agreement, the delegate is financially responsible for;

- ER and post-stabilization services in area; and
- OOA services if responsible for OOA per the participation agreement.

Medical Observation

UnitedHealthcare West or its respective delegate will authorize facility observation status when medically indicated and the case meets nationally recognized evidenced based guidelines. Facility observation status designed to evaluate a member's medical condition to determine the need for inpatient admission, or to stabilize a member's condition. Typically, observation status used to rule out a diagnosis or medical condition that responds quickly to care. The conversion of a member's outpatient observation status may later change to an inpatient admission if medically necessary with criteria met.

Expectation of Utilization Management delegates to support compliance with the review of criteria. The delegated medical group/IPA must issue a facility denial when the Inpatient stay does not meet nationally recognized evidence based guideline, when:

It receives notification of the admission; or,

1. It receives a post-service request for admission authorization prior to claims submission and it determines that the admission does not meet medical necessity criteria, including relevant Medicare inpatient admission requirements, and is not on the CMS list of HCPCS codes that would be paid only as inpatient procedures; or,
2. There is no inpatient order that matches the date of the inpatient admission for Medicare members.

Out-of-Area (OOA) Medical Services

OOA medical services are those emergent or urgently needed services to treat an unforeseen illness or injury that arises while a member is outside of the medical group/

IPA's contracted service area, typically 30 miles from medical group/IPA based on the shortest route using public streets and highways. These OOA services would have been the financial responsibility of the medical group/IPA had the services been provided within the medical group/IPA service area.

- UnitedHealthcare West retains the ultimate accountability for the management of OOA cases, unless otherwise contractually defined. Refer to the Division of Financial Responsibility (DOFR) section of your participation agreement to determine risk (financial accountability) for OOA.
- Medical services provided outside of the medical group/IPA defined service area that are arranged and/or authorized or could be anticipated by the member's medical group/IPA are the medical group/IPA's responsibility, and are not considered OOA medical services. This includes those out-of-network care provider (OON) services referred by a care provider affiliated with the delegated medical group/IPA, whether or not that care provider obtained appropriate authorization. In such cases, it remains the responsibility of the medical group/IPA to perform all delegated medical management activities, including issuing appropriate authorization and denials.
- Members referred by the medical groups/IPA for out of network outpatient consultation who are found at the time of consult evaluation to require medically necessary inpatient care will be deemed the responsibility of the referring medical group/IPA and will not meet the criteria of an OOA case.
- The delegated medical group/IPA remains responsible to issue appropriate denials for member-initiated non-urgent, non-emergent medical services provided outside of the medical group/IPA's defined service area.
- The medical group/IPA shall notify UnitedHealthcare West's OOA department of all known OOA cases no later than the 1st business day after receiving member notification of an OOA admission, procedure and/or treatment.
- Failure to notify us within this timeframe may result in UnitedHealthcare West holding the medical group/IPA financially responsible for the OOA care and service.
 - › Once a UnitedHealthcare West member Member's PCP or medical group/IPA identified specialist speaks with the out-of-area attending care provider to determine the member's stability for transport to an in-area facility;
 - › Member's PCP, or medical group/IPA identified specialist, determines the appropriate mode of transportation;
 - › Member's PCP, or medical group/IPA identified specialist determines the appropriate level of care or facility for the member's care;

- › Medical group/IPA must arrange for a bed at the accepting in-area facility.
- Deemed stable for transfer to an in-area facility, the medical group/ IPA must work actively and collaboratively with UnitedHealthcare West to return the member to a network care provider and facility in a timely fashion.
- The medical group/IPA shall facilitate the return of the member to network care provider by making sure that the following process occurs in a timely fashion, including, but not limited to:
 - If the medical group/IPA delays the transfer of a member considered medically stable for transfer, UnitedHealthcare West may hold the medical group/ IPA financially responsible for any additional out-of-area charges incurred in result of the delay.
 - If an accident or illness occurs within the medical group/ IPA contracted service area, and emergency personnel transport the member to a facility outside the contracted service area for treatment, these services will not be taken into consideration and out-of-area handled by the medical group/IPA in the same manner as in-area services. The medical group/IPA must authorize and direct the member's care in the same manner as if the member were receiving services at the affiliated facility or care provider facility.
 - Travel dialysis not considered an out-of-area medical service unless otherwise contractually defined; it is the responsibility of the medical group/IPA.

Service Area

The medical group/IPA/facility is financially responsible for providing all approved medical and facility services with a designated service area. Please refer to your participation agreement for your specific service area definition.

Urgent or emergent services provided within the medical group/IPA/facility service area are the financial risk of the capitated entity regardless of whether services rendered by the medical group/IPA/facility's network of care providers, unless your participation agreement states otherwise.

Out-of-Area (OOA) Urgent or Emergent Claims

In most contractual arrangements, UnitedHealthcare West has financial responsibility for out-of-area medical and facility services provided on an urgent or emergent basis. UnitedHealthcare West follows applicable laws and regulations regarding payment of claims related to access to medical care in urgent or emergent situations. If we determine the claims are not emergent or urgent, we will forward the claims to the capitated/delegated care provider for further review. Medical services provided outside of the medical group/IPA defined service area that authorized by the member's medical group/IPA are the medical group/ IPA's responsibility and are not considered OOA medical services.

The delegated medical group/IPA remains responsible to issue appropriate denials for member-initiated, non-urgent/emergent medical services outside of the medical group/IPA's defined service area.

Trauma Services

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

The medical group/IPA shall review and authorize care and trauma services using the applicable provision review criteria. UnitedHealthcare West may retrospectively review trauma service claims and medical records in order to verify that the services met trauma criteria and that trauma services delivered. UnitedHealthcare West may also confirm that the trauma facility has an active trauma license. Contracts for trauma services may vary and definitions and reimbursement methods specified therein will apply.

The following provision criteria considered when authorizing trauma services;

- Trauma team activated.
 - Trauma surgeon is the primary treating care provider.
 - Member's clinical status meets the county's current EMS protocols for designating a trauma member.
 - Trauma services, once rendered, shall apply to the first 48 hours post-facility admission, unless there is documented evidence of medical necessity indicating that trauma level services are continuing delivery.
 - Trauma service status shall no longer apply when, based on medical necessity, the member is determined to be hemodynamically stable and/or medically appropriate for transfer out of the critical care arena.
 - Clinical management of a member(s) by the trauma team shall not be the sole criteria used to determine and authorize continued trauma services care.
- Undergoing a transplant evaluation;
 - Receiving a transplant;
 - Within the first year post-transplant;

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

- All care providers must obtain prior authorization for transplant evaluations and transplant surgery, regardless of financial risk.
- Transplant evaluations and surgery must be performed, at one of Optum's Centers of Excellence, or facility approved by UnitedHealthcare West/Optum's Medical Directors.
- For medical groups/IPAs that do not have risk for transplant services, Optum shall be responsible for the authorization and management for all transplant-related care and services including the evaluation, transplant procedure, and through one year post-transplant, unless otherwise dictated by the member's benefit or federal/state law.
- Optum shall be responsible for the authorization and management of donor care and services directly related to transplant services from date of initiation of the stem cell/bone marrow collection, or 24 hours prior to solid organ donation surgery, until 60 calendar days post-transplant date, unless otherwise dictated by the member's benefit or state law.
- Optum shall be responsible for authorization and reimbursement of all travel expenses as covered under the member's benefit plan.
- Authorization and management of all non-transplant-related (e.g., medically necessary, covered services for the member) remain the responsibility of the delegated medical group/IPA. Non-transplant related services include those services needed to treat the member's underlying disease and maintain the member until transplant can be completed. (e.g., ventricular assist devices/mechanical circulatory support devices). Financial responsibility for non-transplant related, medically necessary covered services remain as described in the DOFR.

- Medical groups/IPAs are required to comply with our transplant protocols, policies and procedures. We may at our sole discretion, modify these protocols, policies and procedures from time to time.

- Referrals may be made to Optum as follows:

Phone Referrals: 866-300-7736 or
Fax: 888-361-0502

Transplant Services/Case Management

For medical groups/IPAs that have risk for transplant services, we request that you notify the case management department when a member referred for evaluation, authorized for transplant and admitted for transplant and/or may meet criteria for service denial. For medical groups/IPAs that do not have risk for transplant services, members need referral into UnitedHealthcare's transplant case management program identified as:

- Requiring evaluation for a bone marrow/stem cell or solid organ transplant; or

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

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

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

Prior Authorization Time Requirements for Elective and Urgent Services (Medical Group/ IPA Not Delegated for UM)

A minimum notification of three business days is required for elective services to complete a thorough clinical analysis prior to a member's proposed elective procedure date. Procedures are not considered scheduled, and should not be communicated to the member as being scheduled, until authorized. An authorization or notification number with the approved date range will be returned by fax to your office within appropriate regulatory guideline requirements. For services considered Urgent Care Services and scheduling provided within two calendar days, Medical Management will reply by fax within appropriate regulatory guideline requirements, but not to exceed three calendar days/72 hours. Identify urgent care services, so appropriate priority status clarification.

Prior Authorization Protocol

- For any service, which requires a prior authorization, the admitting care provider initiates an authorization request by fax at least three business days prior to the scheduled date of service.
- The Provider must complete and submit the appropriate *Prior Authorization Request Form* found at UHCWest.com. Incomplete forms are not acceptable.
- Medical Management will document the information, respond to the authorization request, and provide a decision within the required regulatory timeframes. If approved, an authorization number issued to the care provider. If denied, the reason for denial forwarded to the care provider and the member.
- In the case of a denial, the care provider offers the opportunity to speak with UnitedHealthcare West's Medical Director to discuss the case.

- The authorized care provider will deliver care to the member. Documentation of the recommended treatment plan sharing with the member's PCP.
- The network care provider will submit a claim with the authorization number in the usual manner to the appropriate address.

Authorization of Acute Inpatient Rehabilitation Facilities (AIR), Long Term Acute Care Facilities (LTAC), or Air Ambulance

For shared risk groups, the medical group/IPAs are strongly encouraged to consult with UnitedHealthcare medical director prior to authorizing a member transfer to Acute Inpatient Rehabilitation (AIR) Long Term Acute Care (LTAC) and/or air ambulance.

Medical Management Denials/ Adverse Determinations

UnitedHealthcare West or a delegated medical group/IPA may issue a denial /adverse determination. Denial issued when there is no apparent medical necessity for a health care service, a non-covered benefit requested, or when no information or insufficient information is provided. If you disagree with a medical management decision to deny requested health care services, you may request an appeal on behalf of the member as outlined in this section. Our reviewers are available to discuss denial cases with the treating or attending care provider. Reviewers may be a care provider, pharmacist, chiropractor, dentist or other licensed care provider type, as appropriate to the case.

Denials, Delays or Modifications

Decisions to approve, modify, or deny requests for authorization of health care services or to delay delivery of services, based on medical necessity or benefit coverage be communicated in a timely manner appropriate for the nature of the member's medical condition in accordance with the applicable state and federal law.

All authorization decisions based on sound clinical evidence including; but not limited to, review of medical records, consultation with the treating care providers, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual members and characteristics of the local delivery system.

All information to support decision-making shall be consistently gathered and documented. Disclosure of such criteria made in accordance with applicable state and federal law.

Referral requests not meeting the criteria for immediate authorization need review by the Medical Director, or the Utilization Management Committee (UMC)-designated care provider or presented to the collective UMC or

subcommittee for discussion and a determination. Only a care provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may determine to delay, modify or deny services to a member for reasons of medical necessity. Board-certified licensed care providers from appropriate specialty areas utilized to assist in making determinations of medical necessity, as appropriate.

- Care providers will not review their own referral requests,
- Referral requests being considered for denial will be reviewed by care providers qualified to make an appropriate determination, and
- Any referral request where the medical necessity or the proposed treatment plan is not clear clarified then discussed with the requesting care provider thereafter. Complex cases can bring to the UMC/Medical Director for further discussion and decision.
- Individual(s) who meet the qualifications of holding financial ownership interest in the organization may not influence the clinical decision making regarding payment or denial of a service.
- Possible request for authorization determinations include:
 - › Approved as requested—No changes;
 - › Approved as modified—Referral approved, but the requested care provider or treatment plan modification. Denial letter must be sent if requested care provider is changed or specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy);
 - › Extension—Delay of decision regarding a specific service. (e.g., need additional documentation, information, or require consultation by an expert reviewer).
 - › CMS allows delays of decision (extensions) for Medicare Advantage members when the member requests the extension; the extension is justified and in the member's interest due to the need for medical evidence from a non-contracted care provider that may change the decision to deny an item or service; or the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest;
 - › Delay in Delivery—Access to an approved service postponed for a specified period or until a specified date will occur. This is not the same as a modification. A written notification in the denial letter format is required;
 - › Denied—Non-authorization of a request for health care services; reasons for denials of requests for services include, but are not limited to, the following:

- › Not a covered benefit—the requested service(s) is a direct exclusion of benefits under the member's benefit plan—specific benefit exclusion must be noted;
- › Not medically necessary or benefit coverage limitation—specify criteria or guidelines used in making the determination as it relates to the member's health condition;
- › Member not eligible at the time of service;
- › Benefit exhausted—include specific information as to what benefit was exhausted and when;
- › Not a network care provider—a network care provider/service is available within the medical group/ IPA in-network;
- › Experimental or investigational procedure/treatment;
- › Self-referred/no prior authorization (for non-emergent post-service);
- › Services can be provided by the PCP

UnitedHealthcare West has aligned Wrong Surgical or Other Invasive Procedure Events Professional Reimbursement Policy to be consistent with CMS. UnitedHealthcare West will not reimburse for a surgical or other invasive procedure when the care provider erroneously performs:

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

UnitedHealthcare West also will not provide reimbursement for facilities or professional services related to these wrong surgical or other invasive procedures.

Written Denial Notice

The written denial notice serves many purposes and is an important component in the member's chart and the medical group/IPA records. Regardless of the form used, the denial letter serves to document member and care provider notification of:

- The denial, delay, partial approval or modification of requested services;
- The basis of denial, delay, partial approval or modification, including medical necessity, benefits limitation or benefit exclusion;
- Member-specific information relating to how the member did not meet criteria for approval in easily understandable language;
- The appeal rights;
- An alternative treatment plan, if applicable;
- Benefit exhaustion or planned discharge date.

CMS requires network care providers to use the CMS Integrated Denial Notice/Notice of Denial of Medical Coverage (IDN/NDMC) for Medicare Advantage Plan

members. Template alteration in any way, except to add text to the areas indicated on the template. Medicare Marketing guidelines require that non-standard templates have appropriate, plan-specific Medicare Marketing Material ID (MMID) numbers with revision or approval dates. *CMS Standard OMB Forms* do not require MMIDs. We will provide appropriate and approved templates to you.

Minimum Content of Written or Electronic Notification

Written or electronic notice to deny, delay in delivery, or modify a request for authorization for health care services shall include the following:

- The specific service(s) denied, delayed in delivery, modified or partially approved;
- The specific reference to the benefit plan provisions to support the decision;
- The reason the service is being denied, delayed in delivery, modified, or partially approved including:
 - › Clear and concise explanation of the reasons for the decision, in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision, and;
 - › Description of the criteria or guidelines used, reference to the benefit provision, protocol or other similar criterion on which the denial decision is based, and;
 - › How those criteria were applied to the member's condition (member-specific information);
 - › Specific name of the referenced criteria
- Notification that the member can obtain a free of charge copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request (Commercial);
- Notification that the member's care provider can request a peer to peer review (not applicable to Medicare Advantage for standard pre-service decisions);
- Contractual rationale for benefit denials;
- Alternative treatment options offered, if applicable (not applicable for retrospective review or non-covered benefit denials);
- A description of any additional material or information necessary for the member to "perfect" the request, and why that information is necessary;
- If the request is for an experimental or investigational treatment, an explanation of the scientific or clinical judgment for making the determination; and
- Appeal and grievance processes, including:
 - › Information about when, how and where to submit an appeal;
 - › Information regarding the member's right to appoint a representative to file an appeal on the member's behalf;
 - › Member's right to submit written comments, documents or other additional relevant information;
 - › Information notifying the member and their treating care provider of the right to an expedited appeal for the time-sensitive situations (not applicable for retrospective review);
 - › Information regarding the member's right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable;
 - › Information that the member may bring civil action, under Section 502(a) of Employee Retirement Income Security Act (ERISA), if applicable (Commercial); and
 - › Information regarding the Federal Employee Health Benefits Plan appeals process, if applicable, (Commercial).
- The notice to the requesting care provider must include the name and direct phone number of the health care professional responsible for the decision.
- California Commercial: Please refer to the section [Inclusion of 'Notice of Availability of Language Assistance' in Non-Standard Vital Documents Issued by Delegated Care Provider Groups \(CA\)](#) of this guide.
- Medicare Advantage: Envelopes containing organization determination letters should state "Important Plan Information" in a minimum of 12-point font.

CMS Common Conditions, Improvement Strategies and Best Practices

CMS has clearly stated that plans including its delegates notification, several times that these are common industry findings and should immediately remediate any issues within its operations. UnitedHealthcare may escalate its usual oversight and corrective action process to require an immediate corrective action. This may include abbreviating the period in which the delegate must supply a written improvement action plan or demonstrate compliance with the deficiencies.

UnitedHealthcare expects its medical management delegates proactively implement systems and processes to achieve compliance with these common findings.

Medicare Advantage Part C Reopenings

CMS requires adherence to the appropriate handling of reopenings of organization determinations. A reopening is

a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

Reopening Reason Categories:

- New and Material Evidence—(documentation that was not previously available and considered during the decision making process that could possibly result in a different decision).
- Clerical Error—(includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding and computer errors).
- Fraud or Similar Fault –(post-service decision when reliable evidence shows the decision was procured by fraud or similar fault when the claim is auto-adjudicated in the system).
- Other—includes an error on the evidence in the files was misinterpreted or overlooked in making the decision.

Reopening requests made by a party member, member has authorized representative, or a non-contracted care provider, must be:

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

The request does not have to use the actual term “reopening.” UnitedHealthcare (or its delegate) must process a Clerical Error as a Reopening, instead of Reconsideration.

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

- An adverse decision has been issued, and
- The 60-calendar day timeframe for filing a Reconsideration has expired, and
- There is no active appeal pending at any level.

Types of Determinations or Requests that cannot be re-opened are as follows;

- A Pre-Service Organization Determination cannot be reopened for any reason (e.g. New and Material Evidence, Error on the Face of Evidence, Fraud or Similar Fault,) other than for a Clerical Error, unless the 60-calendar day period to file a Reconsideration has expired.
- Upon receipt of previously requested documentation for a [Pre-Service Organization Determination](#) denied due to lack of information, the delegate must consider and submit to UnitedHealthcare as Reconsideration, unless there is a Clerical Error.
- A Pre-Service Organization Determination made as part of the Appeals process.

- Upon request for a peer-to-peer review following an adverse Pre-Service Organization Determination, if the member, member’s representative or non-contracted care provider, provides new and material evidence not previously known or available which changes the decision or the rationale for the prior decision, we will not review as a Reopening and will provide instructions on how to file a Reconsideration;
- A request to review a Post-Service Organization Determination cannot be reopened for any reason (i.e., New and Material Evidence, Error on the Face of Evidence, Fraud or Similar Fault, Other) other than for a Clerical Error, unless the 60-calendar day time frame to file a Reconsideration has expired;
 - › If a verbal request for review of a Post-Service Organization Determination UnitedHealthcare or its delegate may review the request and reopen, if applicable and not already being reviewed as Reconsideration;

Impact on Peer-to-Peer Requests

As stated above, a Pre-Service Organization Determination will not reopen for any reason other than for a Clerical Error. As a result, the post-decision Peer-to-Peer consult process must conclude for the Medicare population.

This requires establishing a pre-decision Medical Director outreach for standard (14-day TAT) OD requests. This includes both inpatient and outpatient adverse determinations. It excludes expedited pre-service requests and administrative denials.

The following situation cannot be treated as reopenings and must be treated as Reconsiderations or Appeals:

- Clinical information received after notification is complete.
- Peer-to-peer requests received after notification is complete.

(See section Part C Risk Adjustment and Medical Records for reporting requirements).

Facility Denial Process (Commercial & Medicare Advantage)

Either UnitedHealthcare West or its delegate may issue a denial (facility denial letter) to a facility or all facilities contracted with UnitedHealthcare West when the facility medical record and/or claim fails to meet medical necessity and timelines either for the provided service or level of care. Either UnitedHealthcare or its delegate through concurrent or retrospective review may determine this. UnitedHealthcare West and medical group/IPAs delegated for utilization/medical management review nationally recognized criteria to determine medical necessity and appropriate level of care for services

whenever possible. UnitedHealthcare West and delegated medical group/IPAs will utilize multiple resources and guidelines to determine medical necessity and appropriate level of care.

UnitedHealthcare West and its delegated medical groups/IPAs will use Medicare Coverage guidelines for Medicare Advantage members to determine medical necessity. Medicare Coverage guidelines include National Coverage Determinations and Local Coverage guidelines. If nationally recognized criteria contradict Medicare Coverage guidelines, UnitedHealthcare West Delegates will follow Medicare Coverage guidelines for Medicare Advantage members reference section [Criteria for Determining Medical Necessity](#). If other nationally recognized criteria contradict Medicare coverage guidelines, UnitedHealthcare and delegated medical group/IPAs will follow Medicare coverage guidelines. Individual criteria provided to you upon request. Facility denials not issued for any inpatient services on the CMS list of HCPCS codes, paid only as, inpatient procedures.

When UnitedHealthcare West has the responsibility to pay facility services, the delegated medical group/IPA must comply with UnitedHealthcare's protocols, policies and procedures for submitting facility, denial letters to UnitedHealthcare. Whether the UnitedHealthcare West, care provider dispute resolution process will manage UnitedHealthcare or its delegate facility disputes issue a denial.

If the delegated medical group/IPA has the responsibility for payment of inpatient facility services, then the delegate need not submit copies of facility denials to UnitedHealthcare. Facility denials, not sent to the member and specifically exclude the member from liability for the denied level of care and/or services. Under these circumstances, any care provider facility disputes managed by the delegated medical group/IPA, care provider dispute resolution process.

A facility denial letter will be available upon request by the member.

Experimental/Investigational Services Denials

UnitedHealthcare West is required to provide an opportunity for an independent, external review whenever an authorization for any drug, device, procedure, or other therapy deemed experimental or investigational is denied to a member who has either a life-threatening or seriously debilitating disease or condition, as defined below.

- Life threatening is defined as:
 - › Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or
 - › Diseases or conditions, with potentially fatal outcomes, where the end-point of clinical intervention is survival;
- Seriously debilitating defined as diseases or conditions that cause major irreversible morbidity;

- Experimental or Investigational therapies are any drug, device, treatment, or procedure that meets one or more of the following criteria:
 - › It cannot be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and such approval have not been granted at the time of its use or proposed use;
 - › It is the subject of a current Investigational new-drug or new-device application on file with the FDA;
 - › It is being provided pursuant to Phase I or Phase II clinical trial or as the experimental or research arm of Phase III clinical trial, as the Phases are defined by regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS);
 - › It is being provided pursuant to written protocol that describes among its objectives determinations of safety and/or efficacy as compared with standard means of treatment;
 - › It is being delivered or will be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and HHS;
 - › The predominant opinion among experts as expressed in the published authoritative literature is that the usage should be substantially confined to research settings;
 - › The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
 - › It is not Investigational or Experimental in itself, as defined above, and would not be medically necessary, except for the provision of a drug, device, treatment, or procedure that is Investigational or Experimental.

UnitedHealthcare West does not delegate utilization management activities related to requests for authorization of experimental/investigational therapies. The delegated medical group/IPA must not issue a denial for experimental/ investigational therapies/service(s) requests. If the delegated medical group/IPA receives a request for authorization of experimental/ investigational services, the delegated medical group/IPA must forward the request and all relevant case documentation to UnitedHealthcare West for review and determination. We will issue a written determination notice to the member and the requesting care provider.

Evaluations Prior to Entry into a Clinical Trial

In many cases consultation and evaluation including laboratory testing, imaging studies, pulmonary and cardiac functional testing, and a variety of other testing and evaluation may be required prior to the decision being

made as to whether or not an individual member will be eligible for a particular clinical trial. Whether or not the trial itself deemed a benefit, evaluative testing and consultation are benefits of both the commercial and Medicare Advantage plans. The responsibility for clinical evaluation and testing prior to a clinical trial and for the purpose of evaluation eligibility for a clinical trial rests with member's medical group/IPA unless otherwise stated in the DOFR.

Approval or Denial of Clinical Trials

The medical group/IPA must forward the request and all relevant case documentation to UnitedHealthcare West for review and determination. We will issue a determination letter to the member and the requesting care provider.

The experimental/investigational denial notice requires disclosure of additional rights and information regarding the independent external review process, which includes:

- An Independent Medical Review (IMR) packet; and,
- Care provider certification form;
- **In addition in CA:** A one-page application form and pre-addressed envelope that the member may return to the Department of Managed Health Care to request the IMR.

Care provider denial notices also include the experimental/investigational information packet. If a UnitedHealthcare West Medical Director determines the member's condition does not meet the experimental/investigational criteria, we shall notify the delegated medical group/IPA. The delegated medical group/IPA shall then make a coverage determination in accordance with established utilization management procedures.

Cancer Clinical Trials

For commercial members, state regulations require health plans to provide coverage for all routine member costs related to the clinical trial for members diagnosed with cancer and accepted into a phase of the IV cancer clinical trial.

The member's care provider must recommend participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the member.

UnitedHealthcare West does not delegate utilization management activities related to requests for authorization of cancer clinical trials, and as such, the delegated medical group/IPA must forward referral requests for cancer clinical trials and all relevant case documentation to UnitedHealthcare West for review and determination. We will issue a written determination notice to the member and the requesting care provider.

Medicare Advantage

Experimental items and medications coverage limited with coverage determinations not delegated. Experimental/investigational services only covered by United Healthcare West when the Medicare coverage requirements met.

You should not authorize or deny services: rather, please contact clinical coverage review at 877-842-3210.

Delegated Medical Management

UnitedHealthcare West may delegate medical management to a medical group/IPA that demonstrates compliance with UnitedHealthcare West has established standards for the medical management function. This function referred to as utilization management. Care providers associated with these delegated IPA/medical groups may use the medical group/ IPA's medical management office and protocols for all authorizations for which the medical group/IPA delegation. The medical group/IPA medical management protocols must be in alignment with those of UnitedHealthcare West. The delegated medical group/ IPA's medical management protocols and procedures must comply with all applicable state and federal regulatory requirements.

A delegated medical group/IPA may have processes and forms that differ somewhat from those outlined in this section. Please contact your provider advocate, as applicable, if you have questions concerning medical management delegation.

UnitedHealthcare West performs a precontractual assessment before delegating medical management functions. UnitedHealthcare West will also perform an initial assessment, within 90 calendar days after the contract effective date. Assessment measures compliance of the medical group/IPA delegation of medical management, with UnitedHealthcare West's standards. At least annually thereafter, UnitedHealthcare West will review the delegated medical group/IPA to help ensure continued compliance. We may initiate a focused or off-cycle assessment based on specific activity at the medical group/IPA that warrants such a review. The medical group/IPA is required to provide specific documents/evidence to the assessment or as applicable.

Based on the compliance assessment, UnitedHealthcare West may require the delegate to develop and implement an improvement action plan designed to bring the medical group/IPA back into compliance. Delegates who do not achieve compliance within the established timeframes may undergo intensive corrective action until they achieve compliance. Medical management is a delegated function that is subject to revocation. Sanctions may consist of delegation with an improvement action plan or revocation. There are costs to the delegate should the function be revoked.

When UnitedHealthcare West reviews a member appeal or a care provider appeal of an adverse determination issued by a delegated medical group/IPA, UnitedHealthcare West will use MCG Care Guidelines as the externally licensed medical management guidelines, even if the delegated medical group/IPA utilized different externally licensed medical management guidelines to make the initial adverse

determination. We will use Medicare coverage guidelines as appropriate for Medicare Advantage appeals.

Semi-Annual Reporting

The delegate provides UnitedHealthcare West with semi-annual reports as outlined in the delegation agreement. Also, reports must meet applicable regulatory requirements and accreditation standards.

Notification Requirements for Facility Admissions (Delegated Care Providers in Shared Risk Groups)

Contracted facilities are ultimately accountable to provide timely notification to both the medical group/IPA and UnitedHealthcare West within 24 hours of admission for all inpatient and observation status cases, including changes in level of care impact billing category. Maternity normal vaginal delivery or C-section delivery notification given before the end of the mandated period 48- hours or 96- hours respectively. Notification is always required if the newborn stays longer than the mother does. In all cases, separate notification is required immediately when a newborns admission to the NICU. The medical group/IPA must have a clearly defined process with the contacted facility whereby the facility provides the medical group/IPA and UnitedHealthcare West information on all facility admissions, updates in member status and discharge dates on a daily basis.

Timely notification of admission required by UnitedHealthcare West and the medical group/IPA to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning.

For emergency admissions, notification shall occur once the member stabilization occurs in the emergency department. Proper notification is requirement by UnitedHealthcare West the day of admission for timely and accurate payment of facility claims.

Authorization Log and Denial Log Submission (Delegated Care Providers in Shared Risk Groups)

Authorization logs for all inpatient acute, observation status and SNF cases as well as Denial Logs must be accurately submitted at least twice a week to the Authorization Log Unit in clinicaloperations@uhc.com. Outpatient Prior Authorization Logs are also required in specified markets. Log delivery scheduled arrangement with the Authorization Log Unit for all new submitters prior to the first submission. Any changes in a group's submission schedule agreed upon in writing and in advance by the Authorization Log Unit. Any medical group/IPA undergoing a system change

or upgrade that may affect delivery of authorization logs must notify the Authorization Log Unit prior to change date and work with United HealthCare to ensure a seamless transition.

.Logs must include all cases worked between the previous submission and current submission:

- Cases generated upon admission,
- length of stay changes/extensions
- discharged cases and
- completed outpatient prior authorization cases

In the event that there are no applicable cases to report, the medical group/IPA is required to submit an authorization log indicating either "no activity" or "no admissions" for each of the designated admission service type for the applicable reporting time.

Logs must include, but not limited to, the following data elements:

- Member ID
- Member Name
- Member Date of birth
- Requesting care provider: (Name and Address, with TIN if available or NPI)
- Attending/Service care provider: (Name and Address, with TIN if available or NPI)
- Facility care provider: (Name and Address, with TIN if available or NPI)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Actual Admission Date
- Actual Discharge Date
- Service Start Date
- Service End Date
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge Disposition
- Planned Admission Date
- Planned Discharge Date
- Service Type
- Authorization number (if available)

The medical group/IPA must have a clearly defined mechanism for determining medical necessity and authorizing outpatient services, which payment as either shared risk or plan risk per the medical group/IPA contract. The medical group/IPA must be capable of submitting, pursuant to plan demand, authorization or denials for all

shared risk or plan risk services for which the group has authorized or denied care on behalf of UnitedHealthcare.

Medication Therapy Management Program (MTMP) (Medicare Advantage)

The MTMP is a clinical program designed effectively to improve the quality and safety of clinical care provided to targeted beneficiaries. The goal of MTMP is to improve therapeutic outcomes by:

Making sure appropriate use of medications; and

Help in reducing the risk of adverse events including drug interactions. This program offered to Medicare Part D beneficiaries who meet the MTMP eligibility criteria according to the requirements established by the Centers for Medicare & Medicaid Services (CMS). A beneficiary must meet all of the following criteria to be considered eligible for OptumRx's MTMP:

- Have at least three of the following five chronic disease states:
 - › Congestive Heart Failure (CHF)
 - › Diabetes
 - › Hyperlipidemia
 - › Hypertension
 - › Rheumatoid Arthritis
- Have filled at least eight distinct chronic, covered Part D medications during the identification period, and
- Identified as an individual, who is likely to incur annual costs for covered Part D medications that exceeds \$3,507;

No additional work will be required of care providers for a member to participate in the MTMP. OptumRx will send member-specific reports to the care provider that identify therapeutic management options when there are potential problems with a prescribed drug regimen or as opportunities arise for improving medication use. The intent of sharing these reports with care providers is to assist them in caring for their members.

Authorizing and Dispensing Injectable/Infusion Medications

A member may use OptumRx's Specialty Pharmacy or a network care provider retail pharmacy to obtain covered self-injectable and injectable/infusion medications. All medications are subject to the member's benefit plan and delegation of medical/care provider groups.

The care provider must submit the following information to request a covered injectable and/or self-injectable medication for a member:

- Completed *Prior Authorization Form* including, the requesting care provider's signature so that the vendor may accept the document as a legal prescription.
- Recent history and physical;
- Copies of any pertinent laboratory results;
- Copies of any reports by consultant care providers

Submit requests to OptumRx's Specialty Pharmacy at 800-711-4555, or fax requests directly to 800-853-3844. OptumRx verifies the member's eligibility, notify the care provider of the determination, and if appropriate, contact the care provider's office to coordinate delivery of the medication(s). In the case of approved self-injectable, the vendor will contact the member to coordinate delivery of the medication(s). For those self-administered drug coverage by Medicare Part D, please refer or download a copy of the formulary online at AARPMedicarePlans.com, UHCMedicareSolutions.com, or UHCRetiree.com.

Intensity Modulated Radiation Therapy (IMRT)

(Commercial, for Services Carved Out of Capitation)

This policy applies if UnitedHealthcare has financial responsibility for IMRT currently covered under the commercial member's medical benefit.

Prior Authorization Process for IMRT

UnitedHealthcare has a prior authorization process in place to provide for review of Commercial IMRT services carved out of capitation. Prior authorization is required for CPT codes 77385 and 77386 and HCPCS codes G6015 and G6016.

UHC will review the request for IMRT services for compliance with the UnitedHealthcare IMRT Medical Management Guideline. Noncompliant services will not be eligible for coverage. Failure of the care provider medical groups (medical group/IPA) to obtain this review and receive prior authorization from UnitedHealthcare West prior to the start of IMRT services will result in denial of reimbursement for the IMRT services.

Prior Authorization Necessary in Order for Payment to be processed

The request for prior authorization for Commercial IMRT services taken care of by the medical group/IPA and doing so, by utilizing a *Prior Authorization form*. Additionally, forms obtained by contacting your provider advocate, network care provider or clinical contacts at UnitedHealthcare West.

Prior authorization staff will not process the request until all necessary information received from the medical group/IPA. Prior authorization staff will communicate with the medical group/IPA regarding whether or not the

IMRT services approved or not. Once all the necessary information receives requested, a determination made within the applicable timeframe. No decisions made on requests that are incomplete or require additional information.

IMRT services, is authorized in accordance with benefit design, provided the member’s benefit restrictions are not exceeded. In these cases, PRIOR AUTHORIZATION IS REQUIRED.

Therapeutic Radiation Services

(Medicare Advantage, for Services Carved Out of Capitation)

This policy applies if UnitedHealthcare has financial responsibility for the outpatient Medicare Advantage services noted below. In these cases, PRIOR AUTHORIZATION IS REQUIRED.

- Intensity Modulated Radiation Therapy (IMRT)
- Stereotaxic Radiosurgery (SRS)
- Stereotaxic Body Radiation Therapy (SBRT)

National Coverage Decision (when applicable), Local Coverage Decision and UnitedHealthcare Medical Policies used to determine eligibility of coverage. Authorization is required prior to the start of therapy and each time a patient starts a new IMRT, STS or SBRT treatment regimen.

Prior Authorization Necessary in Order for Payment to be processed

The request for prior authorization, Medicare Advantage outpatient therapeutic radiation services (IMRT, STS, and SBRT) carved out of capitation made by the medical group/IPA at UnitedHealthcareOnline.com to vendor website to initiate the prior authorization process. Prior authorization staff will not process the request until all necessary information received from the medical group/IPA. Once all the necessary information requested received, a determination will be made within the applicable timeframe. No decisions are determined on requests that are incomplete or require additional information.

Therapeutic radiation services will be authorized in accordance with benefit design provided the member’s benefit restrictions are not exceeded.

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

A written communication of case resolution faxed to the medical group/IPA for each case serviced.

Any denial determinations require a letter sent to both member and care provider stating the reason why the

requested service denied and outlining the process for filing standard and expedited appeals.

IMRT, SRS and SBRT CPT and HCPCS Codes Requiring Prior Authorization

Codes	Description	Code Type
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	CPT
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	CPT
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session	HCPCS
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session	HCPCS
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of one session; multi-source Cobalt 60 based	CPT
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of one session; linear accelerator based	CPT
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed 5 fractions	CPT
G0339	Image guided robotic linear accelerator base stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment	HCPCS
G0340	Image guided robotic linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment	HCPCS

Injectable Medication Utilized in a Patient’s Home

In all cases the delegated medical group/IPA will be responsible for authorizing and arranging for medically necessary services. When the division of financial responsibility assigns risk for injectable medications to a medical group/IPA the medical group/IPA shall be responsible for authorizing and paying for all injectable medications; whether self-injected or given with the assistance of a health professional in the home.

Chapter 7: Claims

Capitation Processing

Capitation is per member per month (PMPM) payment to a medical group/IPA or facility that covers contracted services for assigned members. This is an alternative to the fee-for-service arrangement. Capitation payments made whether or not the member seeks services from the capitated care provider.

Under a shared risk arrangement, the medical group/IPA receives capitation for professional services rendered to its assigned members. Under a partial risk contract, the facility also receives capitation for institutional services rendered to their assigned members.

Refer to the Division of Financial Responsibility (DOFR) grid in your participation agreement for a detailed listing of capitated services. Services not specifically excluded from capitation are included in the capitation payment made to the medical group/IPA or facility, as applicable.

Capitation Reports

UnitedHealthcare West runs capitation reports by process month for both commercial and Medicare Advantage products. Typically, all current activity and retroactivity up to the standard six-month system window reflected in each month's capitation reporting and payment. The participation agreement may define a non-standard eligibility window for less than the standard six-month system window. This non-standard eligibility window will override the standard six-month system window. For Medicare Advantage plans, the non-standard eligibility retro window will not limit the retroactivity related to premium increases/decreases from CMS.

Capitation reports and first-of-the-month eligibility reports run from the same snapshot of membership data. The actual date of this snapshot varies, but typically occurs on or around the 15th calendar day of the prior month for Commercial and during the last week of the prior month for Medicare Advantage.

15/30 Rule

The capitation system uses a 15/30 rule to determine whether capitation paid for the full month or not at all. If the effective date of a change falls between the first and 15th of the month, the change is effective for the current month, and capitation paid for that month. However, if the effective date falls on the 16th or later, the change reflected the first of the following month and capitation paid for the following month.

For purposes of capitation payments, members added on the first day of the month, or terminated on the last day of the month, with the exception of newborns added on their dates of birth. Commercial capitation paid for full months and, conversely, recouped for full months if appropriate.

Retroactive Add

A member added retroactively on the 15th of the month would generate a capitation payment for the entire month. However, a member added on the 16th or later would not generate a capitation payment for that month, even though the considering member for eligible for services.

Retroactive Term

A member retroactively terminated on or before the 15th of the month would generate a capitation recoupment entry for the capitation previously paid for the entire month. However, a member retroactively terminated on the 16th or later, would not generate a capitation recoupment entry for the capitation previously paid for the entire month.

To assist the care provider in identifying a non-capped member due to the 15/30 rule, the member's standard services capitation reports as \$0. Additionally, the capitation flat file (comma delimited file which contains all capitation transactions for a care provider) identifies the affected member, record type 1 R, with the field name Cap Indicator, value = N.

In addition, the Commercial capitation process uses the member's age as of the 15th of the month as a basis for capitation calculations driven by member age. The Medicare Advantage capitation process uses the member's date of birth (DOB), as reported by CMS, as a basis for capitation calculations driven by member age.

Extended Retro Process (Medicare Advantage)

CMS sends Medicare Advantage premium payment adjustments to UnitedHealthcare that can span over a 72-month timeframe on the Monthly Membership Report (MMR).

Our capitation processing engine can only process retroactivity up to 48 months, regardless of contractual or eligibility limitations on retroactive changes. The Premium capitation calculation methodology is applicable. These extended retro process adjustments appear on the capitation flat file, 3M record type with the following adjustment codes:

- MMR—Standard retroactive premium payment adjustments;
- MME—Adjustments represent transactions outside of the six-month retro window that error out during the processing of the MMR;
- MMX—Adjustments represent transactions for members that could not be identified during the processing of capitation or are beyond the 48-month system limitation;
- The MME and MMX adjustments processed in subsequent months after they occur, due to the research involved to complete these transactions;

Claims Processing for Non-Capitated Services

To order *CMS-1500 forms*:

The National Uniform Claim Committee (NUCC) is responsible for the design and maintenance of the *CMS-1500 form*. CMS does not supply the form to care providers for claim submission. To purchase claim forms, please contact the U.S. Government Printing Office at 202-512-1800, local printing companies in your area, and/or office supply stores. Vendors sell the *CMS-1500 claim form* in its various configurations (e.g., single part, multi-part, continuous feed, laser).

To order *UB-04 (CMS-1450) forms*:

The National Uniform Billing Committee (NUBC) is responsible for the design and printing of the form. You may obtain copies of the *UB-04 form* from the Standard Register Company, Forms Division. Their phone number found online at standardregister.com. Blank copies of the form may also be available through office supply stores in your geographic area.

Claims Adjudication

UnitedHealthcare West reviews and evaluates claims submissions for medical necessity and the possibility of billing irregularities. We may adjust or decline benefit payments consistent with the evaluation findings.

Payments for services made based on current CPT® codes. UnitedHealthcare West's fee schedule utilizes the CMS Resource-Based Relative Value System (RBRVS) units for most services, and the American Society of Anesthesiologists (ASA) units for anesthesia services.

Industry-recognized claims adjudication and/or clinical practices, such as American Medical Association guidelines and the CPT system coding standards, state and federal guidelines, and/or UnitedHealthcare West policies, procedures and data utilized to determine appropriate criteria for payment of claims. To find out more about this information, please contact your network care provider account manager or provider advocate, as applicable, or visit our website at UnitedHealthcareOnline.com.

Submission of Claims for Medical Group/IPA Reimbursement

Insured Services

Insured Services are those service types defined in the participation agreement to qualify for medical group/IPA reimbursement, assuming the qualifications of certain designated criteria. The medical group/IPA is responsible to pay the claim and submit it to UnitedHealthcare West per this process for reimbursement. Examples of an insured service could include eligibility guarantee, AIDS, or pre-existing pregnancy.

Indemnified Services

UnitedHealthcare West may retain financial risk for services (or service categories) cannot submit through the regular claims process due to operational limitations. These limitations include, but are not limited to, ambiguous coding and/or system limitations that can cause the claim to become misdirected. Misdirected claims are a risk to both organizations in terms of meeting regulatory compliance and inflating administrative costs.

Claims that meet either of the above definitions qualify for payment to the capitated entity as defined in the medical group/IPA or facility agreement. Should you have additional questions surrounding this process, please speak with your provider advocate.

National Provider Identifier (NPI)

UnitedHealthcare West accepts the NPI on all HIPAA transactions, including the HIPAA 837 professional and institutional (paper and electronic) claim submissions. A valid NPI is required on all covered claims (paper and electronic) and encounters in addition to the TIN. For institutional claims, please include the billing care provider National Uniform Claim Committee (NUCC) taxonomy code. For professional and institutional encounters, please include the rendering and billing care provider taxonomy code. CMS requires you to include a valid NPI for all care providers on all Medicare claims and encounters submitted.

Communications about changes to NPI policy sent to care providers, organizations, and trading partners. Such communications will indicate when we will reserve the right for further acceptance of HIPAA transactions that do not contain a valid NPI. If you have not yet applied for and received your NPI, please do so immediately by visiting nppes.cms.hhs.gov. We will accept NPIs submitted through any of the following methods:

- **National Provider Identifier** Complete details regarding NPI.
- **Phone:** 877-842-3210 through the Enterprise Voice Portal, select the "Health Care Professional Services" prompt. State "Demographic changes" and your call directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.

NPI and NUCC taxonomy indicator(s) are collected as part of credentialing, recredentialing, new care provider contracting, encounter data collection and re-contracting efforts.

CA Commercial NPI

The California Department of Managed Health Care (DMHC) Timely Access to Non-Emergency Health Care Services Regulation applies to California Commercial HMO membership only. The regulation establishes time elapsed

standards or guidelines to make sure that members have timely and appropriate access to needed healthcare services, including a 24/7 telephonic triage or screening requirement. Health plans are required to comply with certain provisions of the regulation and provide an annual report detailing the status of the plan's network care provider and enrollment, which includes the care provider's NPI. To comply with this regulation, UnitedHealthcare requires all California Commercial HMO care providers to include their NPI with all care provider additions or when submitting a claim.

Delegated Claims Process

UnitedHealthcare West may delegate claims processing to capitated medical groups/IPAs and or capitated facilities that have requested delegation and have shown through a pre-delegation assessment that they are capable of claims processing that are compliant with all state and/or federal regulations, as well as UnitedHealthcare standards for claims processing. Within this section, medical groups/IPAs/facilities referred to as "Delegated Entities".

Delegated Entities considered for delegation or approved for delegation are required to develop and maintain claims processing procedures that allow for accurate and timely processing of claims and meet all Applicable state and federal regulatory requirements. UnitedHealthcare standards met. Delegated Entities are responsible for ensuring that all claims entered into the claims processing system accurately and that receipt of claims acknowledgement, and in accordance with state and federal regulations. The Delegated Entity is responsible for processing claims appropriately in compliance with state and federal laws and regulations, and in accordance with the member's benefit coverage. The delegated entity is required to meet all reporting requirements and adhere to requests for review including data request to perform assessment reviews.

Medicare Advantage Claims

Prompt Payment

CMS regulations require the delegated Medical Group to pay or deny 95% of the clean claims from non-contracted providers within 30 calendar days of receipt. The Medical Group must also pay or deny 95% of all other claims within 60 days.

Date Stamp

It is important that each delegated medical group/IPA/facility have a clearly identifiable date stamp that used for the receipt of all paper claims. Electronic claims date stamps must be in accordance with federal standards.

Timely Filing

The claims "timely filing limit" defined as the calendar day period between the claims last date of service or payment/

denial by the primary payer, and the date by which UnitedHealthcare West or its delegate receives the claim.

Determination of the date of UnitedHealthcare West's or its delegate's receipt of a claim, the date of receipt shall be deemed to be the calendar day when a claim, by physical or electronic means, is first delivered to UnitedHealthcare West's specified claims payment office, post office box, designated claims processor or to UnitedHealthcare West's capitated care provider for that claim. The following date stamps utilized to determine date of receipt:

- UnitedHealthcare West HMO Claims department date stamp;
- Primary payor claim payment/denial date as shown on the Explanation of Payment (EOP);
- Delegated care provider date stamp;
- Third party administrator date stamp;
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender;

Refer to the official CMS website for additional rules and instructions on timely filing limitations.

Misdirected Claims

In order to meet legal and regulatory timeliness standards, it is important that misdirected claims forwarded to the proper payer in accordance with state and federal regulations. If claims sent to a UnitedHealthcare West Delegated Entity and UnitedHealthcare West is responsible for adjudicating the claim, the Delegated Entity shall forward the claim to UnitedHealthcare West within 10 working days of the receipt of the claim.

Misdirected claims to UnitedHealthcare West, rather than to the appropriate Delegated Entity once identified, batched, forwarded in accordance with state and federal regulations. Claims sent directly to the Delegated Entity responsible for processing the claim. We will send the care provider of service a notice that the member's claim forwarded to the Delegated Entity for processing.

All claims received in error at the Delegated Entity identified and tracked within the guideline or systematically. Tracking must include the name of the entity of where the claims sent, and the date mailed. Claims forwarded to the appropriate payor immediately upon receipt, in accordance with state and federal regulatory timeframes. If it is determined that the member assigned to another medical group/IPA on the date of service, the care provider should forward the claim to the appropriate Delegated Entity in accordance with state and federal regulatory timeframes for processing.

The Delegated Entity must, however notify the care provider of service who the correct payor is, if known, on the Explanation of Payment (EOP) provided to the care provider when the claim is adjudicated. Please submit misdirected

claims to our Claims Department using the Misdirected Claims cover sheet, at UHCWest.com.

Payment Methodology

Delegated Entities must ensure appropriate reimbursement methodologies are in place for non-contracted and contracted care provider claims.

A Medicare Advantage non-contracted care provider claim processed in accordance with federal requirements for claims processing. Non-Contracted care provider claims, should be reimbursed in accordance with, but not limited to, the established Medicare Care Provider Fee Schedule, DRG, and APC pricing at the current applicable specific locality rates published in the Federal Register.

For payment of non-contracted network care provider services the letter, EOP, or PRA issued must notify them of their dispute rights if they disagree with the payment amount. Members are not billed for the difference of the billed amount and the Medicare allowed amount.

Medicare Advantage contracted care provider claims must be processed in accordance with the agreed upon contract rates and within state and federal regulatory requirements.

Interest Payment

Delegated Entities are required automatically to pay applicable interest on claims according to state and federal requirements.

For Medicare Advantage products, CMS requires the payment of interest for non-contracted care provider clean claims not paid within 30 calendar days from the first date stamp on the claim. Interest paid at the current rate for the period beginning on the day after the required payment date and ending on the date the check mailed. CMS updates the interest factor twice annually (Jan and July). This information found in the federal register or on the official CMS website.

Maximum Out-Of-Pocket (MOOP)

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

Claim Denial Letters

When a claim received for a commercial or Medicare Advantage member, the Delegated Entity must assess the claim for the following, but not limited to, components before issuing a denial letter:

- Member's eligibility status with UnitedHealthcare West on the date of service;
- Responsible party for processing the claim (forward to proper payor);
- Contract status of the care provider of service or referring care provider;

- Presence of sufficient medical information to make a medical necessity determination;
- Covered benefits;
- Authorization for routine or in-area urgent services;
- Maximum benefit limitation for limited benefits;
- Prior to denial for insufficient information, the medical group/IPA/capitated facility must document their attempts to obtain necessary information to make a determination.

Member Denials

In instances when a member is financially responsible for a denied service, UnitedHealthcare West or the Delegated Entity's claims department (whichever hold the risk) must provide the member with written notification of the denial decision in accordance with federal and state regulatory standards.

The Delegated Entity must use the most current CMS-approved Notice of Denial of Payment letter template to accurately document and issue a claim denial letter to a member. The denial letter sent within the appropriate regulatory timeframes.

If the member enrolls in a benefit plan subject to another, a claim denial letter issued to the member must clearly state the reason for the denial and provide proper appeal rights with a denial letter issuance to member, within 30 calendar days of receipt of the claim.

The Delegated Entity remains responsible to issue appropriate denials for member-initiated, non-urgent/emergent medical services outside of the Delegated Entity's defined service area.

Care Provider Denials

In instances when the member is not financially responsible for the denied service, it is not necessary to notify the member of the denial. The care provider must receive notification of the denial and their financial responsibility (i.e., writing the charges off for the claims payment). UnitedHealthcare West or the Delegated Entity's claims department (whichever holds the risk) is responsible for providing the notification.

The denial notice (letter, EOB, or PRA) issued to any non-contracted care provider of service must notify them of their appeal right. The denial notice must also specify the member is not to be balance billed.

When the member has no financial responsibility for the denied service, the denial notice (letter, EOB, or PRA) issued to any contracted care provider of service must clearly state that the member is not to be billed for the denied or adjusted charges. In addition, the contracted care provider notifies member of their right to dispute the decision or discuss it with a care provider reviewer.

ERISA Claims Processing

For claims falling under the Department of Labor’s ERISA regulations, a determination to pay or deny made within 30 calendar days. Denials issuance within 30 calendar days of receipt of the complete claim, and payment issued within 45 working days or within state regulation, whichever is more stringent. The legislation does not differentiate between clean, unclear, and non-participating claims. Interest is automatically paid on all uncontested claims not paid within 45 working days after receipt of the claim. Interest shall accrue at the rate established by state regulatory requirements, per annum, beginning with the first calendar day after the 45 working day period and must be included with the initial payment. If interest is not included, there is an additional penalty paid to the care provider in addition to the interest payment.

Non-compliant Assessments

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

Submission of Bulk Claim Inquiries

The Claims Project Management (CPM) Team handles bulk claim inquiries for 20 or more claims received from care provider service. The care provider of service should contact the Claims Research Department at the address below to initiate a bulk claim inquiry:

UnitedHealthcare West Bulk Claims Rework Reference Table

Care Provider’s State	Contact Information	Notes
Arizona	UnitedHealthcare Attn: WR Claims Project Management P.O. Box 52078 Phoenix, AZ 85072-2078	Submit requests for 20 or more claims.
California	Claims Research Projects CA120-0360 P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for 19 or more claims.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983	Submit requests for 20 or more claims.

Care Provider’s State	Contact Information	Notes
Nevada	For Medicare Advantage claims: UnitedHealthcare Attn: WR Claims Project Management Claims Research Projects P.O. Box 95638 Las Vegas, NV 89193-5638	The Nevada delegated payer handles bulk claim inquiries received from care providers of service. The care provider of service should submit the bulk claims with a cover sheet indicating “Appeal” or “Review” to the Claims Research Department at the designated address to initiate a bulk claim inquiry. Submit requests for ten or more claims.
Oklahoma	Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967	Submit requests for 20 or more claims.
Oregon	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for ten or more claims.
Texas	Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975	Submit requests for 20 or more claims.
Washington	Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968	Submit requests for ten or more claims.

UnitedHealthcare West’s Response

- Reworks/disputes requiring medical determination: Individuals with clinical training/background who were not previously involved in the initial decision will review all clinical rework/dispute requests. A letter sent to the care provider giving an outline of the outcome of the determination and the basis for the decision.
- Reworks/disputes requiring claim process determination: Individuals not previously involved in the initial processing of the claim will review rework/dispute request.
- Response details:
 - If claim requires an additional payment, the Explanation of Payment (EOP) will serve as notification of the outcome on the review.
 - If the original claims status is upheld the care provider being sent a letter outlining the details of the review.

CA: If claim requires an additional payment, the EOP itself is insufficient to serve as notification of the outcome of the review, a letter sent to the care provider with the determination notification. In addition, payments sent within five days of such determination based on the date on the determination letter.

We will respond to the care provider within the applicable time limits set forth by federal and state laws and regulations. If the applicable time limit has passed, the care provider may contact care provider relations at 877-847-2862 to obtain a status.

Claim Reconsideration

If you believe underpayment occurred by us please refer to the [Claims Research and Resolution](#) section of this guide for further details on how to address this issue.

Overpayments

If you identify a claim for which you were overpaid by us, or if we inform you of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. If refund or disputes not made within 45 calendar days of our request, UnitedHealthcare West shall recoup the amount of overpayment through other means, which may include future claim payments, to the extent permitted by your agreement with us and the applicable law.

All refunds of overpayments in response to overpayment refund requests received from us, or one of our contracted recovery vendors, sent to the name and address of the entity outlined on the refund request letter. Refunds of any credit balances existing on your records sent to:

UnitedHealthcare
Attn: Audit and Recovery Operations
2717 N 118th Circle
Omaha, NE 68164-9672

Please include appropriate documentation that outlines the overpayment, including member's name, health care ID number, date of service and amount paid. If possible, please also include a copy of the remittance advice that corresponds with the payment from us. If the refund is due because of coordination of benefits with another carrier, please provide a copy of the other carrier's EOB with the refund.

When we determining a claims payment paid incorrectly, we may make claim reconsiderations without requesting additional information from the network care provider or other participating health care professional. In the case of an overpayment, we will request a refund at least 30 calendar days prior to implementing a claim reconsideration, or as provided by applicable law. You will see the adjustment on the EOB or PRA. When additional

or correct information needed, we will inquire with you to provide it.

If you disagree with claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you must submit the dispute, in writing, to the following location:

UnitedHealthcare West
Attention: Recovery Dispute Team
P.O. Box 30975
Salt Lake City, UT 84130-0975

If you dispute the refund request, the recovery of claims overpayment will not occur until after you have exhausted UnitedHealthcare West appeals process.

Chapter 8: Billing and Encounter Submissions

Compliance Assessments

We have established policies and procedures specifically designed to monitor the Delegated Entities' compliance with state and federal claims processing requirements. Our auditors will conduct claims processing compliance assessments of each Delegated Entities found in compliance reviewed at minimum annually. Performance of additional reviews for other circumstances, including, but not limited to;

- Assessment results indicate non-compliance;
- Self-reported timeliness reports indicate noncompliance for two to three months;
- Non-compliance with reporting requirements;
- Lack of resources or staff turnover;
- Overall performance warrants a review, (claims appeal activity, claims denial letters or member and care provider claims-related complaints);
- Allegations of fraudulent activities or misrepresentations;
- Information systems changes or conversion;
- New management company, or change of processing entity;
- Established Management Service Organization (MSO) acquires new business;
- Significant increase in members or volume of claims;
- Significant increase in claims-related complaints;
- Regulatory agency request;
- Significant issues concerning financial stability.

As part of the claims processing compliance assessment, we will request copies of the Delegated Entity's universal claims listing for contracted and non-contracted care providers. The auditor will review the reports accuracy and randomly select claims for examining. The Delegated Entity informed of the claims selected at random from the universal claims listing must have the following ready for the auditor at the time of assessment. The categories assessed include, but not limited to, the following:

- Timeliness Assessment;
- Financial Accuracy (including proper benefit application, appropriate administration of member cost share accumulation);
- Administrative Accuracy;
- Customer Denial Accuracy and Denial Letter Review;
- Care Provider Denial Assessment;
- Non-Contracted Care Provider Payment Dispute Resolution (Overturns and Upholds) Claims Assessment;
- Fraud, Waste and Abuse Inspection;

If the Delegated Entity found to be non-compliant, we will require the Delegated Entity to develop an improvement action plan (IAP) to correct any deficiency including, but not limited to, the following:

- Processing timeliness issues;
- Failure to pay interest or penalties;
- Failure to submit Monthly/Quarterly Self-reported Processing Timeliness reports;
- Canceling Assessments;
- Failure to submit requested claims listings;
- Failure to have all documentation ready for a scheduled assessment;
- Failure to provide access to canceled checks or bank statements.

A Delegated Entity on Improvement Action Plan (IAP) placed on cure period (90-calendar days (CD) timeframe granted to a delegated entity after a non-compliant review in which they have to demonstrate compliance) until such time that compliance achievement. Other frequent reviews conducted during the cure period with Delegated Entities who do not achieve compliance within the established cure period sanctioned. Claims processing is a delegated function that is subject to revocation. Sanctions may consist of additional/enhanced assessing, on-site claims management, revocation of delegated status, and/or enrollment freeze. There may be costs to the Delegated Entity, depending on the sanction put in place.

Reporting

The Delegated Entity is accountable for submitting all required information to UnitedHealthcare and in accordance with the guidelines established by state and federal regulations. UnitedHealthcare requires all Delegated Entities to report timeliness compliance results at a minimum monthly. Additionally, other reporting, deemed by UnitedHealthcare necessary to conduct the proper level of oversight monitoring, requirement of submission at a minimum on a monthly basis, or as needed depending on the need as it arises.

In addition, the Delegated Entity will be required to submit Claims Quarterly Reports (CMS Part C Reporting Requirements) in accordance with state and federal regulations.

CA/OR/WA: Updated versions of the Medicare Claims self-timeliness report (ICE Claims Medicare MTR) and the Commercial Claims self-timeliness report (ICE Claims Comm Mo Qtr.) found on the Iceforhealth.org website. The most current version of the form needs submission at all times. This applies to both Commercial and Medicare Advantage products. The California Delegated Entity must submit the timeliness form via email

to providerAuditClaimsReports@uhc.com. Monthly timeliness report submissions are due within 15 days from the end of the reporting month. Commercial quarterly reports submitted no later than the 30th day following the end of the quarter. Medicare quarterly report submissions are due by the 15th day, following the end of a quarter. Maintain a copy of the reports for your records.

CA: In accordance with state regulatory requirements, UnitedHealthcare West shall verify on a quarterly basis that our Delegated Entities have the administrative and financial capacity to meet contractual obligations through routine reviews of financial indicators and monitoring financial solvency deficiencies. UnitedHealthcare West requires Delegated Entities to provide copies of quarterly financial statements, including a balance sheet, income statement and statement of cash flow, prepared in accordance with generally accepted accounting principles within 45 calendar days of the end of each calendar quarter. Copies of assessed annual financial statements together with copies of all auditors' letters to management in connection with such reviewed annual financial statements submissions due within 150 calendar days of the end of each fiscal year. In the event that quarterly/annual financial statement submissions include deficiencies in financial solvency grading criteria defined by state regulations. A self-initiated Improvement Action Plan (IAP) proposal shall be submitted in an electronic format (template may be found on the lceforhealth.org website) to UnitedHealthcare West within 45 calendar days of the end of the reporting period for which the deficiency was reported. In addition, quarterly progress reports need submission to UnitedHealthcare West within 45 calendar days of the end of each subsequent reporting period until compliance with all financial grading criteria achievement. The Delegated Entity must submit financial statements and IAPs via email to UnitedHealthcare West at financialstatementsubmission@uhc.com.

Both UnitedHealthcare West and the delegate entity are responsible to provide compliance oversight of the Delegated Entities financial reporting IAP.

Delegation is a function that is subject to revocation for continued noncompliance with UnitedHealthcare standards. Failure to meet financial solvency requirements may be cause for revocation of delegated services.

Other UHC West Delegated States (AZ/CO/NV/OK/TX): The Delegated Entities in these states are required to submit the Monthly Self-Reported Timeliness Reports within 15 calendar days following the month being reported.

Delegated Provider Dispute Resolution (PDR) Process Medicare Advantage

Contracted Care Provider Disputes

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

Non-Contracted Care Provider Disputes—CMS Non-Contracted Care Provider Payment Dispute Resolution Process (applicable to non-contracted Medicare Advantage paid claims)

Care provider payment dispute resolution process includes; any decision where a non-contracted care provider contends that the amount paid by the organization, in this instance the Delegated Entity, for a covered service is less than the amounts been paid under Original Medicare. This process also includes instances where there is a disagreement between a non-contracted care provider and the Delegated Entity about the entity's decision to pay for a different service than that billed, for example: bundling issues, rate of payment, DRG payment dispute. The timeframe for submitting a payment dispute is 120 calendar days from the original claim determination. At a minimum, the Delegated Entity must adhere to the following requirements when handling Medicare non-contracted care provider, claim payment disputes;

- Well-defined internal payment dispute process in place, including a system for receiving PDRs;
- Proper identification of payment disputes in place. Care providers must clearly state what they are disputing and why, supply relevant information that will help support their position, including description of the issue, copy of submitted claim, supporting evidence to demonstrate what Original Medicare would have allowed for the same service, etc.;
- Well-defined internal dispute process in place, including a system for tracking disputes;
- Monitoring of PDR claims inventory soundly in place;
- Timeframe for submitting a payment dispute (Timely Filing Limit of 120 calendar days from the original claim determination) accurately established and communicated to the non-contracted care provider at time of claim payment;
- Information on how to submit an internal claim payment dispute to the organization communicated to the non-contracted care provider at time of claim payment, including the organization's mailing address where disputes are to be submitted and other appropriate information for disputes (e.g., email addresses, phone numbers);

- Timeframe of 30 calendar days from the PDR claim received date to process and respond (i.e., to finalize the PDR claim) to the non-contracted care provider is in place and being met;
- Helping to ensure correct calculation of interest payments on overturned PDRs made. Interest required on a reprocessed non-contracted care provider clean claim if the group made an error on the original organization determination; interest is only applied on the additional amount paid; and interest calculated from the 'oldest receive date of the original claim' until the 'check mail date' of the additional amount paid;
- Complete and clear rationale provided to the non-contracted care provider for upheld PDRs;
- Information contained in the care provider Remittance Advice (PRA) or Explanation of Payment (EOP), and Uphold PDR Determination Letter is appropriate and meets requirements.
- Information given within the care provider notice on upheld or overturned payment disputes on how to contact the organization if the non-contracted care providers have additional questions;
- Process in place to update the organization's claims system, if needed, if the root-cause of overturned PDRs identified to be system-related so that future claims from non-contracted care providers will reimburse appropriately;
- Process in place to identify similar claims for that contract year for the non-contracted care provider who submitted a payment dispute to help ensure that they may be paid correctly;
- Ongoing training program in place for any component of the internal claim payment dispute process with training to include educating all areas of the organization, including, but not limited to customer service, claims, appeals, etc.;
- Internal compliance monitoring conducted on a consistent basis to help ensure CMS requirements are met on non-contracted care provider disputes;
- End-to-end quality review process in place, from the time a dispute received from the non-contracted care provider to the time when the dispute decision sent to the non-contracted care provider;

Second Level Payment Disputes (Medicare Advantage Claims)

Forward second level disputes to UnitedHealthcare. Delegated entities are required to submit all materials relating to the dispute when requested by UnitedHealthcare in a timely manner to help ensure all relevant documentation is considered. We have 60 calendar days to review and respond to second level disputes.

Commercial Claims (CA)

A Delegated Entity that is contractually delegated to process and adjudicate claims or approve or deny referrals for service shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted care provider disputes in accordance with state and federal regulations.

If the dispute request is for services payable by the Delegated Entity, we will determine if the appropriate payer has reviewed the request for dispute. If the appropriate payer has not reviewed the dispute request, we will forward the dispute request to the appropriate payer. We will notify the care provider of service of the forwarding dispute request to the Delegated Entity for processing.

The Delegated Entity is accountable for submitting all required information to UnitedHealthcare West and the appropriate state agency in accordance with the guidelines established by state and federal regulations. All delegated claims processing entities are required to report PDR processing compliance results quarterly in accordance with state and federal regulations. Submission of quarterly reports, are due no later than the 30th day following the end of the quarter.

We will conduct a compliance assessment of the PDR Process of each Delegated Entity on a regular basis. Care providers reviewed at minimum annually.

As part of the compliance assessment, we will request copies of Delegated Entity Provider Dispute report. The auditor will review the reports and randomly select finalized disputes for reviewing. The auditor will also require a copy of the Delegated Entity's PDR Policy and Procedures, and evidence of the availability of the PDR mechanism. If the capitated medical group/IPA or capitated facility found to be non-compliant with UnitedHealthcare West, state or federal requirements, the Delegated Entities expected to develop an improvement action plan designed to bring them back into compliance.

Care providers who do not achieve compliance within the established timeframes sanctioned until compliance achievement. PDR processing is a delegated function that is subject to revocation. Sanctions may consist of additional/enhanced reviewing, on-site claims/PDR management, and/or revocation. There may be costs to the Delegated Entity depending on the sanction put in place.

If a care provider continues to have a Commercial claims dispute with the Delegated Entity related to medical necessity and Utilization Management, the care provider must forward all claim information and correspondence between the Delegated Entity and the care provider to UnitedHealthcare West for review. No reviews given until supporting documentation received.

Commercial care provider claims must be processed in accordance with the agreed upon contract rates

or member benefit plan and within state & federal requirements.

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

Commercial interest rates and timeframes for processing may vary, depending on the applicable state requirements. In some states, an additional penalty for late claims payments may also apply and be paid by the delegated medical group/IPA/facility.

Requests for Reimbursement by the Medical Group/IPA/Facility CA only

A request for reimbursement for any overpayment of a claim completed in compliance with state and federal regulations and completed utilizing the following guidelines:

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

Member's Request for Confidentiality

There are state and federal requirements that allow an individual other than the subscriber to request confidential treatment as it relates to referrals, authorizations, denials, claims payments e.g. receipt of the Explanation of Benefits, selection of primary care provider. UnitedHealthcare requires that when a member requests confidential status, that the member must submit their request in writing to the medical group/IPA, and includes their current address and private telephone phone number. The reason for the written request is that the member cannot dispute at a later date/time the information that was provided is incorrect; for example, the current address was not the correct address. The member is expected that every time a change in address or phone number occurs, that the member is solely responsible for resubmitting a new confidentiality form to update current information.

Delegated claims Member Denial Letters

The medical group/IPA/capitated facility must use the most current, approved Commercial Claims Denial Letter template to accurately document and issue a claim denial letter to a member. The denial letter must be sent out within the appropriate regulatory timeframes.

Electronic Data Interchange (EDI)

EDI is the preferred method for conducting business transactions with care provider industry partners, participating and non-participating. Using EDI to exchange information with us and other payers has many advantages:

- Send and receive information faster.
- Identify submission errors immediately and avoid processing delays.
- Exchange information with multiple payers.
- Reduce paper, postal costs and mail time.
- Cut administrative expenses.

If you are not taking advantage of all available electronic transactions, you are not maximizing your savings and experiencing the full benefits of EDI.

Getting Started

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

EDI Education and Support

Our [EDI Education](#) section of [UnitedHealthcareOnline.com](#) offers a variety of resources to help you with EDI connectivity, tips to submit claims electronically and better understand the purpose of each available EDI transaction. We publish [UnitedHealthcare Companion Guides](#) noting the required data elements for exchanging EDI transactions with us, and a [Companion Guide Directory](#) related to our strategic partners.

Verifying Eligibility, Benefits and your Network Participation Status

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

There are three easy ways to verify eligibility and benefits:

- Online using the eligibilityLink app (requires login)
- EDI Transactions 270 (Inquiry) and 271 (Response) through your vendor or clearinghouse
- By calling 877-842-3210

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

The EDI transaction is a powerful productivity tool that allows you obtain members' eligibility and benefit information in "real-time," using a computer instead of the

phone, prior to scheduling and confirming the patient's appointment. The HIPAA ANSI X 12 270/271 format is the only acceptable format for this EDI transaction. One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. You may verify the eligibility of members before you see them and obtain information about their benefits including required copayments and deductibles, out-of-pocket maximums or coinsurance for which your patients are responsible. Your network status is not returned on 271 transactions at this time so be sure to know your status prior to submitting 270 transactions. Learn how to get better results with your 270/271 EDI transactions with UnitedHealthcare.

Eligibility Grace Period for Individual Exchange Members

Health insurance plans are required to provide a three-month grace period before terminating coverage for individuals who enroll in a health plan through the Individual Health Insurance Marketplace (also known as Individual Exchange). The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least one full month's premium within the benefit year.

There are three ways to verify if a member is within the grace period:

- Online using eligibilityLink app (requires login)
- EDI Transactions 270/271 via your vendor or clearinghouse
- By calling 877-842-3210

If the date of service scheduled to occur after the date, the member is in the grace period and at risk of retroactive termination if the premium not paid in full at the end of the three-month period.

Understanding Your Network Participation Status

As our product portfolio evolves and new products are introduced, it is important for you to confirm your network status and tier status (for tiered benefit plans) while checking eligibility on [Link](#) or by call us at 877-842-3210. If you are not participating in the member's benefit plan or are outside the network service area for the benefit plan (i.e., Compass) the member may have higher cost share or no coverage. Tiered benefit Plans information at [UnitedHealthcareOnline.com](#)

HIPAA

The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA enacted as part of an effort by the federal government to reform the healthcare industry. One part of HIPAA establishes standards for privacy and security of health information. Another part of HIPAA is a section on Administrative Simplification (HIPAA-AS), which

regulates and standardizes the exchange of electronic information.

The table below includes standardized HIPAA-compliant EDI transactions available at UnitedHealthcare West:

ANSI ASC X12N* Transactions	HIPAA EDI Transactions Acceptable UnitedHealthcare West Versions	Available at UnitedHealthcare West Transaction Descriptions
270/271	005010X279A1	Eligibility Benefits Inquiry and Response (Real Time and Batch)
276/277	005010X212	Claim Status Inquiry and Response (Real Time and Batch)
820	005010X218	Premium Payment
834	005010X220A1	Benefit Enrollment and Maintenance
835	005010X221A1	Claims Payment and Remittance Advice
837	005010X222A1	Healthcare Claim/ Encounter Professional
837	005010X223A2	Healthcare Claim/ Encounter Institutional

*American National Standards Institute Accredited Standards X1 2 Committee

ASC X12 Technical Report Type 3/ Companion Guides

The ASC X12 Technical Report Type 3 publications are the authoritative source for EDI Transactions. The ASC X12 Technical Report Type 3 publications purchase available from Washington Publishing via the following [wpc-edi.com](#). United has developed guides to provide transaction specific information required by UnitedHealthcare West for successful EDI submissions. UnitedHealthcare West Companion Guides are available for viewing or download from [UnitedHealthcareOnline.com](#).

Member Cost Share

- Cost Share information comes from different sources derived through claims and encounter data submissions.
- UnitedHealthcare will sum Cost Share totals from the sources.
- Cost Share information will be available to view accumulation on the care provider portal for each Delegated Entity.
- The following reports will be available to view the Member's Cost Share accumulation:
 - › EL915 M
 - › EL917
 - › EL918

- › IVR
- › 5010 version of the 270/271—refer to companion guide
- Members notified when their annual out-of-pocket copayment/deductible maximums met. Delegated Entities can view members who have met the annual copayment/deductible maximum on the EL 917.
- The EL918 report is a daily Member Cost Share report that shows the cost share information for all active members belonging to a care provider. Report is available in both csv and data formats.
- Delegated entities are responsible for updating their systems to help ensure members no longer charged for copayments/coinsurance/deductibles once the annual copayment/deductible maximum met.
- UnitedHealthcare conducts assessments to help ensure appropriate administration of member cost share accumulation.

Encounter Data

Requirements for Submission of Encounter Data (Commercial)

Professional and institutional encounter data consist of an itemization of medical group/IPA/capitated facility capitated and sub-capitated services provided to commercial members.

The capitated medical group/IPA, or other submitting entity, must certify the completeness and truthfulness of its encounter data submissions, as required by the state regulatory agency. The medical group/IPA, or other submitting entity, is required to submit all professional and institutional encounter data for UnitedHealthcare West members:

- To comply with the Affordable Care Act for risk adjustment reporting;
- To comply with Essential Health Benefits (EHB)
- To comply with NCQA-HEDIS® reporting requirements;
- To provide the medical group/IPA, or other submitting entity, with comparative data;
- To facilitate utilization management oversight;
- To report member out-of-pocket maximums;
- To facilitate quality management oversight;
- To facilitate settlement calculations, if applicable;

In order for UnitedHealthcare to administer current commercial copayments effectively, coinsurance and deductible plans and products where member cost share administration is essential, we require capitated medical group/IPAs and capitated facilities to submit timely and compliant encounter data. The member cost share amount that should be included on the encounter data

submissions based on the member's benefit plan and not the amount the member paid at the time of service. The encounter should clearly distinguish between copayment, coinsurance and deductible amounts within the Claim Adjustment Segments (CAS) segment of Loop 2430 as indicated on the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned commercial members.

In order for UnitedHealthcare to comply with the required reporting for the Affordable Care Act submissions for risk adjustment, we require all contracted care providers to submit all diagnosis and procedure codes to the highest level of specificity relevant to the encounter data submission.

The capitated medical group/IPA/capitated facility or other submitting entity, are encouraged to submit encounter data on a weekly basis. UnitedHealthcare welcomes your encounter submissions more frequently than weekly (e.g., twice a week, or daily). Frequent encounter submissions, allows us to support various state and federal regulatory requirement for reporting.

We continuously monitor encounter data submissions for quality and volume. Submission levels below the established monthly threshold of 100% are non-compliant. The Encounter Data Collection Team is your point of contact for additional questions.

The capitated medical group/IPA, or other submitting entity, must correct any encounter errors identified by a clearinghouse or trading partner on a monthly basis at a minimum. As a capitated, Delegated Entity processing claims on our behalf, it is our expectation that all encounter submissions are accurate reflections of the original claim received without exception.

All encounter data submitted to United Healthcare West is subject to state and/or federal assessment. We have the right to perform routine medical record chart assessment on any or the entire medical groups/IPA's network care providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data, including ICD-10-CM and CPT coding. The medical group/IPA will give notification in writing of review results pertaining to coding accuracy.

You may be subject to financial consequences if you or another submitting entity fails to submit or meet encounter data element requirements. In addition, the medical group/IPA may be required to perform a complete medical record chart review of its network care providers with notice from UnitedHealthcare West.

Delegation is a function that is subject to revocation for continued noncompliance with UnitedHealthcare standards. Failure to comply with the requirements to submit encounter data may be cause for revocation of delegated services.

Requirements for Submission of Encounter Data (Medicare Advantage)

Professional and institutional encounter data consist of an itemization of medical group/IPA/capitated facility, capitated and sub-capitated services provided to Medicare Advantage members.

CMS reimburses all Medicare Advantage plans based on the member's health status. CMS uses the diagnosis codes from the Medicare Advantage claims and/or encounter data (inpatient, outpatient and care provider) to establish each member's health status or Hierarchical Condition Category (HCC). The HCC used by CMS to help calculate Medicare reimbursement payments for each member.

As a result, we are required to send all adjudicated claims and capitated encounter data for Medicare Advantage members to CMS. These claims and encounters must pass all the edits that CMS applies to its fee-for-service HIPAA 5010 837 and CMS-1500 and UB-04 submissions.

In order to minimize rejected claims, care providers need to process their Medicare Advantage claims and encounters in the same manner as their Medicare fee-for-service bills, subject to the specific claims submission and other requirements stated in this guide.

If the claim data does not pass the CMS edits, which mirrors within the UnitedHealthcare systems, UnitedHealthcare will notify the care provider and the care provider will need to resubmit the claim or encounter to UnitedHealthcare West.

CMS may at any time assess our submission. The medical record must support the diagnoses submitted by the care provider.

Only the care provider can change or submit new CMS-1500 or UB-04 data. Accordingly, compliance on the care provider's part is needed in order for us to submit the correct data.

We require the medical group/IPA/capitated facility or other submitting entity to submit all professional and institutional claims and/or encounter data for Medicare Advantage members:

- To comply with regulatory requirements of the CMS Balanced Budget Act (BBA);
- To submit to CMS for risk adjustment reporting and accurate Medicare reimbursement;
- To comply with NCQA-HEDIS reporting requirements;
- To provide the submitting entity with comparative data;
- To facilitate utilization management oversight;
- To facilitate quality management oversight;
- To support Services 75 FR 19709 -Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B;

- To facilitate settlement calculations, if applicable;

In order for UnitedHealthcare West to comply with the CMS regulation 75 FR 19709 to report member cost share as well as out-of-pocket maximums, we require contracted care providers to submit current, complete and accurate encounter data. This includes member cost share/revenue, to within the CAS segment of the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned Medicare Advantage members.

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

Medicare Advantage Organizations (MAOs) are required to report the total costs incurred by the health plans for capitated and/or delegated provider services. MAOs must populate dollar amounts for capitated and/or delegated providers in the "Total cost" and "Plan's share" columns in the Monthly or Quarterly Summary EOB. The "Total cost" field on the member EOB includes what the member pays and what the health plan pays.

Medicare Managed Care Service Organizations (MSOs), capitated medical groups, facilities, and ancillary care providers are required to submit the Payor Amount Paid at the claim level, the Service Line Paid Amount and the member cost share which is based on the member's benefit plan for all professional and institutional Medicare encounter data. The Payor Amount Paid submitted in the encounter should not be a zero unless the claims denied. The Pay Amount Paid referred to as the contracted rate, Medicare Fee Schedule Rate, or Calculated Capitation Rate less any applicable member responsibility.

The capitated medical group/IPA/capitated facility or other submitting entity, are encouraged to submit encounter data on a weekly basis. UnitedHealthcare welcomes your encounter submissions more frequently than weekly (e.g., twice a week, or daily). Frequent encounter submissions, allows us to support various state and federal regulatory requirement for reporting. UnitedHealthcare West requires that all encounter data submitted via Electronic Data Interchange sent to Payer ID 95958 or check with your clearinghouse.

We will continuously monitor encounter data submissions for quality and quantity. Submission levels below the desired monthly threshold of 100% non-compliance. The capitated medical group/IPA or other submitting entity must correct any encounter errors identified by a clearinghouse or trading partner on a monthly basis at a minimum. As a capitated, Delegated Entity processing claims on our behalf, it is our expectation that all encounter submissions are accurate reflection of the original claim received without exception. All encounter data submitted to UnitedHealthcare West are subject to state and/or

federal assessment. We have the right to perform routine medical record chart assessments on any or all of the medical group's/IPA's network care providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data ICD-10- CM and CPT coding. The medical group/IPA notifies in writing of assessment results pertaining to coding accuracy.

The medical group/IPA may be subject to financial consequences if it or another submitting entity fails to submit or meet encounter data element requirements. In addition, the medical group/IPA may be required to perform a complete medical record chart review of its network care providers with notice from UnitedHealthcare West.

Delegation is a function that is subject to revocation for continued noncompliance with UnitedHealthcare standards. Failure to comply with, or attest to compliance, with CMS requirements may be cause for revocation of delegated services.

Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and coordination of benefits rules.

Subrogation—To the extent permitted under applicable 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.

In the event that UnitedHealthcare West assigns its right to recover to the care provider for collection, any claims or demands against such third parties for amounts due for the care provider's services will be subject to the following conditions:

- Care provider shall utilize *lien forms* which are provided by UnitedHealthcare West or approved in advance by UnitedHealthcare West to the extent liens are utilized.
- Care provider is required to notify UnitedHealthcare West each time it pursues and each time it obtains a signed lien from a member.
- Care provider shall not commence any legal action against a third party without obtaining the written consent of UnitedHealthcare West.
- Care provider shall make no demand upon UnitedHealthcare West for reimbursement until all third party claims have been pursued and it is determined that full payment cannot be obtained within 12 months from the date of the service.
- UnitedHealthcare West may immediately rescind the assignment of any or all claims and demands against third parties by providing written notice of rescission to the care provider.

- In the event that a care provider receives payment from a third party after receipt of payment from UnitedHealthcare West, care provider is required to reimburse us to the extent that the combined amounts received from all parties exceeds the amounts set forth in the UnitedHealthcare West participation agreement.

Coordination of Benefits (COB)—Our benefit plans are subject to coordination of benefits (COB) rules. COB is the practice of two or more plans coordinating the provision of health benefits to members who have multiple plans. COBs administered according to the member's benefit plan and in accordance with applicable state laws and regulations.

- For professional/ancillary professional claims, UnitedHealthcare West's secondary payment will be the member liability after the primary carrier's payment and adjustment (i.e. the amount the member would be legally obligated to pay in the absence of any other coverage), up to a maximum of our contracted rate with the care provider (or billed charges of non-contracted care providers).
- For facility claims, UnitedHealthcare West's secondary payment will be the lesser of (1) our contracted rate minus the primary carrier's payment or (2) the member's out-of-pocket expense (after primary payer's payment and adjustment) for covered services.

Unless your care provider agreement calls out specific COB language, the table below describes the language/process that we would follow in claims.

Primary Plan	Plan that pays benefits first.	Benefits under the primary plan no reduction due to benefits payable under other plans.
Secondary Plan	Plan will pay benefits after the primary plan.	Benefits under the secondary plan may have a reduction due to benefits payable under other primary plans.
Tertiary Plan	Three or more group benefit plans may provide benefits for the same medical expense.	Tertiary plans would offset the incurred expenses with the benefits paid by the primary and secondary carriers, and provide benefits for any remaining unreimbursed expenses.

COB - Medicare—When coordinating benefits with Medicare, all COB types coordinate up to Medicare and the allowed amount when the care provider accepts assignment. Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary.

Other coverage is primary over Medicare in the following instances:

- Aged Employees: For members who are entitled to Medicare due to age, Commercial is primary over Medicare if the employer group has 20 or more employees.
- Disabled employees (Large Group Health Plan): For members who are entitled to Medicare due to disability,

Commercial is primary to Medicare if the employer group has 100 or more employees.

Workers' Compensation—In cases where an illness or injury is employment-related, workers' compensation is primary. If notification received that the workers' compensation carrier has denied the claim, the care provider should process claims as determined by your contract. Please advise UnitedHealthcare West of any workers' compensation disputes.

End-Stage Renal Disease

If a member has (or develops) ESRD while covered under an employer's group plan, the member must use the benefits of the employer's group plan for the first 30-months before becoming eligible for Medicare, as a result of his/her ESRD. After the 30-months elapse, Medicare becomes the primary payor. ESRD Medicare will be the primary payor if employer-group plan coverage was secondary to Medicare when the member developed coverage.

Medicaid (Medicare Advantage)

Qualified Medicare Beneficiaries (QMB) held harmless for Medicare cost sharing under applicable CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copays included under Medicare Advantage Plans.

Care providers will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Medicare Advantage member, who is eligible for both Medicare and Medicaid. Nor the said member's representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, coinsurance) when the state is responsible for paying such amounts. Care providers will either (1) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (2) bill the appropriate state source for such cost-sharing amount.

Continuation of Benefits-COBRA

Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances, such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. COBRA generally requires group health plans sponsored by employers with 20 or more employees in the prior year to offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end. Continuation coverage may be available to the member at group premium rates. Coverage benefits and limitations for COBRA members are identical to those of the group.

- UnitedHealthcare West is not responsible for initiating a terminated member's election of continuation coverage.
- Interested members should contact the subscriber's Human Resources office for information on eligibility.
- Members eligible for COBRA may elect to convert to the UnitedHealthcare West individual health plan, where available.
- COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. Detailed outlined COBRA eligibility at the [COBRA website](#).

Coverage begins on the date that coverage would otherwise have been lost because of a qualifying event and will end at the end of the maximum period. It may end earlier if:

- Premiums are not paid on a timely basis;
- The employer ceases to maintain any group health plan;
- After the COBRA election, coverage obtained with another employer-group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if other group health coverage obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election;
- After the COBRA election, a beneficiary becomes entitled to Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election;

Although COBRA specifies certain periods of time, that continued health coverage offering occurs to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Note: In some cases, there may be an extensive period where a continuing member does not appear on the eligibility list. If this occurs, contact your network care provider account manager or provider advocate as applicable, for assistance.

Chapter 9: Laboratory

Laboratory Claim Submission Requirement

Many benefit plan designs exclude from coverage outpatient diagnostic services that not ordered by a network care provider. Benefit plans may also cover diagnostic services differently when a portion of the service (e.g., the draw) occurs in the care provider's office, but analysis performed by a laboratory care provider. In addition, many state laws require that laboratory services ordered by a licensed care provider.

Therefore, all laboratory claims and encounters for laboratory services must include the name of the referring care provider, the NPI number of the referring care provider, and the other elements of a complete claim described in this guide.

Laboratory claims and/or encounters that do not identify the referring care provider processes as though no care provider ordered the service. This may affect the level of benefits and payment associated with the laboratory claim.

This requirement applies to claims and encounters for laboratory services, both anatomic and clinical, received from both participating and non-participating laboratories, unless otherwise provided under applicable law. However, this requirement does not apply to claims for laboratory services provided by care providers in their offices.

Submission of Claims for Services Subject to Medical Claim Review

In some instances, claims could pend for medical claim review under an applicable medical or drug policy. To facilitate claim processing for such services, you are encouraged to include additional information or reports along with your original claim, see [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com).

In-Office Laboratory Tests and Clinical Laboratory Improvement Amendments (CLIA) Waived Tests

Laboratory tests performed in the care provider's office should be limited to those urgently needed for prompt member diagnosis. There is a listing of the codes approved for network care providers to perform in the office setting. The list of approved codes may not include all CLIA waived tests. Prior to performing a test in the office, the Provider must make sure the test is on the approved list.

All other laboratory tests required for treatment or diagnosis referral to a participating or capitated laboratory is necessary. A list of approved codes with a list of participating laboratories found at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) and or [CMS.gov](https://www.cms.gov).

Note: Some plans are capitated for Laboratory services no performance allowed in the care provider's office, with capitated laboratory care provider only utilized for services.

In addition, care provider offices, whom granted a CLIA Certificate of Waiver, may conduct a limited number of tests in-house. Tests that may conduct under a certificate of waiver must meet the descriptive criteria specified at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) and or [CMS.gov](https://www.cms.gov).

Participating Laboratories

It is essential that only medically necessary laboratory studies requested, and we will periodically complete a retrospective analysis regarding the appropriateness and necessity of laboratory services.

The appropriate requisition form must accompany each member referred by a network care provider to a participating laboratory. This form outlines the specific laboratory or pathology tests requested by the care provider. Reference the laboratory's courier/delivery requirements for pick up as appropriate. Our laboratory network care provider includes a combination of regional along with; local laboratory service care providers.

LabCorp is the sole national capitated laboratory services care provider for the HMO benefit plans in several markets including UnitedHealthcare of California, PacifiCare of Colorado and PacifiCare of Arizona, if UnitedHealthcare has financial risk for laboratory services.

If a medical group/IPA has financial risk, it will direct members to its contracted laboratory care provider. However, the medical group/IPA must hold the member harmless from balances billed by their participating laboratory care provider. Any payment disputes are the sole responsible of the medical group/IPA. Failure to hold the member harmless may result in UnitedHealthcare un-delegating the medical group/IPA and participating labs at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com).

Chapter 10: Pharmacy

Pharmacy In-Network

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

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

Mail Service

Each UnitedHealthcare West member with a prescription drug benefit is eligible to use our prescription mail service. When appropriate, prescriptions written for a three-month (90-day) supply and up to three additional refills. Only medications taken for chronic conditions ordered through the mail. Acute prescription needs such as antibiotics and pain medications obtained through a network pharmacy site to avoid delay in treatment.

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

Drug Utilization Review Program

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

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

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

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

Medications Not Covered Under Capitation (Medicare Advantage)

You may be delegated to make decisions to authorize specific pharmacy services in the terms of your agreement. A member or care provider may request authorization

from you for medication carved out of the terms of your agreement. You should notify the member that you are not responsible for the authorization of these services; you may want to recommend the member refer to any Part D coverage they may have.

Prior Authorization Process for Medications Carved Out of Capitation (Commercial)

If UnitedHealthcare has financial responsibility with medications currently covered under the Commercial member's medical benefit, then this policy will apply to those medications listed in your agreement. UnitedHealthcare has a "prior authorization" process in place to provide for review of any medication carved out of capitation (see list of medication(s) below). This authorization process affects medical groups/IPA providing care to UnitedHealthcare West members when UnitedHealthcare has retained financial responsibility for these medications. The administration of these medication(s) reviewed for compliance with the NCCN drug compendium recommended uses for the drug, as it pertains to treatment regimen and/or line of therapy.

Noncompliant services will not be eligible for coverage or payment reimbursement by UnitedHealthcare to the medical group/IPA. Failure of the medical group/IPA to obtain this review and receive prior authorization from UnitedHealthcare West prior to administration of this drug will result in denial of reimbursement for the drug. This policy does not apply to bevacizumab (Avastin) used for non-oncological indications.

Prior Authorization is Necessary in Order for Payment to be processed

The request for prior authorization of a select drug will be made by the care provider medical group (medical group/IPA), or Medical group/IPAs. *Avastin Authorization/Patient Profile Form*. Additionally, forms obtained by contacting your provider advocate, network care provider or clinical contacts at UnitedHealthcare West.

Prior authorization staff will not process the request until all necessary information received from the medical group/IPA. Prior Authorization Staff will communicate with the medical group/IPA regarding whether or not the medication has approval. Once all the necessary information requested received, a determination will be made within the applicable timeframe. No decisions made on requests that are incomplete or require additional information.

The medications that require prior authorization will be authorized in accordance with benefit design, provided the member's benefit restrictions (applied to the requested agent(s)/therapeutic class, and the prior authorization process), are not exceeded.

The Medical group/IPA must provide compelling medical evidence supporting the use of a requested alternative

medication over the select agents where the requested therapeutic class is necessary for medical management.

A written communication of case resolution faxed to the medical group/IPA for each case serviced.

Any denial determinations require a letter sent to both the member and care provider stating the reason why the requested medication denied and outlining the process for filing standard and expedited appeals.

HCPCS Code	Generic Description	Proprietary Drug Name (Drugs May Have Multiple Names)
J9035	Bevacizumab injection	Avastin

Drug Formularies

Commercial Benefit Plans

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

Any prescription for a non-formulary drug is the member’s financial responsibility, unless the member meets the criteria for coverage of a non-formulary drug and the care provider requests and receives prior authorization for such drug.

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

Formulary changes found at; UHCWest.com. Click on the desired formulary. You will then be able to search by drug name or therapeutic class. Any restriction or limitation noted along with formulary alternatives, when applicable.

The formulary updates twice a year, in Jan and July. Care provider requests for formulary review of medications or pre-authorization guidelines are welcome. *Prior authorization guideline changes, request forms, and formulary change request form* obtained by request.

Medicare Advantage Prescription Drug Formulary

UnitedHealthcare West utilizes the United States Pharmacopoeia’s drug classification system in the development of the Formulary for Medicare Advantage.

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

Medicare Advantage Formulary Tier Structure

The Medicare Advantage Prescription Drug Formulary is a list of drugs that are covered as a pharmacy plan benefit for Medicare Advantage members. For non-group plans, medications are categorized into 5 tiers: preferred generics (Tier 1), generics (Tier 2), generics and preferred brands (Tier 3), non-preferred generics and non-preferred brands (Tier 4), and specialty generics and brands (Tier 5). For group plans, several formularies are available. Medications are often categorized into 4 tiers: preferred generics (Tier 1), generics and preferred brands (Tier 2), non-preferred generics and brands (Tier 3), and specialty generics and brands (Tier 4).

For Medicare Advantage Prescription Drug Formulary information, see AARPMedicarePlans.com, UHC Medicare Solutions.com, or UnitedHealthcareOnline.com.

Medicare Advantage Prescription Drug Benefit

UnitedHealthcare offers several prescription drug coverage plans based on the member’s county of residence and the member’s prescription drug needs. The benefit structure follows the CMS model:

- Prescription Drug Deductible—some benefit plans will have a deductible that must be satisfied before the member will have access to the prescription drug benefit. In some plans, this deductible will only apply to specific drug tiers, (e.g., Tier 3, Tier 4 and Tier 5 only).
- Initial coverage limit—During the initial coverage limit the member is responsible for a specific copayment or coinsurance for prescription drugs.
- Coverage gap—While in the coverage gap, the member will pay 40% of the total cost of brand-name drugs and 51% of the total cost of generic drugs in 2017. Depending on the member’s coverage plan, the member may pay even less if the plan offers additional coverage in the coverage gap.
- Catastrophic coverage level—members who reach the catastrophic coverage level will have a significantly lower copayment/coinsurance for prescription drugs, until the end of the year.

Any prescription for a non-formulary or non-covered drug is not covered unless the member or the member’s care provider requests and receives an approved formulary exception through the prior authorization process.

The member will need to pay 100% of the cost of the drug based on the UnitedHealthcare Medicare Advantage contracted rate with the pharmacy. This process does not apply to any excluded medications.

Refer to the exceptions process described below for the criteria for coverage of a non-formulary/or non-covered drug.

Non-Formulary Medications

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

Non-formulary medications coverage possible for the commercial plan member's applicable pharmacy benefits copayment when the member's employer purchases an Open Formulary or Buy-up Plan. Charges may occur to the member the usual and customary cost of the medication or the non-formulary copayment (depending on the member's benefit design).

Prior Authorization/Exceptions Process

UnitedHealthcare West has a prior authorization or exceptions process in place to provide for coverage of select formulary and non-formulary/non-covered medications. UnitedHealthcare West delegates prior authorization services to OptumRx. OptumRx staff will adhere to plan-approved criteria, National Pharmacy and Therapeutics Committee (NPTC) practice guidelines, and other professionally recognized standards in reviewing each case. A decision rendered based on established protocols and guidelines, and cases referred to clinical pharmacists in accordance with standing procedures.

Request for Prior Authorization of Non-Formulary Medications

Request for prior authorization of a non-formulary drug, only made by the care provider or a designated employee or individual under the direction and control of the care provider, who is located in the care provider's office or other site where the member is receiving medical services. Additionally, a member may initiate a prior authorization request as long as the care provider submits a supporting statement. Prior authorization functions may not delegate to a third party who is not located at the care provider's office, or other site where the member is not receiving medical services. Clinical pharmacists working in a utilization management capacity, within a medical group or direct employment by or contracted; with that medical group/IPA may also make requests for non-formulary drugs.

Prescribers or their designated agents may request authorization by:

- Phone: Toll-free number 800-711-4555
- Written request: Fax 800-527-0531 for oral medications and 800- 853-3844 for injectable/specialty medications. Obtain a *Prior Authorization Medication Request Form* at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) after login or through [Optumrx.com](https://www.optumrx.com) for injectable medications.

- [Optumrx.com](https://www.optumrx.com) and log in using your [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com) credentials. After log-in with a unique NPI number and password, a care provider or healthcare professional may securely submit member details, enter a diagnosis, and medical justification for the requested medication, and, in many cases, receive authorization instantly. A care provider may submit information that previously collected by phone or fax. Additional clinical review may be required and typically completed within 72-hours. Care providers and healthcare professionals can use the service to check on the status of a Prior Authorization request, even if it no submission online.

The OptumRx prior authorization staff will not process a request for a non-formulary drug until all necessary information received from the care provider. They will communicate with the care provider or designated employee or other individual under the direction and control of the care provider regarding whether or not, the non-formulary drug coverage. Once all the necessary requested information received, OptumRx will make a coverage determination within the applicable timeframe.

Non-formulary medications or other medications that require prior authorization may be authorized in accordance with benefit design provided the member's benefit restrictions; (applied to both the requested agent(s)/therapeutic class, and the prior authorization process) not exceeded, if the requested medication is being used for an FDA-approved or medically accepted indication, and when one of the following criteria is met:

- Documented failure of or intolerance to a therapeutic trial of alternative formulary agents;
- The Formulary alternative(s) is/are contraindicated for treatment;
- The member experienced an allergic reaction to the formulary alternative (e.g., rash, urticaria, drug fever, anaphylactic type, or established adverse effects as published in the package insert of respective product relating to the pharmacological properties of the medications, formulations or differences in absorption, distribution, or elimination of the medications); or
- No other formulary agent is appropriate to treat the member's condition.

The prescriber must provide compelling medical evidence supporting the use of the requested non-formulary medication over the formulary agents where the requested therapeutic class is necessary for medical management.

The following information is required to evaluate each case prior to issuance of an authorization:

- Member's name
- Member's ID number
- Member's date of birth

- Member's gender
- Prescriber's name
- Prescriber's specialty
- Prescriber's address
- Prescriber's phone/fax number
- Name and dosage strength of the requested medication
- Directions for use
- Diagnosis
- Date member started on the non-formulary medication
- Name of specific drug(s) tried and failed
- Documentation of member chart notes in accordance with the specifications outlined in the NPTC guidelines or, where appropriate, as the community standard of practice.

A written communication of case resolution faxed to the care provider for each case serviced.

Denial determinations require a letter sent to both the member and the prescriber stating the reason(s) why the requested non-formulary medication denied and outlining the process for filing standard and expedited appeals.

Additional Information (Medicare Advantage)

For Medicare Advantage members, OptumRx's prior authorization staff will follow the coverage determination timelines as established by CMS. Standard coverage determination completed within 72 hours.

Expedited coverage determinations completed within 24 hours. OptumRx will communicate with the care provider or designated employee, or other individual under the direction and control of the care provider, and the member regarding, whether or not the non-formulary drug covered or the cost-sharing exception approved.

For Medicare Advantage members, under certain circumstances, members or care providers may request a reduction in the copayment or coinsurance amount for a drug on the Formulary.

For example, for non-group plans, a Tier 4 non-preferred brand drug requested for a Tier 3 copayment/coinsurance.

Criteria for cost share reduction are (a) the member's failure, contraindication, or intolerance to all equivalent formulary drugs in the lower preferred tier(s) (e.g., Tier 1 and Tier 2 and Tier 3); and (b) FDA approval for the condition being treated or treatment is supported by a citation in one of the following compendia:

- AHFS (American Hospital Formulary Service) Drug Information; or
- DRUG DEX Information System from Micromedex

Non-formulary/non-covered products approved through the prior authorization/exceptions process are not eligible for further cost-sharing reductions.

Prescription Drug Prior Authorization Request Form (California Commercial)

When the medical group/IPA assumes financial risk for prescription drug benefits of specific drugs subject to a prior authorization process, California Senate Bill 866 requires the use of the state-developed *Prescription Drug Prior Authorization Request Form*. The medical group/IPAs contracted care providers must use this form to submit prior authorization requests to the medical group/IPA.

The medical group/IPA:

1. Makes the form available to its contracted care providers;
2. Accepts only that form through any reasonable means of transmission;
3. Requires only the minimum amount of material information to make a decision;
4. Two business days of receipt of request, information for approval or disapproval with accurate written explanation of reasoning, for disapproval to prescribing care provider. The disapproval reason may include that the request not submitted on the required form, with a request to resubmit on the required form;
5. Provides notification in the same manner under in which received, or another mutually agreeable method;

The medical group's/IPA's compliance with the above specified prescription drug prior authorization process will be subject to oversight by UnitedHealthcare.

Prescription Drug Appeals Process

Care providers should be aware that members initiate an appeal for coverage of a prescription drug if the initial determination is adverse to the member. An appeal initiated in the following circumstances:

- The requested drug is not on the formulary;
- The drug is not considered medically necessary;
- The drug is furnished by an out-of-network care provider pharmacy;
- The drug is not a drug for which Medicare will pay under Part D;
- A coverage determination is not provided in a timely manner;
- The delay would adversely affect the health of the member;
- A request for an exception is denied; or
- The member is dissatisfied with a decision regarding the copayment required for a prescription drug.

Chapter 11: Capitation Payments and Reporting

Capitation Payments

UnitedHealthcare West makes monthly capitation payments to the medical group/IPAs and capitated facilities as payment for providing and arranging covered services to our members.

Capitation payments delivered via check or electronic funds transfer on the date specified in the participation agreement. If the due date falls on a non-banking day, the capitation payment delivered the next banking day.

Electronic Funds Transfer (EFT)

In order to receive capitation payments via Electronic Funds Transfer (EFT), UnitedHealthcare West requires a signed *EFT Payments form*, detailing the bank account and bank routing information. The EFT initial set-up, or a change in banking information, requires three weeks processing time to take effect.

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

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

The *Authorization Agreement Electronic Funds Transfer (EFT) Payments form* online at [Link](#). Submit completed forms to your provider advocate, as applicable.

Capitation Calculation Methods (Commercial)

Capitation calculation methods detailed, in your participation agreement. For commercial products, there are four capitation calculation methods:

- Flat rate—A flat rate PMPM;
- Fixed rate age/gender adjusted—A flat rate adjusted by age and gender PMPM;
- Fixed rate age/gender/benefit adjusted—A flat rate adjusted by age, gender, and benefit factor PMPM;
- Fixed rate age/gender/copayment adjusted—A flat rate adjusted by age, gender, and copayment adjustment PMPM.

Flat Rate Calculation

Flat rate capitation calculated by applying the flat rate for each member to yield the standard services capitation amount. The flat rate detailed in the participation agreement. Each member level transaction reported on both the flat file and image reports.

Fixed Rate Age/Gender Adjusted Calculation

Fixed rate age/gender adjusted capitation uses age/gender factors to modify the flat base rate up or down in order to

align “standard services capitation” with age-weighted risk. The flat base rate multiplied by the age/gender factor yields the standard services capitation amount.

Age/gender factors work to weight for age/gender risk consideration with respect to the demographic population. UnitedHealthcare West actuarially develops age / gender factors. The age/gender factors may vary between medical groups/IPAs and are included in the participation agreement.

The age/gender factors and standard services capitation amount reported at the member level on the flat file. Only the standard services capitation amount reported on the image reports.

Fixed Rate Age/Gender/Benefit Adjusted Calculation

Fixed rate age/gender/benefit adjusted capitation contains three components: (1) flat base rate; (2) age/gender factor; and (3) benefit factor.

- Flat base rate detailed in the participation agreement;
- Age/gender factors work to weight for age/gender risk consideration with respect to the demographic population;
- UnitedHealthcare West actuarially develops age/gender factors. The age/gender factors may vary between medical groups/IPAs and are included in the participation agreement;
- Copayment adjustment works to evaluate the member’s copayment made directly to the care provider;
- UnitedHealthcare West actuarially derives copayment adjustment for each copayment level.

The copayment adjustment added to or subtracted from the flat base rate. The sum of flat base rate +/- copayment adjustment multiplied by, the age/gender factor to yield the standard services capitation amount.

The flat base rate, age/gender factor, copayment adjustment and standard services capitation amounts reported at the member level on the flat file. Only the standard services capitation amount reported on the image reports.

Commercial Capitation Contracts with Multiple Rates

The capitation source system has the capability to administer a single Commercial contract with multiple rates, if the contract requires a different rate for members enrolled in a specific plan or in-network. Contracts identified by the Primary Care Provider Network Indicator, or PC PNI. The four capitation calculation methods described above under [Capitation Calculation Methods](#) section apply. This will allow the care provider to manage

their capitation under one medical group/IPA number and is only available for a Commercial contract plan type.

Capitation transactions reported at both summary and detailed levels. All individual transactions summarized by PNI code and reported on several capitations image reports. Additionally, detailed care provider PNI transactions reported on both the flat file (CP7810, column U, field 21) and image reports (CP7210, CP7230). Member PNI reported on the flat file (CP7810, column AP, field 42).

Compliance with CMS (Medicare Advantage)

UnitedHealthcare has contracts with CMS, which authorizes us to arrange for comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in a UnitedHealthcare Medicare Advantage plan.

As a Medicare Advantage plan, UnitedHealthcare and its network care providers agree to meet all laws and regulations applicable to recipients of federal funds. The medical group/IPA and capitated facility acknowledge that they will be required to comply with certain laws applicable to entities and individuals receiving federal funds.

CMS Premium (Medicare Advantage)

The Medicare Modernization Act payment methodology for Medicare Advantage organizations such as UnitedHealthcare, defines a competitive bid process. CMS will compare the bid from each organization against the CMS benchmark and modify the payment made to Medicare Advantage organizations accordingly.

The CMS premium received by UnitedHealthcare based on several member-specific variables, including:

- Age
- Gender
- State and County Code
- Plan benefits package selection and benefit configuration
- Health status
- The Medicare Advantage plan's competitive bid
- The Medicare Advantage plan's member premium
- Risk-adjusted factors based on the member's Hierarchical Condition Category (HCC), based on inpatient and outpatient encounter data.

UnitedHealthcare West uses the premium reported on the Monthly Membership Report (MMR) from CMS as the first step in development of the premium that used for the percent of premium calculation.

The algorithm, methodology-blend percentage and rates/factors posted on the [CMS website](#) for all periods.

Unpaid CMS Premiums

If we do not receive payment from CMS for a particular member, and any care provider in the member's service network, care provider receives percent of premium or Risk

Adjusted Fixed Rate capitation, we do not pay standard services capitation for that member.

A member's service network, care provider could be comprised of the following service care providers:

- Medical group/IPA with which the member's assigned PCP is affiliated;
- Capitated facility, in a partial risk arrangement, affiliated with the member's medical group/IPA;
- Sub-capitated care provider that is affiliated with the member's assigned medical group/IPA;
- Capitated third party care provider that provides services for members assigned to the medical group/IPA. As an example in this scenario, we did not receive the current month premium from CMS, and the member's service network care provider consists of:
 - › Medical group/IPA—paid Flat Rate capitation;
 - › Capitated facility—paid percent of premium capitation; or
 - › Third party service care provider to administer vision benefits paid flat rate capitation.

As a result, the medical group/IPA, capitated facility and third party service care provider will not receive current month capitation for that member.

In order to aid the medical group/IPA in tracking the unpaid capitation:

- The member is listed on the capitation report with a zero dollar (\$0) capitation amount;
- The capitation flat file identifies the affected members, record type 1 R, with the field name CMS_Premium_Indicator, value = N.

Typically, unpaid CMS premiums occur in the 1st month of eligibility and the payment is usually received within 60 calendar days. UnitedHealthcare West processes the "late" premium by reversing the zero dollar (\$0) transaction, and recalculating the member month.

If the medical group/IPA has unpaid premiums, it must continue to arrange for the member's medical care and pay for services accordingly. If CMS does not retroactively pay the premium within 120 calendar days, the medical group/IPA should notify its provider advocate with the specific information for that member so that the nonpayment can be pursued with CMS.

Out-of-Area Premium

UnitedHealthcare receives premium from CMS based, in part, on the member's State and County Code (SCC) as reported by CMS. We use the premium reported by CMS as a basis for percent of premium capitation.

CMS may report a member in a different state than the state the member's assigned medical group/IPA is located. As an example, CMS may report a member's SCC as

Washington, yet the member's assigned medical group/IPA is in Oregon.

Once the SCC updates via the CMS system, CMS will pay the correct SCC going forward. Typically, CMS does not retroactively adjust premium for changes in SCC.

End Stage Renal Disease (ESRD) Premium

ESRD premiums paid using a Risk-Adjusted model. The model provides a 3-tier approach: (1) Dialysis status; (2) Receiving a transplant; and (3) Functioning graft status.

CMS communicates these tiers using the member's Risk-Adjusted Factor Type Code.

In addition to the ESRD flag, the flat file will report the member-level Risk-Adjusted Factor Type code to aid the medical group/IPA with identifying their ESRD membership. The risk-adjusted factor type code not reported on the image reports. Additional information on the Risk-Adjusted ESRD model, go to [CMS website](#).

Working Aged Premium Adjustment

The working aged adjustment reflected as a member specific adjustment in the premium payment to UnitedHealthcare from CMS. The working aged adjustment calculated based on a yearly Medicare Secondary Payor (MSP) factor determined by CMS. The working aged adjustment reported at the member level on the flat file (1 R record type for adjustments within the six-month retro window and the 3M record type for adjustments beyond the six-month retro window). Specifics on the CMS Working Aged Program found on the [CMS website](#).

CMS User Fee Premium Adjustment

CMS deducts a user fee from all Medicare Advantage plans to fund various education programs for persons eligible for Medicare. The user fee adjustment reflected as a non-member specific adjustment by CMS in its payment to UnitedHealthcare. The user fee adjustment allocated to every member. The user-fee rate modifications may occur by CMS on a monthly basis. However, typically the percentage changes three times per year. The user fee adjustment reported at the member level on the flat file, 1 R record type, with the field name CMS_User_Fee.

Sequestration Premium Adjustment

As a result of the CMS announced sequestration reductions to Medicare payments to care providers, facilities and other healthcare professionals, UnitedHealthcare implemented reductions to care provider, facility, ancillary care provider and other healthcare professional payments from its Medicare Advantage Plans, including Medicare Advantage Dual Special Needs Plans (Dual SNP). Specifically, UnitedHealthcare's Medicare Advantage plans began reducing care provider capitation payments for Medicare Advantage membership by 2% beginning in April, 2013. The 2% sequestration reduction is reported at the member level

on the flat file, 1 R record type, with the field name called the MSBP.

Capitation Calculation Methods (Medicare Advantage)

For Medicare Advantage products, there are three capitation calculation methods:

1. Flat rate—a rate is paid PMPM.
2. Percent of premium—The percent of CMS premium calculation begins with the premium identified from the MMR, less any premium adjustments, and multiplied by the contracted percentage.
3. Risk adjusted fixed rate—Risk adjusted fixed rate capitation calculated using the base rate detailed in the participation agreement, multiplied by various factors.

Flat Rate Capitation

Flat rate capitation calculated by applying the flat rate for each member to yield the standard services capitation amount. The flat rate detailed in the participation agreement.

Each member level transaction reported on both the flat file and image reports.

Percent of CMS Premium Capitation

The percent of CMS premium calculation begins with the premium identified from the MMR:

- The CMS premium adjusted for any premium adjustments;
- The user fee amount then deducted to create the premium net of premium adjustments, and user fee; or,
- The contracted percentage amount;

The CMS premium, net of all adjustments described above, reported at the member level on the flat file, 1 R record type, with the field name Cap_Premium_Gross_Cap.

Medical groups/IPAs and capitated facilities with a percentage of premium contract will receive their contracted percentage rate of this cap premium gross cap amount as the standard services capitation amount for each member.

Standard services capitation reported at the member level on the flat file, 1 R record type, by summing the fields Group_Capitation_Amt plus Facility_Capitation_Amt. Standard services capitation amount also reported at the member level on the image reports.

Risk-Adjusted Fixed Rate Capitation

Risk-adjusted fixed rate capitation contains three components:

1. Base rate—is detailed in the participation agreement
2. Risk Adjusted Factor (RAF)—score for each Medicare Advantage Plan member taken directly from the Monthly

Membership Report (MMR) provided by CMS. This factor reported on the flat file and image reports.

3. Health status variables- the base rate adjusted for members categorized as ESRD or Hospice by CMS on the MMR report. For details on the ESRD and Hospice adjustments, please see your participation agreement.

The risk-adjusted fixed rate capitation amount will vary monthly resulting in changes in the risk adjustment factor and demographic factors for Medicare Advantage Plan members for the applicable month. Each member level transaction reported on both the flat file and image reports. The retro window for risk-adjusted fixed rate capitation is the standard six-month system retro window. Payments made by CMS, outside the six-month retroactivity window are not included with this calculation methodology.

Sample Member Capitation Assessment

As detailed in the Percent of *CMS Premium Capitation* section above, the “cap premium gross cap” amount reported in the capitation reports. A medical group/IPA and/or capitated facility with a percent of premium contract requesting a, sample member capitation assessment. For Medicare Advantage plans, the review will reflect the premium received from CMS and the transactions detailed in the preceding CMS premium sections to calculate the standard services capitation payment.

A request for, sample member capitation assessment is limited to one request per contract year. Additionally, Medicare Advantage Plan requests are limited to one review month only within the last 12-month period. Each request is limited to not more than six members.

A medical group/IPA or capitated facility may request one member capitation assessment, covering one month within the last 12-month period, and not more than six members, per contract year.

Confidentiality

Sample member capitation review results include confidential and proprietary information. The medical group/IPA or capitated facility must sign a confidentiality agreement prior to the presentation of the sample, member capitation assessment. The confidentiality agreement indicates that all assessment results, not removed from the premises. UnitedHealthcare will present this information only in one of its offices.

Capitation Reconciliation

UnitedHealthcare West produces capitation using two separate systems:

- Core transaction processing system—Information from this system reflected in the capitation flat file and on the image reports. The summary reports, CP7030 or CP7010, foot to the payment summary.

- Payment system—Information from this system reflects the sum of the core transaction system, system transaction plus any non-system guide adjustments.

We provide a capitation payment summary to each medical/IPA care provider group to allow the medical group to reconcile the monthly capitation payment. The payment amount is the sum of (1) the amount from the core transaction processing system, plus (2) any non-system adjustments.

Non-system Guide Adjustments

Non-system guide adjustments and corresponding back-up documentation at UnitedHealthcareOnline.com. Each non-system guide adjustment reported as a separate line item on the payment summary.

In order to force non-system guide adjustments through the system, the adjustment typically reversed in the next processing-period processed as a system adjustment and reported on the flat file and image reports.

Provider Remittance Advice (PRA)

The invoice number on the PRA is an indication of the source system from which the transaction originated. Each transaction originated from either the (1) core transaction processing system (NICE) or (2) payment system as a non-system guide adjustment (ORACLE). Each of the source systems follows an invoice numbering convention as follows:

- Core transaction: YMMPPNNNNSSDD (Example: 1701CO 00013301). This amount will foot to the CP7030 or CP701 0 [image reports]:
 - › YY—last two [four] digits of the year (06)[(2006)]
 - › MM—month (06) PP—product type (CO) Commercial [(SH) Medicare]
 - › NNNN—computer generated sequential number (0001)
 - › SS—UnitedHealthcare State code (33)
 - › DD—UnitedHealthcare division code (01)
- Non-system guide adjustment: YYM M PPAAACTN N N N N N I IOSSDD (Example: 0606COALG 1101 [SHQMB] 2345JSC [ZZC] 3301). This amount will not be included in the Capitation Reporting:
 - › YY—last two digits of the year (06) MM—month (06)
 - › PP—product type (CO) Commercial [(SH) Medicare]
 - › AAA—adjustment code (Example MBR would be for a member adjustment.)
 - › C—transaction count (1)
 - › T—contract type (1) values include; 1-Primary Care, 2-Facility, 3-Subcap, 4-Third Party
 - › NNNNNN—care provider number (01 2345)
 - › II—internal document tracker (JS) [(ZZ)]

- › – ORACLE system indicator (C)
- › SS—UnitedHealthcare State code (33)
- › DD—UnitedHealthcare division code (01)

Capitation Adjustment Codes

Capitation adjustments used in a variety of circumstances. Each adjustment consists of a three-character Capitation Adjustment Code. Each adjustment code has a corresponding description. The adjustment code used to administer a specific system-generated payment or carve-out in accordance with the participation agreement. A code also used for a non-system adjustment.

The flat file contains only the capitation adjustment code. However, the CP7020 image report contains both the capitation adjustment code and corresponding description.

UnitedHealthcare will provide medical groups/IPAs with documentation, as specified in this guide, in support of each Capitation Payment.

Hierarchical Condition Category (HCC) and Capitation Reporting

CMS payments based on the Hierarchical Condition Category; (HCC) Reporting. This payment methodology requires Medicare Advantage health plans to submit accurate diagnosis information, at the greatest level of specificity available.

CMS HCC Risk Adjustment

UnitedHealthcare administers an alternate method of collecting CMS Risk Adjustment data in addition to its normal collection process. All encounter submissions required to process in a HIPAA 5010 compliant 837 Claim/Encounter format. To supplement a previously submitted 837 Claim/Encounter, you may submit an 837 replacement Claim/Encounter or send additional diagnosis data related to the previously submitted 837 through the Optum ASM Operations FTP process. If you choose to submit via ASM, you will first need to contact the Optum ASM Operations team at cas_ops@ingenix.com to start the onboarding process.

Capitation Reporting

The reports mentioned throughout this section are available online and provide detailed information regarding each care provider's capitation payments. The types of reports available include:

- Flat file—Contains approximately 198 data elements in CSV (Comma Separated Value) format;
- Image reports—In Standard PDF format and are at both the member and summary levels;
- Supplemental care provider reports—Details any non-standard deductions from capitation (i.e., claims that

are the financial risk of the care provider and paid by UnitedHealthcare West);

Reports are available at UHCWest.com, on the date specified in the participation agreement. If the due date falls on a non-business day, the reports will be available on the next business day.

Accessing Capitation Reports Online

Capitation reports are available at UHCWest.com.

- **Reports**—this option allows you to view image reports in a PDF format (Adobe Acrobat is required) or download the file.
- **Data Files**—this option allows you to download the flat file(s) from a zipped file format.
- **All**—this option contains both the image reports and flat file(s) in one zipped file for downloading.

Claims Withhold Reports and Data Files

Supplemental care provider Reports for Claims Withhold are available online. These reports have two capitation reporting options described below: reports and data files.

- Claims Withhold Reports
- Claims Withhold Data Files

Medical Drug Benefit Reports and Data Files

Medical Drug Benefit reports are available online.

- Medical Drug Benefit Reports
- Medical Drug Benefit Data Files

Note: The “Claims Withhold” and “Medical Drug Benefits” reports dated 1 month behind the current Capitation Report month. For example, all claims on the Claims Withhold and Medical Drug Benefit reports that paid in April will process in the May capitation. In order for the care provider to reconcile May capitation, the care provider will need to view the April Claims Withhold and April Medical Drug Benefits Reports.

- Shared Risk Claims Data Files

Note: The “Shared Risk Claims” Report dated one month behind the current Capitation Report month. For example, all Shared Risk claims paid in May will process in the Jun capitation.

Capitation reports maintained online, or the current month and the prior month, with previous reports purging from the UHC West website before the new reports posted.

We recommended that you complete your capitation download in a timely manner to make sure that you have complete and accurate capitation information.

Chapter 12: Contractual and Financial Responsibilities

Contractual/Financial Responsibility Changes during Inpatient Admissions

An inpatient admission includes:

- Inpatient acute care;
- Skilled Nursing Facility (SNF);
- Detoxification;
- Medical rehabilitation; and
- All related services.

Partial Risk to Shared Risk

If a member's assigned care provider is partial risk at the time of admission and then changes to shared risk prior to the member's discharge all claims related to this confinement from admission through discharge will be processed according to the partial risk DOFR in effect at the time of the admission.

Shared Risk to Partial Risk

If a member has assigned care provider is shared risk at the time of admission and then changes to partial risk prior to the member's discharge all claims related to this confinement from admission through discharge processed according to the shared risk DOFR in effect at the time of the admission.

Level of Care Documentation and Claims Payment

Claims processed according to the authorized level of care documented in the authorization record. All claims reviewed to determine if the billed level of care matches the authorized level of care.

If the billed level of care is at a higher level than the authorized level of care, UnitedHealthcare West will pay only the authorized level of care and the care provider may not bill the member for any charges relating to the higher level of care. If the billed level of care is at a lower level than authorized, we will pay the care provider based on the lower level of care, determined by care provider to be the appropriate level of care for the member.

Level of Specificity—Use of Codes

In order to track the specific level of care and services provided to its members, UnitedHealthcare West requires care providers to utilize the most current service codes (i.e., ICD-10-CM, UB and CPT codes). We also require that the care provider make sure the documented bill type is appropriate for the type of service provided.

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

Facility-Based Outpatient Surgery services are defined using CMS Guidelines, CPT/HCPCS coding conventions, as well as clinical and/or proprietary standards.

The following denotes services considered Facility-Based Outpatient Surgery services under this definition:

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

Additionally, all Facility-Based Outpatient Surgery CPT/HCPCS codes (as defined in the UnitedHealthcare West Surgical Code Listing) that are billed with a surgery revenue code listed below will be considered Facility-Based Outpatient Surgery and will follow the reimbursement and financial risk rules for the contract and/or care provider.

- Surgery Revenue Codes,
- Operating Room codes (UB 360-369, 490-499),
- Lab pathology (UB 310-319),
- Radiology (UB 320 when billed with CPTs 19101, 19102, and 19103,
- Cardiology (UB 480-489),
- Clinic charges (UB 500-529),
- Labor and delivery (UB 720-729),
- Gastrointestinal services (UB 750-759),
- Treatment or Observation services (UB 760-769),
- Lithotripsy (UB 790-799),
- Acquisition of body components (UB 810-819),
- Other diagnostic services (UB 920-929), and
- Other therapeutic services (UB 940-949);

Facility-Based Outpatient Surgery services do not include the following:

- Any code that is not in the surgery range (10000—69999) will not be classified as Facility-Based Outpatient Surgery, unless it falls under any of the notations specified above;
- Minor skin, casting, needle biopsies, catheter placement, nerve injection, non-invasive studies, transfusions and blood product exchange, and other minor procedures;
- Procedures historically designated by Medicare as office only procedures under the ASC system as of 2007;
- Biopsies of the skin, puncture of lesions, removals of skin lesions and all fine needle biopsies are not Facility-Based Outpatient Surgery;
- Emergency room codes (UB 450-459) without a clinic or operating room charge, and billed with surgical CPT codes, are not Facility-Based Outpatient Surgery;

- Transfusion and blood product exchange;
- Injections into joints, cysts or peripheral nerves that is minor and usually performed in the care provider's office;
- Any code in the 70000 series that is not billed with a designated surgical procedure is not Facility-Based Outpatient Surgery; and
- Anesthesia services in the series 00100-01999 not considered Facility-Based Outpatient Surgery.

Member Financial Responsibility

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

Commercial or Medicare Advantage Copayment guideline grids located at UHCWest.com.

Coinsurance Calculation (Medicare Advantage)

For all Medicare Advantage products, coinsurance calculated as follows:

1. For services reimbursed via a service-specific contracted rate, or on a fee-for-service basis: Coinsurance based on the contracted rate or billed amount, whichever is less or as agreed upon in the care provider contract.
2. For services reimbursed under a downstream capitation agreement between your organization and a care provider of the service, and where payment is not issued for each specific service rendered: Coinsurance is based on the Medicare Allowable Rate for the location at which the service is rendered.

This coinsurance calculation is consistent with the definition of coinsurance as an amount a member may be required to pay as share of the cost for services or prescription drugs. The methodology is used for all UnitedHealthcare Medicare Advantage plans nationwide. The correct system setup and consistent coinsurance calculation will help reduce member appeals and complaints.

Collection of Fees

Unless the member's benefit plan or applicable law dictates otherwise, in the following instances, a medical group/IPA may collect a fee, in addition to the office visit copayment, for completion of specific forms the member needs for other than medical reasons:

- *DMV forms;*
- *Camp or school forms;*
- *Employment or insurance forms;*

- *Adoption form;*

The medical group/IPA/care providers may not collect an additional fee, copayment, or surcharge in the following instances:

- Completion of *Prior Authorization form for non-formulary drugs;*
- Completion of *disability forms;*
- Missed appointments/no shows or late cancellations;
- Member cannot pay office visit copayment at the time of visit, for basic healthcare services. (In this instance, the medical group/IPA may reschedule the member's appointment. If the member requires urgently needed care or emergency care, the medical group/IPA must render care).

Copayments collection when professional services rendered. As a point of clarification, professional services include, but are not limited to, the following examples:

- Services rendered by a licensed medical doctor or doctor of osteopath as defined by the state;
- Services rendered by a care provider's assistant; or
- Services rendered by a nurse practitioner.

Non-collection of copayments when there is no office visit generated or charged. For example:

- Injections administered by a nurse or medical assistant without an office visit; or
- Routine immunizations administered by a nurse or medical assistant without an office visit.

Annual Copayment/Deductible Maximum (Commercial)

Annual out-of-pocket maximum is the combined total of annual deductible (if any) and Annual Copayment Maximum (if any), as shown on the member's Schedule of Benefits. Cost sharing for certain types of Covered Services may not apply toward the annual out-of-pocket maximum. Please refer to the member's Schedule of Benefits to determine applicability to the benefit plan. When an individual member's out-of-pocket expenses has reached the Individual

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

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

No coverage for certain covered services until the member meets the annual deductible. Only amounts incurred for covered services that are subject to the deductible will count toward the deductible. Benefit plans may have an individual deductible only or both individual and family deductible amounts. No further deductible will be required for the individual member when the individual deductible amount has been satisfied for the year. For plans with both individual and family deductibles, no further deductible will be required for all members of the family unit when members of the family unit satisfy the family deductible for the year.

As specified above, only certain covered services apply to the annual deductible. Other covered services not included in the annual deductible may incur a member cost share considered separate from and not applied to the annual deductible. The annual deductible applies to the annual out-of-pocket maximum. The amounts applied to the annual deductible based upon UnitedHealthcare's contracted rates, percentage copayments (coinsurance) and contracted rates.

Annual Out-of-Pocket Maximum (Medicare Advantage)

Annual out-of-pocket maximum is the total of the member's annual copayment maximum (if any), as shown on the member's Evidence of Coverage.

Cost sharing for certain types of covered services may not apply toward the annual out-of-pocket maximum. Please refer to the member's Evidence of Coverage to determine applicability to the benefit plan. When an individual member's out-of-pocket expenses has reached the Individual annual out-of-pocket maximum, no further cost share amounts will be due by the member for those services that apply to the annual out-of-pocket maximum. Plans with benefits that do not apply to the annual out-of-pocket maximum will still require cost sharing for those excluded benefits after the annual out-of-pocket maximum reached.

Cost share defined as amounts paid by the member such as copayments, coinsurance and deductibles according to their Plan Benefits.

Member Out-of-Pocket/Deductible Maximum

UnitedHealthcare is required to monitor and track each member's annual individual out-of-pocket/deductible maximum amount. The member's annual individual out-of-pocket/deductible maximum accumulation calculated through member's cost share data collected from all or some of the following sources:

- Medical group/IPA/capitated hospital encounters.
- Prescription related encounters.
- Behavioral Health-related encounters.

- Claims processed by UnitedHealthcare or its delegates.

UnitedHealthcare and its capitated care providers share responsibility in monitoring the member's individual out-of-pocket/ deductible maximum. For additional information on the reporting available from UnitedHealthcare, see the member Cost Share section of this guide. When a member meets their annual individual out-of-pocket/deductible maximum, UnitedHealthcare will validate the reported cost share information and notify the member and their capitated care provider in writing that the member has met their annual individual out-of-pocket/deductible maximum.

If the member exceeds their annual individual out-of-pocket/deductible maximum due to the capitated care provider collecting member cost share amounts after the member has met their annual individual out-of-pocket/deductible maximum, the capitated care provider will be required to refund any cost share amounts collected in excess of the members' annual individual out-of-pocket/deductible maximum amounts to the member. Additionally, the capitated care provider asked by UnitedHealthcare to verify that the member has received all appropriate reimbursements.

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

If necessary, UnitedHealthcare will work with the capitated care provider to help ensure that each member reimbursed for any amounts collected in excess of the member's annual individual out-of-pocket/deductible maximum amounts as specified in the member's benefit plan.

In the event the capitated care provider fails to reimburse a member for amounts collected in excess of the member's annual individual out-of-pocket/deductible maximum, UnitedHealthcare may reimburse the member directly and recover the payment via capitation deduction as specified in your participation agreement.

No Balance Billing

No UnitedHealthcare West plan member shall be subject to balance billing by a care provider. Care providers may not look to UnitedHealthcare West members for payment and for covered services beyond the member's copayment, coinsurance, deductible, and non-covered services specifically agreed upon in writing by the member prior to the delivery of the service. In addition, care providers shall not bill a UnitedHealthcare West member for missed office visit appointments. Furthermore, for a member who is eligible for both Medicare and Medicaid, care providers may not look to the member, his or her representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, coinsurance) when the state is responsible for paying such amounts. The care provider or health care professional 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.

Services Provided to Ineligible Insured

In the event that UnitedHealthcare West provides eligibility confirmation that indicates that a member is eligible at the time the health care services provided and it is later determined that the member was not in fact eligible,

UnitedHealthcare West will not be responsible for payment of services provided to the member, except as otherwise required by state and/or federal law. In such event, the care provider is entitled to collect the payment directly from the member (to the extent permitted by law) or from any other source of payment.

Claims Status Follow-Up

If a care provider submits a claim within timely filing guidelines, the care provider should receive an Explanation of Payment (EOP) within the timeframes in accordance with state and federal law. However, if the care provider has not received, or wants to check prior to receipt, they may follow-up on the status of a claim using one of the following methods:

- The [Link](#) website provides real-time data and is the quickest method for retrieving claim status information.
- Care providers may also submit an Electronic Transaction (HIPAA 276/277). Please contact your EDI clearinghouse for additional information.
- Enterprise Voice Portal provides access to claim status information by calling the toll-free number found on the back of the member's health care ID card, and simply following the prompt instructions over the phone. This system provides a fax of claim status, detail information available.

Medical Bill Review

We reserve the right to review claims for appropriateness in accordance with nationally accepted coding practices and adjust payment and reimbursement to the care provider at the revised allowable. The care provider shall cooperate with our assessments of claims and payments by providing access to requested claims information, all supporting documentation and other related data.

Medical Claim Review (Delegated Medical Group/IPAs)

A delegated medical group/IPA must implement and maintain a post-service/retrospective review process that is consistent with processes utilized by UnitedHealthcare West.

Post-service/retrospective/medical claim review defined as the review of medical care treatments, medical documentation and billing after the service provided. Medical Claim Review performed to provide fair and

consistent means, to review medical claims to confirm the following criteria met;

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

Medical Claim Review performed on claims that do not easily allow for additional focused or ad-hoc reviews, such as:

- High dollar claims;
- Claims without required authorization;
- Claims for unlisted procedures;
- Trauma claims;
- Implants that are not identified on our Implant guidelines used by our Claim department;
- Claim check or modifier edits based on our claim payment software;
- Foreign claims;
- Claims with level of service (LOS) or level of care (LOC) mismatch;

The delegated medical group/IPA is accountable for conducting the post-service review of emergency department claims and unauthorized claims. A care provider shall review presenting symptoms, as well as the discharge diagnosis, for emergency services. Consideration of emergency department claims must include:

- Coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed;
- Coverage of emergency services if an authorized representative, acting for the organization, has authorized the provision of emergency service;
- Appropriate care provider review of presenting symptoms, as well as the discharge diagnosis;
- Medical group/IPA shall monitor appeals and overturn rates for emergency department claims and develop and execute improvement action plans when deficient performance or processes are identified;

Chapter 13: Member Rights and Responsibilities

Member Rights and Responsibilities (Commercial)

Our members have certain rights and responsibilities, all intended to uphold the quality of care and services they receive from you. These rights and responsibilities outlined in the member materials for Commercial and Medicare Advantage benefit plans on: UHCWest.com.

Member Rights and Responsibilities (Medicare Advantage)

Our members have the following rights and responsibilities, all of which intentions are to help uphold the quality of care and services. Please feel free to distribute this statement to our members.

Medicare Members Have the Right:

- To receive information about the organization, its services, its care providers and member rights and responsibilities;
- To be treated with respect and recognition of their dignity and right to privacy;
- To participate with care providers in making decisions about their health care;
- To a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage;
- To voice a complaint or appeal about the organization or the care it provides;
- To make recommendations regarding the organization's member rights and responsibilities policy;
- To receive assistance in a prompt, courteous, responsible and culturally competent manner;
- To choose a contracted Primary care provider, when applicable, without interference;
- To refuse treatment, including any experimental treatment, and be advised of probable consequences of their decision;
- To initiate a grievance procedure if they are not satisfied with your Medicare Advantage Health Plan's decision regarding their complaint;
- To receive timely access to the records and information that pertains to them.
- To have an Advance Directive to designate the kind of care they wish to receive should they become unable to express their wishes;
- To have your care provider or other health care professional request your consent for all treatment unless

there is an emergency, and you are unable to sign a consent form and your health is in serious danger.

Medicare Members Have the Responsibility:

- To know their benefits prior to receiving treatment;
- To show their member health care ID card before receiving services and to protect against the wrongful use of their identity for health care services ID card by another person;
- To keep scheduled appointments and pay any necessary copayments/coinsurance at the time they receive treatment;
- To express your opinions, concerns and complaints to us;
- To supply information (to the extent possible) that the organization and its care providers need in order to provide their care;
- To follow plans and instructions for care that they have agreed to with their care providers;
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;

Inform Members of Advance Directives

The Federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, care providers including facilities, skilled nursing facilities, hospices, home health agencies and others must provide written information to members on state law about advance treatment directives, about members' rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform members of state laws on advance directives through our member's benefit material. We encourage these discussions with our members.

Chapter 14: Credentialing

Credentialing/Profile Reporting Requirements

Credentialing Program

UnitedHealthcare (also referred to as Credentialing Entity) has a comprehensive, written credentialing program, outlined in the Credentialing and Recredentialing Plan. This established credentialing program in accordance with the standards of the NCQA and applicable state and federal regulatory requirements, is reviewed and revised at least every two years.

Contracted organizations delegated to perform credentialing activities are required to meet UnitedHealthcare West's standards as outlined in this guide and the delegation agreement.

Non-Discrimination

Credentialing and recredentialing decisions are not based on a care provider's or other health care professional's race, ethnic/ national identity, gender, age, sexual orientation or the types of procedures or members in which the care provider or other health care professional specializes. This does not preclude the Credentialing Entity from including in its network care providers who meet certain demographic or specialty needs such as but not limited to cultural needs of its covered persons.

Network Care Providers and Business Needs

The network care providers and other business needs considered, along with the care provider's professional credentials and qualifications, in making decisions whether to approve or deny the application or reapplication of the care provider to provide health care services to Commercial and/or Medicare Advantage members.

UnitedHealthcare West's Discretion

The credentialing criteria, standards and requirements set forth in this guide not intended to limit UnitedHealthcare West's discretion in any way or to create rights on the part of care providers who seek to provide health care services to UnitedHealthcare West members. The Credentialing Entity retains the right to approve, suspend and terminate individual care providers and sites in situations where it has delegated credentialing decision-making.

Confidentiality

Our staff treats information obtained in the credentialing process as confidential. Credentialing Entity will therefore maintain mechanisms appropriately limit review of confidential credentialing information. Credentialing Entity will also contractually require Delegated Entities to maintain the confidentiality of credentialing information. Credentialing staff or representatives must not disclose confidential care provider credentialing and recredentialing information to any persons or entity except with the express

written permission of the care provider or as otherwise permitted or required by law.

Care Provider Rights Related to the Credentialing Process

Care providers applying for participation in the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application with the exception of peer review protected materials;
- To correct erroneous information the Credentialing Entity will notify applicant in writing, via fax or email of identification of any information that varies substantially from the information provided by the applicant. At the time of notification, the applicant advised where and within what period the applicant must respond. Applicants must submit any corrections in writing as directed by the Credentialing Entity within 3-30 days of the applicant's notification of the discrepancy, pending where the file is in process.
- To be informed of the status of your credentialing or recredentialing application, upon request. You can check on the status of your application by calling the Enterprise Voice Portal at 877- 842-3210, say or enter their TIN, and then say, as prompted, other professional services—credentialing—medical and lastly get status.
- While current board certification is not a requirement for network care provider's participation, it is a requirement for designation in the UnitedHealth Premium designation program. Providing updated board certification is part of the credentialing application at UnitedHealthcareOnline.com.

Right to See Members

Approved is not synonymous with "Active." care providers may not begin seeing UnitedHealthcare West members until the care provider has received written notification from UnitedHealthcare that the applicable contract has been activated.

Right to Reapply

Care providers who have been denied initial credentialing or have had participation terminated (for reasons other than network care providers need) may reapply under current criteria, no sooner than 24 months from the date of the denial. Credentialing Entity reserves the right to review the applicant against all credentialing criteria applicable at the time of the reapplication.

Initial Credentialing Process

Completing Application Form

Applicants must contact the Enterprise Voice Portal at 877-842-3210. Once the applicant has contacted the Enterprise Voice Portal line and entered the applicant's Tax ID number, they should select the following prompts: healthcare professional services, credentialing, join the network. After entering the last prompt, the system provides the applicant the information required for the credentialing process. The applicant's call transferred to a credentialing member service representative.

The credentialing member service representative will obtain demographic and identifying information from the applicant at that time to set up a record and assign a Council for Affordable and Quality Healthcare (CAQH), care provider identification number, if the applicant does not already have one. The applicant supplied with a fax that includes; CAQH care provider identification number along with instructions on how to complete an application via CAQH.

Applications should be completed online for faster processing, but CAQH will also accept paper applications if submitted appropriately. The applicant must contact CAQH directly about receiving and completing a paper application. The applicant must submit a completed signed and dated *Credentialing Application Form* ("application"), including an Attestation and Release. The applicant must provide all information requested on the application, documentation or any other requested information.

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

Network care providers and other health care professionals are responsible to verify licensure and other credentials, as applicable, of their clinical support staff.

Credentialing Criteria

Each licensed independent practitioner (LIP) must meet the following credentialing criteria, which needs verification:

- Having the requisite medical or professional education and training to practice within the scope of the care provider's license, including residency completion if applicable to practice;
- Verification of post-graduate education or training;
- Current license or certification without material restrictions, conditions or any other disciplinary action in all states where the applicant practices;
- Valid DEA or Controlled Substance Certificate or Acceptable Substitute, as required per practice;
- Medicare/Medicaid program participation eligibility;
- Work history—5 years;
- Malpractice Insurance or State-Approved Alternative, equal to or greater than the minimum amounts required and outlined in care provider's contract;

- Malpractice history—5 years;
- Passing score on site visit, as applicable;
- No sanction or limitation on licensure;
- No prior denials or terminations within the preceding 24 months;
- Facility staff privileges or arrangements with a participating licensed care provider to admit and provide facility coverage at a network care provider.

A completed application includes a signed statement attesting to

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

The credentialing program applies to:

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

Collection and Verification of Information

Upon receipt of a completed application, the care provider's professional credentials and qualifications verified through primary sources of verification.

Recredentialing Process

The Credentialing Entity performs recredentialing of network care providers at least every 36 months. The recredentialing process identifies and evaluates any changes in the care provider or health care professional licensure, training, experience, current competence, or health status that may affect the care provider or health care professionals' ability to perform the delivery of healthcare services.

Recredentialing Application Form

A letter sent out to each care provider that falls within the scope of this policy. The letter includes; CAQH care provider identification number, along with the specific CAQH application status, as well as instructions on what the next steps are. The care provider or health care professional must complete a *re-credentialing application form* via CAQH, including the attestation and release, and must provide all information requested on the application, documentation or any other requested information. Failure to return the requested information in the established timeframe may result in the termination of the participation agreement.

Collection and Verification of Information

Upon receipt of a completed recredentialing application, the care provider's professional credentials and qualifications re-verified through primary sources of verification.

Care Provider Office Site Quality Review

The Credentialing Entity has established office site and medical/treatment record keeping thresholds and standards that address:

- Physical accessibility, such as handicapped accessible;
- Physical appearance;
- Adequacy of waiting and examining room space;
- Availability of appointments;
- Adequacy of treatment record keeping (e.g., secure/confidential filing system);

The Credentialing Entity continually monitors member complaints relating to the above standards against its established complaint threshold. It conducts full-assessment site visits of offices when it receives member complaints within 60 days of determining that the complaint threshold met.

The Credentialing Entity will use a standardized *site visit survey form* incorporating office-site and medical/treatment record-keeping standards.

Based on the results of the site visit, the Credentialing Entity institutes corrective action to improve those office sites that do not meet thresholds and evaluates the effectiveness of those actions at least every 6 months via follow-up visits, until offices meet the thresholds. The Credentialing Entity will document each step of the process.

Monitoring of Network Care Providers

UnitedHealthcare continuously monitors sanction activity from state medical boards, CMS, OIG and other regulatory

bodies. Care providers found no longer eligible to participate due to a sanction resulting in loss of license or material restriction will be terminated from the network. The termination date for a sanctioned care provider will be retroactive to the first day of the month of that action to support the group capitation and facilitate member transitions as required.

Credentialing Committee Decision Making Process (Non-Delegated)

Care Providers Who Meet Criteria

On a daily basis, credentialing information on care providers who meet established criteria are sent to select one of the National Medical Director for review and approval.

Care Providers Who Do Not Meet Criteria

Care providers who do not meet Credentialing Entity's established criteria presented to the National Credentialing Committee. The information provided to the National Credentialing Committee includes the care provider's profile and all documentation related to the issue or issues in question. The National Credentialing Committee may request further information from any persons or organizations, including the care provider, in order to assist the committee with the evaluation process.

Determination of Approval or Denial

Upon completion of its review and evaluation of all of the care provider's credentialing information, the National Credentialing Committee shall approve or deny the care provider for participation.

Care Provider Notification

For initial credentialing, care providers notified of the National Credentialing Committee's decision to approve or deny credentials within 60 calendar days of the committee decision. For recredentialing, care providers notified of a decision to terminate a care provider's participation within 60 calendar days of the committee's decision if applicable.

Listings in Care Provider Directories and Other Member Materials

Information provided in member materials, including care provider directories, is consistent with the publicly available information obtained in the credentialing process, which may include, but is not limited to education, training, certification and specialty.

Delegated Credentialing Program

Credentialing Entity maintains standards, policies and procedures for credentialing and recredentialing of care providers and other licensed independent health care professionals, facilities and other organizational care provider facilities that provide medical services to our

members. Credentialing Entity may delegate credentialing activities to a medical group/IPA that demonstrates compliance with standards for credentialing and recredentialing.

The medical group/IPA will maintain a written description of its credentialing program that documents the following activities, in a format that meets Credentialing Entity's standards:

- Credentialing;
- Recredentialing;
- Assessment of network care providers and other licensed independent health care professionals;
- Sub-delegation of credentialing, as applicable;
- Review activities, including establishing and maintaining a Credentialing Committee;

Delegation Oversight

The Credentialing Entity may delegate credentialing functions to the medical group/IPA that demonstrates compliance with established standards for the credentialing function outlined in the credentialing and recredentialing plan. The delegated medical group/IPA is also referred to as the delegate.

The Credentialing Entity will perform an initial assessment to measure the compliance of the medical group/IPA with the established standards for delegation of credentialing. At least annually thereafter, the Credentialing Entity will assess the delegated medical group/IPA to monitor their compliance with established standards, including NCQA standards, and state and federal requirements. Credentialing Entity may initiate a focused assessment review based on specific activity by the delegate that warrants such an assessment.

Improvement Action Plans

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

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

Credentialing Reporting Requirements for Delegated Medical Group/IPAs

Credentialing Entity requires all delegates to adhere to the following standards for notification procedures. The delegate shall provide prior written notice to Credentialing Entity of the addition of any new care providers or other licensed independent health care professionals. Notice shall include credentialing information on all new care

providers accepted and approved by the delegate, as well as any changes to current care providers, including, but not limited to the following as applicable:

- Demographic information including, but not limited to, name, gender, specialty and medical group/IPA address and locations;
- License;
- DEA registration;
- Education and Training, including board certification status and expiration date;
- Facilities with admitting privileges, or coverage arrangements;
- Billing information—to include:
 - › Legal entity name;
 - › Billing address; and
 - › TIN or social security number;
- Product participation (e.g., Commercial, Medicare Advantage);
- Languages spoken by the care provider or clinical staff;

Negative Actions Reporting Requirements

The delegate is required immediately to notify the Credentialing Entity, in writing, of any of the following actions taken by or against a specialty care provider or other licensed independent health care professional, as applicable:

- Surrender, revocation, or suspension of a license or current DEA registration;
- Exclusion of care provider from any federal program (e.g., Medicare or Medicaid) for payment of medical services;
- Filing of any report regarding care provider, in the National Practitioner Data Bank, or with a state licensing or disciplinary agency;
- Change of facility staff status or facility clinical privileges, including any restriction or limitations;
- When the delegate reasonably determines if serious deficiencies in the professional competence conduct or quality of care of the network care provider that affects, or could adversely affect, the health and safety of the member;

Reporting Changes

The delegate is required to provide to Credentialing Entity additional information on all new care providers and other licensed independent health care professionals, and/or changes to a status. Changes include:

- Address
- TIN

- Open/closed status to enrollment –of an open, closed or existing only practice
- Product participation

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

*California- In accordance with California Senate Bill 137, effective July 1, 2017, UnitedHealthcare West is required to perform ongoing updates to its provider directories, both online and hardcopy. UnitedHealthcare West is required to contact all contracted medical groups/IPAs on an annual basis, and independent physicians every six months. The provider outreach will include a summary of the information that UnitedHealthcare West has on record and requires the medical group/IPA or physician to respond confirming information is accurate, or with applicable changes. If UnitedHealthcare West does not receive a response within 30 business days either from the provider confirming that the information on file is correct, or by providing the necessary updates, UnitedHealthcare West will have 15 business days to attempt to verify the information. If these subsequent attempts are unsuccessful, UnitedHealthcare West shall notify the provider that, after 10 business days the removal from the directory if the provider continues to be nonresponsive. If the final 10 business-day period lapses with no response from the provider, UnitedHealthcare West will remove the provider from the directory. and UnitedHealthcare West retains the right to terminate provider contracts if there is a pattern or repeated failure to provide the information required for UnitedHealthcare West to comply with this regulatory requirement.

To ensure UnitedHealthcare West has up to date data, medical groups/IPAs or physicians can make applicable changes via email to: Pacific_DelProv@uhc.com or delprov@uhc.com.

Delegate Reporting of Terminations

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

Note: Effective dates of termination must be the last day of the month to properly support; group capitation with mid-month terminations not accepted.

Termination notice requires the following information:

- Reason for termination;
- Effective date of termination;
- Direction for reassignment of members (if UnitedHealthcare West does assignment);
- Product participation;

When a PCP terminates affiliation with a delegate, UnitedHealthcare West members have two options:

- Stay with their existing medical group/IPA and change care providers.
- Transfer to another medical group/IPA to stay with the existing care provider.

If the member fails to indicate the member's preference, UnitedHealthcare West's default position is to assign the member to another PCP within the same medical group/IPA, based on the medical group/IPA's direction for reassignment. Exceptions to this policy made on a case-

by-case basis. Members may change their care provider prospectively as described in their benefit plan.

Note: Credentialing Entity retains the right, in its sole discretion to approve, suspend, or terminate any network care provider or other licensed independent health care professional. Care providers and other licensed independent health care professionals with disapproval by the Credentialing Entity; shall not be permitted by the medical group/IPA to provide covered services to members.

Panel Restriction

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

Changes in Capacity

The medical group/IPA shall provide at least 90 calendar days (*CA- please see below) written notice to UnitedHealthcare West prior to any significant changes to the medical group/IPA or network care providers, which include:

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

The medical group/IPA and its care providers and other licensed independent health care professionals shall continue to accept members until the expiration of the notice period. UnitedHealthcare West has developed specific definitions for open, closed or existing only practices to promote consistency throughout the participating network care provider related to acceptance of new or transferring members. For purposes of this section, a new member may be a member who has switched health plans and/or coverage plans, such as a member who switches from a Fee-For-Service (FFS) plan to a Commercial HMO/MCO plan.

The medical group/IPA and network care providers and other independent licensed care providers must follow these definitions:

- Open status is defined as the PCP's practice is open to additional new members and transferring members.
- Closed status is defined as the PCP's practice is closed to all new members and transferring members.
- Existing only status defined as the PCP's practice accepts new or transferring members who have an established chart with the care provider's office.

*California- Effective July 1, 2017 UnitedHealthcare West requires providers to update UnitedHealthcare West within 5 business days if there are any changes to their ability to accept new members. If UnitedHealthcare West receives notification that the information is inaccurate, provider group/IPA or physician will be subject to corrective action.

Credentialing Reporting

If Credentialing Entity determines that the medical group/IPA does not obtain and maintain credentialing information, the medical group/IPA will assist UnitedHealthcare West in obtaining the information. The medical group/IPA will obtain for each care provider and other licensed independent health care professional a signed waiver allowing UnitedHealthcare to access to such credentialing information. The medical group/IPA not delegated for credentialing under these circumstances.

Chapter 15: Quality Improvement Program

UnitedHealthcare West is committed to providing high quality health care products for our members. We have built an infrastructure to measure our performance and quality, and to make health care simpler and more efficient. From the time our member enrolls in one of our plans, our quality improvement activities touch every claim, phone call and care provider visit. Our evidence-based wellness and care management programs help our members achieve the best possible health, in coordination with care providers like you and with the support of our own clinicians. The excellent care you deliver to our members reflected in the quality of our health programs. By incorporating feedback from our members' health care experience and working with you, we can provide higher quality health programs to our members, and together, help them live healthier lives.

UnitedHealthcare West's Quality Improvement Program addresses the care and service of our entire member population, from newborns to the elderly. Our clinical programs target common medical conditions that occur frequently among our membership. The Program goals and objectives include:

- Promoting and incorporating quality into the health plan's organizational structure and processes;
- Providing effective monitoring and evaluation of member care and services provided by contracted practitioners/care providers as compared to the requirements of evidence based medicine;
- Ensuring prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up;
- Coordinating quality improvement, risk management, member safety and operational activities;
- Maintaining compliance with local, state and federal regulatory requirements and accreditation standards;
- Serving culturally and linguistically diverse populations; and
- Serving members with complex health needs;

Quality Improvement Activities

Our quality improvement activities designed to accomplish the program goals, which serve to promote the quality of care and service our members receive. A collaborative work effort with participating practitioners and other care providers is required and encouraged.

All participating practitioners and care providers must cooperate with quality improvement activities and programs to improve quality of care and services and member experience.

These include, but are not limited to, the following:

- Participation in committees;

- Timely provision of medical records upon request including contracted business associates requests;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Participation in quality assessments and surveys, including site visits and medical record standards reviews, HEDIS record review, and Access Studies;
- Identification of barriers when opportunities for improvement are identified;
- Implementation of targeted interventions recommended by the plan; and
- Review and use practitioner and care provider performance data.

Medicare Advantage and Prescription Drug Plans

Several industry quality programs, including the 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 derived from four sources:

- Consumer Assessment of HealthCare providers and Systems (CAHPS®) or member satisfaction data;
- HEDIS or medical record and claims data;
- Health Outcomes Survey (HOS) or member health outcomes data; and
- CMS administrative data on plan quality and member satisfaction;

To learn more about Star Ratings and view current Star Ratings for Medicare Advantage and Part D plans, go to the [CMS' website](#).

Reporting

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

Access Standards

The following guidelines; adopted by UnitedHealthcare West for access to health care:

Type of Care	Guideline
Regular or Routine	14 calendar days Exceptions: <ul style="list-style-type: none"> California members are offered appointments for non-urgent PCP within ten business days, of request for non-urgent specialist within 15 business day's request.
Preventive Care	Four weeks Exceptions: California: Preventive care services and periodic follow up care, including but not limited to, standing referrals to specialists, for chronic conditions, Periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. <ul style="list-style-type: none"> Medicare Advantage within 30 days
Non-Urgent, but in Need of Attention (Medicare Advantage)	Within one week
Urgent Exam (PCP or Specialist)	Same day (24 hours) Exceptions: <ul style="list-style-type: none"> California Commercial members are offered appointments within 48 hours when no prior authorization required, and within 96 hours when prior authorization is required.
Emergent Exam	Immediately (exception: only if open 24 hours a day/7 days a week). Exceptions: <ul style="list-style-type: none"> California: Emergency health care services available and accessible within the health -plan service area 24 hours, seven days a week; ambulance services for the area served by the plan to transport the member to the nearest 24-hour facility with care provider coverage.
PCP After-Hours—On Call Coverage	24 hours per day, seven days per week*
Office Wait Time	Less than 15 minutes from the time of the appointment until the member is with the care provider in the exam room. Exceptions: <ul style="list-style-type: none"> California member's office wait time is less than 30 minutes. Triage and screening services provided in 30 minutes.
Referral Process	Notification to the member should complete in a timely manner, not to exceed five business days of a request for non-urgent care, or 72 hours of a request for urgent care.
Non-urgent Ancillary (Diagnostic)	15 business days
Behavioral Health Care for a Non-Life-Threatening Emergency	Six hours
Behavioral Health Urgent Care	48 hours
Behavioral Health Routine Office Visit	10 business days

*A care provider's office after-hours line should provide a member access within 30 minutes to someone who can direct the member in determining/securing necessary care. The after-hours line may be monitored by an answering service that pages or contacts the on-call care provider, or an answering machine with clear instructions and a second number to call to reach a care provider, or another person to page the care provider. Regardless of the method, the after-hours communication must instruct the member to call 911 or go to the nearest emergency room if the member is experiencing an emergency.

Contracting care providers expected to conform to these guidelines. Compliance measured annually at a minimum. Assessments conducted through one or more of the following methods:

- Member complaints for access-related issues and primary care provider transfers;
- Quality of care issues related to access;
- Onsite for clinical appropriateness;
- Telephonic assessments (by UnitedHealthcare West or its contracted vendor);
- Care provider satisfaction surveys, and/or
- Member satisfaction surveys.

Timely Access to Non-Emergency Health Care Services (CA)

The timeliness standards require licensed care providers to offer members appointments that meet the California timeframes. Applicable waiting time for a particular appointment potentially extended. The extension occurs, if the referring or treating licensed care provider, providing triage or screening services acting within the scope of his or her practice consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

- Triage or screening services by phone provided by licensed staff, 24-hours per day, seven days per week and wait time for triage and screening should not exceed 30 minutes. Under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advice, or make any decision regarding the condition of member or determine when an member needs to be seen by a licensed medical professional.
- UnitedHealthcare of California Commercial HMO members have access to free telephonic triage and screening services 24 hours a day, seven days a week through OptumHealth's Nurseline at 866-747-4325.

Health Management Programs

UnitedHealthcare supports the importance of providing easily accessible health management programs for members. These programs integrated into our core products so that they are available to all members and developed to support quality initiatives. Examples of such programs listed below. If you have members who would benefit from these health management programs, you can refer them to the appropriate program by calling the number on the back of the member's health care ID card. Health and Disease Management programs available to members may vary for Commercial and Medicare members, depending on the particular product and benefit plan in which a member enrolled.

Taking Charge of Your Diabetes: This self-directed intervention program designed to empower members and helping in successful management of diabetes, by addressing self-care and lifestyle issues. The program encourages members to participate with their care provider in developing a plan of care (medications, tests, diet and lifestyle). Clinical information shared with care providers regarding gaps in care to enhance communication and coordination with the care provider and the member.

Customer support includes regular mailed interventions and web-based resources focusing on self-management, lifestyle modification, education on the disease process, symptom management and medication adherence. Program effectiveness outcomes are measured using annual HEDIS rates for diabetes and compared to the 50th national Quality Compass percentiles.

Taking Charge of Your Coronary Artery Disease: A self-directed intervention program designed to empower members to successfully manage their chronic condition. The program encourages members to participate with their care provider in developing a plan of care (medications, tests, diet and lifestyle). Clinical Information may be shared with care providers regarding gaps in care to enhance communication and coordination with the care provider and the member. Member support includes regular mailed interventions and web-based resources focusing on self-management, lifestyle modification, education on the disease process, symptom management and medication adherence. Program effectiveness outcomes are measured using annual HEDIS rates for Coronary Artery Disease are compared to the 50th national Quality Compass percentiles.

Taking Charge of Your Heart Health Heart Failure: Self-directed lifestyle management program focusing on behavior modification, including; diet, exercise, stress, tobacco use and self-care. Educational programs focus on appropriate monitoring, testing and medication management for members diagnosed with heart failure. The program utilized in conjunction with a clinically based cardiovascular disease management program offered by the care providers. The program also utilized in conjunction with the case-based Disease Management Program on heart failure.

The Quit for Life Program: A telephone based self-directed, interactive program designed customization to each individual's needs and readiness to quit smoking. The components of the intervention build the member's self-confidence in their ability to quit smoking through goal oriented lifestyle modification. Tobacco cessation coaching tools assist members to stay tobacco-free, [quitnow.net](#). Members with a UnitedHealthcare West pharmacy plan have access to specific cessation medications, after their care provider prescribes the medication, and when the member is participating in a tobacco cessation program. Further information is available to the member by

calling the member Service number on the back of their membership card.

Taking Charge of Asthma: This Program focused on improvement and understanding of the disease and compliance with treatment thereafter. Interventions consist of mail-based or online education, tools and resources for understanding peak flow meters and spacer devices, and medication compliance. Members are encouraged to work with their PCP to develop and use an action plan for managing their condition. The program focuses primarily on Commercial members aged five to 85 years old, with persistent asthma.

Taking Charge of Chronic Obstructive Pulmonary Disease: This program focuses on self-care and lifestyle issues, primarily through member education, for members over age 40 diagnosed with Chronic Obstructive Pulmonary Disease. Materials focus on encouraging members to work with their PCPs to create action plans for managing their disease.

Healthy Pregnancy Program (HPP): HPP is a maternity wellness program designed to provide members with additional support and education during their pregnancy. HPP works with expectant mothers to identify and manage high-risk pregnancies and potential NICU members before delivery. The program includes: Obstetrics (OB), nurse clinical assessments, educational resources, including a book, ongoing telephonic management of high-risk cases by experienced obstetrical Nurses; around-the-clock telephonic OB nurse support through two weeks postpartum, and an outcomes assessment on the delivery and mothers' well-being, including assessment for postpartum depression. Information shared with care providers regarding members needing postpartum care to enhance communication and coordination for follow up appointments with the care provider and the member.

24-Hour Health Information Programs: Commercial and Medicare Advantage member can receive information by phone or online resources:

NurseLine 866-747-4325 offers decision support and health information services through a variety of channels. Registered Nurses are available 24 hours a day, seven days a week, to deliver symptom decision support, evidence-based health information and education, and medication information Live Nurse Chat provides health education via real-time internet chats and aids members in navigation to credible medical information websites. Symptomatic members referred to the NurseLine 800 number associated with their health plan for telephonic triage. Live Nurse Chat provides one-to-one Internet chat access with OptumHealth Nurses 24 hours a day, seven days a week. The internet-based information helps to educate members about a variety of conditions and health-related topics and encourage their participation in making health care decisions. The program consists of tools such as online health information and 24-hour Nurse Line.

Online Health Coach offers members' access to a five-week computer based program designed to help members live a healthier lifestyle through nutrition and exercise. Each part consists of five levels and each level includes informative articles, a tool and short quiz to demonstrate learning. In addition, there are multiple tracking tools including Meal and Exercise Trackers. Online Health Coaching is available for Nutrition, Stress, Smoking, Exercise, Weight Loss, Diabetes and Heart Health.

Case Management Programs

Case Management is the process that proactively assesses, plans, implements, and coordinates care across the continuum of care needs, as well as monitors and evaluates options and services to meet an individual's needs to promote quality cost-effective outcomes. Care providers affiliated with non-delegated medical group/IPAs may refer individuals to any of the programs by calling the toll free phone number located on the member's healthcare ID card, and selecting the prompt to speak with a representative to initiate referral to the appropriate program available in your area. The member assessed for need and triaged to the appropriate level of intervention by a program case manager through our outbound call program.

UnitedHealthcare's Case Management Program

The Case Management program designed to address both the management of acute events as well as the reduction of future risk. The Case Management Program consists of the following components:

Transitional Case Management (TCM):

- Consumers contacted after facility discharge to reduce risk of readmission; the focus of the contact is on understanding discharge instructions, medications, follow-up appointments, etc.
- Typically requires one to two phone calls to complete a case.

Condition/General Care Management:

- Referrals from multiple sources included; (facility discharge, high-risk and/or high-cost case identification through predictive model and other referrals such as self-referrals, other program). Cases may require multiple contacts, but do not meet criteria for promotion into Complex Case Management (CCM).

Complex Case Management (CCM):

- Cases are highly complex and/or expected to take longer than 60 days to manage;
- Should be reserved for the cases truly in need of long-term intensive outreach;
- The program is subject to applicable URAC and NCQA requirements;

The UnitedHealthcare West Case Management Program is available to members enrolled with directly contracted care providers or delegated care providers in shared risk groups. Medical groups/IPAs with fully capitated arrangements expected to have comparable programs available to members.

Medical group/IPAs delegated for Complex Case Management may develop their own programs and must comply with all applicable regulatory and accreditation standards. At least annually, we will assess the delegated medical group/IPAs against applicable requirements. The delegated medical group/IPA may be required to undergo corrective action if assessment results do not meet delegation requirements.

Disease Management Programs

For our Commercial members, high intensity, disease management programs are available for each member with heart failure and ESRD. Neonatal Resource Services are also available for neonates requiring treatment in a neonatal intensive care unit. The programs are voluntary, opt-in programs and are available at no cost to the member. For a member managed in the high intensity outbound call program, PCP notification when a member enrolls in one of the programs. Many programs may not be available in all states. Enroll a member, call 877-840-4085 or fax referral form 877-406-8212.

- **Heart Failure** includes daily in-home monitoring of member's weight and symptoms and member or caregiver education to improve symptom monitoring and help prevent complications. Changes in status and specific information regarding their member's medication compliance confirmed and forwarded to the member's care provider. The focus of the program is to increase members' self-management skills and provide care providers with member-specific information. Members who are eligible for this program have been hospitalized two or more times within the previous 24 months with a diagnosis of heart failure coded in any of the first five fields. Exclusions include members diagnosed with ESRD or acquired immune deficiency syndrome; enrolled in hospice, under age eighteen or who have Medicare as their primary payer.
- **ESRD** includes coordination of care by a Renal Nurse Consultant. The Nurse Consultant develops an individualized care plan, educates the dialysis member on managing renal disease and notifies the member's care provider of members self-reported compliance with medication regimes. If member receives hospitalization, the Nurse Care Manager assists in the execution of the discharge plan and helps to prevent future admits.
- **Neonatal Intensive Care** provides families with clinical information to help them understand their child's conditions and treatments while in the Neonatal Intensive Care Unit (NICU) and for a minimum of 30 days post-

discharge, evaluates and coordinates the clinical care plan with the facility and assists with discharge planning. The collaborative, Neonatologist-directed program provides NICU-trained Registered Nurse Care Managers who perform concurrent review for those neonates, interact regularly with the NICU's Medical Staff and educate and support families.

For Medicare Advantage members, our approach aligns traditional disease management with care management concepts and evidence-based guidelines. Care Management integrates services into a seamless system of care, focuses on care that slows progression of illness and involves members, care providers and other care providers in the care planning process. The key process features of Care Management are risk stratification, community and social assessment, interdisciplinary care planning, evidence-based interventions, focus on delivery of coordinated services, promotion of self-care and ongoing monitoring and evaluation. The disease management programs available for Medicare Advantage members are congestive heart failure, coronary artery disease, diabetes, and ESRD programs. Care providers may refer members for any of these programs by calling the toll-free phone number located on the member's health care ID card for programs available in your area.

Medical group/IPAs delegated for Disease Management may develop their own programs and must comply with all applicable regulatory and accreditation standards.

Member Satisfaction

We use several mechanisms to measure member satisfaction with the plan, care providers, care and service.

- Member experience surveys—UnitedHealthcare West contracts with an NCQA-certified vendor to conduct an annual assessment using the CAHPS® survey. Members rate their experience in multiple areas including their overall satisfaction with the health plan, their health care, care providers, access, referral process, specialty care, benefits, and member service.
- For California, in addition to the NCQA CAHPS® survey, the annual California HMO member Assessment Survey conducted based on a sample of members at the Care Provider Organization or Medical Group level. These results are important for the evaluation of member perspectives about access to PCP, specialty and after hours care and are summarized at the medical group level and used in identifying improvement opportunities. In addition to access, topics include care coordination, interactions with the doctor and the office staff. Results from this survey used to support the Integrated Healthcare Association's Pay-for-Performance Program.

Member Complaints

All complaints received from members, both written and verbal, reviewed and the information entered into a

centralized system to identify trends and opportunities for improvement related to care and service.

In accordance with applicable NCQA UM standards, a medical group/IPA delegated for medical management activities must continually assess member and Practitioner experience with UM processes to identify areas in need of improvement.

Preventive Health and Clinical Practice Guidelines

UnitedHealthcare uses evidence-based clinical and preventive health guidelines from nationally recognized sources to guide our quality and health management programs. These guidelines reviewed against clinical evidence at least every two years or more frequently if national guidelines change. We hope you will consider this information and use it, when it is appropriate for your eligible members. These guidelines are available on UnitedHealthcareOnline.com. A list of the clinical guidelines published each September in the [Network Bulletin](#).

Quality Management Programs

The Quality Management (QM) program focuses on ensuring access to the delivery of health care and services for all our members through the implementation of a comprehensive, integrated, systematic process that is based on quality improvement principles.

The QM Program activities include:

- Identification of the scope of care and services rendered by you
- Development of clinical guidelines and service standards by which clinical performance will be measured
- Objective evaluation and systematic monitoring of the quality and appropriateness of services and medical care received from our network of health care providers
- Assessment of the medical qualifications of participating physicians and other health care professionals
- Continued improvement of member health care and services
- Efforts to help ensure patient safety* and confidentiality of member medical information
- Resolution of identified quality issues

The ultimate authority and oversight responsibility for our QM Program lies with our board of directors. Day-to-day QM operations delegated to the Regional Quality Director and Senior Medical Director.

Quality Management Committee Structure

The Medical Advisory Committee (MAC) oversees QM activities and addresses specific issues that arise. These issues include review and recommendations regarding clinical practice guidelines, medical policies, service standards, over- utilization and 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 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 National Provider Sanctions Committee (NPSC) provides a forum for qualified UnitedHealthcare physicians to discuss and take action on sanction reports that raise issues regarding compliance with UnitedHealthcare's 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).

California Quality Improvement Committee

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

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

Medical Record Documentation

UnitedHealthcare West and regulatory use medical record documentation to review clinical care provided to members. Medical record documentation may be used to satisfy a state requirement to evaluate documentation

standards met by providers as a method to assess coordinated quality of care, is used in the resolution of member grievances and appeals related to healthcare. The medical record is a legal document subject to discovery during litigation. All medical records and books pertaining to UnitedHealthcare West Commercial members kept for a minimum of six years, unless state or federal laws dictate longer periods. All medical records and books pertaining to Medicare Advantage members kept for a minimum of ten years, unless state or federal laws dictate longer periods.

Care providers are required to make sure the following coding procedures followed when documenting in UnitedHealthcare West medical records:

- Coding adheres to ethical standards;
- Understand the fundamentals of ICD-10-CM coding;
- Make sure your office is using the most up to date codes;
- Make sure the inpatient claims are coded with the conditions of the highest degree of certainty for that visit, such as symptoms, signs, abnormal test results, or other reasons for the visit; and
- Coding at highest level of specificity (up to five digits if needed);

Medical Record Confidentiality

UnitedHealthcare recognizes that the information contained in medical records is highly confidential with protection by state and federal law from certain types of disclosures. All care providers must have policies and procedures in place to address the following requirements:

- Protect member records, whether in paper or electronic form, against loss, destruction, tampering or unauthorized use. For electronic medical records, you must establish security safeguards in order to prevent unauthorized access or alteration of records without leaving an inspection trail to identify the breach. Such safeguards programmed for no override or turn off.
- Maintain medical records in a confidential manner and provide periodic training to office staff regarding confidentiality processes. Records storage must allow for easy retrieval, be secure and allow access only by authorized personnel.

Medical Record Availability

In addition to assuring that medical records be stored in a secure manner, the records must allow easy access by authorized personnel only, including UnitedHealthcare, regardless of any licensing terms that may apply to an electronic health record being used by the care provider's office. Well-organized medical record documentation facilitates communication, coordination, and continuity of care to promote the most efficient and effective treatment of the member.

On a periodic basis, UnitedHealthcare staff will require periodic access to member medical records for the

purpose of quality improvement and peer review. On at least an annual basis, we will require care provider staff assistance and full cooperation in collecting medical record information for HEDIS reporting. HEDIS reporting requirement Selected employers and regulatory and accrediting agencies.

Chart Assessments and Failure to Comply

UnitedHealthcare West shall have the right to perform routine medical record chart assessments of a care provider's records at such time or times as we may reasonably elect to determine the completeness and accuracy of ICD-10-CM and CPT coding. The care provider shall be notified in writing of such assessment results. UnitedHealthcare West may invoke a penalty, as outlined in the participation agreement, if the submitting entity fails to submit the data.

Medical Record Guidelines

Medical records will contain all information necessary and appropriate for quality improvement activities, support claims for services submitted by you. Network care providers expected to have written policies to address the following critical measures:

- Medical record guidelines requiring maintenance of a single, permanent medical record that is legible, current, detailed, organized and comprehensive for each member and available at each visit;
- A process for monitoring and handling missed appointments;
- Non-discrimination in the delivery of health care;
- Confidentiality, safe record keeping and periodic staff training;
- Release of information;
- Medical record retention;
- Availability of the medical record when housed in a different office location;
- Coordination of care between medical and behavioral providers and specialist;

General Documentation Guidelines

- We also expect you to follow guidelines for medical record information and documentation such as those listed below. Several of these general guidelines also considered critical.
- Date all entries, and identify the author and their credentials when applicable. For records generated by word processing software or electronic medical record software, the documentation should include all authors and their credentials. It should be apparent from the documentation which individual performed a given service.
- Clearly label or document subsequent changes to a medical record entry by including the author of the

change and date of change. The care provider must also maintain a copy of the original entry.

- Generate documentation at the time of service or shortly thereafter. Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.
- Include demographic information including name, gender, date of birth, member number, emergency contact name, relationship and phone number(s), and insurance information.
- Include family and social history, including marital status and occupational status or history.
- Prominently place information on whether the member has executed an advance directive (critical element).
- Include a problem list documenting medical history, chronic conditions and significant illnesses, accidents and operation. Include the chief complaint and diagnosis and treatment plan at each visit.
- Prominently document including medication allergies and adverse reactions. Also, note if the member has no known allergies or adverse reactions (critical measure).
- Include name of current medications and dosages. Also, list over the counter drugs taken by the member.
- Reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the care provider/health care professional.
- Document member history and health behaviors such as:
 - › Tobacco habits, including advice to quit, alcohol use and substance abuse (age 11 and older);
 - › Immunization record;
 - › Preventive screenings/services and risk screenings;
 - › Screenings for depression and evidence of coordination with behavioral care providers;
 - › Blood pressure, height and weight, body mass index.
 - › Physical assessment for each visit;
 - › Growth charts for children and developmental assessments;
 - › Physical activity and nutritional counseling;
- Clinical decision and safety support tools in place to insure evidence based care and follow up care. Examples include:
 - › Lab, X-ray, consultation reports, behavioral health reports, ancillary care providers' reports, facility records and outpatient records show care provider review by signature or initials;
 - › Report from eye care specialist related to medical eye examinations (e.g., Dilated Retinal Exam or other note/report of retinopathy);

Record Accuracy Goals

- 90% of medical records will contain documentation of critical measures;
- 80% of medical records will contain documentation of all other elements when those elements are included in quality improvement medical record assessments;
- 100% of medical records will contain documentation of allergies and adverse reactions;

Member Encounters and Continuity of Care

When you see one of our members, document the visit by noting:

- Member's complaint or reason for the visit;
- Physical assessment;
- Unresolved problems from previous visit;
- Diagnosis and treatment plans consistent with your findings;
- Member education, counseling or coordination of care with other care providers, including behavioral health practitioners, when applicable;
- Date of return visit or other follow-up care, including phone calls.
- Review by the primary care provider (initialed) on consultation, lab, imaging, special studies, and ancillary, outpatient and inpatient records;
- Consultation and abnormal studies initialed and include follow-up plans

Documentation of services for the diagnosis or treatment that are not reasonable and necessary not considered when selecting the appropriate Evaluation and Management (E&M) service. This includes: injury, illness or, to improve function of malformed body member, (over documentation) Only the medically reasonable and necessary services for the condition of the particular member at the time of the encounter as documented considered when selecting the appropriate E&M level.

Cultural Competency

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

Interpretive/Auxiliary Aide Services

Delegated care providers are required to have mechanisms to make sure the provision of auxiliary aides, including sign language interpreters to sensory-impaired members as required to provide members with an equal opportunity to access and participate in all health care services. The delegated care provider shall provide auxiliary aides and/or sign language interpreters at no cost to the member.

The medical group/IPA must arrange provision of these services in a timely manner so as not to delay provision of care to the members.

Interpretative and/or auxiliary aide services provided, at no cost to the member, upon request. Customers have the right to a certified medical interpreter or sign language interpreter to translate health information accurately. The interpreter must respect the member's privacy and keep all information confidential. Family and friends of limited

English proficiency or hearing impaired members may provide interpretive services only after standard UnitedHealthcare West methods explained and offered, and the member refuses. Care providers are strongly encouraged to document the refusal of professional interpretation services in the member's medical record.

Non-Discrimination

Non-discriminatory actions against any member not tolerated, with regard to quality of service or accessibility of services. The basis that the member is a member of UnitedHealthcare West 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 demonstrate you do not discriminate in the delivery of service and accept for treatment any members in need of the service you provide.

California Language Assistance Program (CA Commercial)

California law establishes standards and requirements for health plans to provide to Commercial members who have limited English proficiency, accessibility to translated written materials and oral interpretation services, free of charge, to assist such members in obtaining covered benefits. This regulation does not apply to sign language interpretation or the provision of auxiliary aides, as required by federal law.

UnitedHealthcare West does not delegate any Language Assistance Program (LAP) functions that fall under these regulations. Nonetheless, there are systems and processes that contracted care providers must have in place in order to support our program. Please see resources on [California Language Assistance Program Information](#). The LAP Assessment Tool developed to raise awareness and provide support regarding UnitedHealthcare West's LAP processes, to capitated, care provider groups. Some medical group/IPAs delegated for medical management. UnitedHealthcare West will annually assess the delegated medical group/IPA's cooperation with our LAP Program. We will review medical group/IPA LAP policies and procedures, documentation of training of staff and

contracted care providers including PCP, SCP, and ancillary care provider, evidence of availability of

UnitedHealthcare West LAP contact information and evidence of implementation of required notification of translation services (denial letter LAP requirements).

Verbal Interpreter/Written Translation Services

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

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

UnitedHealthcare SignatureValue (HMO/MCO):
800-624-8822; Dial 711 TDHI

Spanish: 800-730-7270; 800-855-3000 TDHI

Chinese: 800-938-2300

Where to Obtain the Member's Language Preference

The member's preferences for spoken language, written language, and eligibility for written language service displayed in the eligibilityLink app on [Link](#).

Availability of Grievance Forms at Practice/Care Sites (CA Commercial)

Upon request by the member, care providers and their staff are required to assist the member to obtain a form. Care providers and staff may do this by printing a form from [myuhc.com](#) or by providing telephonic access for the member to call member Services to file the grievance orally. *Grievance forms* are available in English, Spanish and Chinese.

Documentation of Member Refusal of Interpreter Services

If member offered an interpreter refused the service, you must note the refusal in the medical record for that visit. Documenting the refusal of interpreter services in the medical record not only protects the care provider, it also makes sure consistency when medical records monitored through site reviews/assessments by UnitedHealthcare West to make sure compliance with this documentation.

If a member desires to use a family member or friend as an interpreter, consider offering a telephonic interpreter in addition to the family member/friend to make sure accuracy of interpretation. For all Limited English Proficiency (LEP) members, it is a best practice to document the member's preferred language in paper and/

or electronic medical records (EMR) in the manner that best fits your practice flow.

Inclusion of ‘Notice of Availability of Language Assistance’ in Non-Standard Vital Documents Issued by Delegated Care Provider Groups (CA)

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

ICE Instructions include two options:

Option 1: UnitedHealthcare West LAP Notice of Translation—[California Language Assistance Program Information](#)

Option 2: UnitedHealthcare West-Specific Templates. CSDN and Commercial Delay-Extension containing LAP Notice of Translation Documents are available on the ICE website. Go to [Iceforhealth.org](#)

Complete Claims Requirements

Care providers submit a clean claim by providing the required data elements, examples specified below, along with any attachments and additional elements, or revisions to data elements, of which the care provider properly notified, and any coordination of benefits or non-duplication of benefits information if applicable.

Network care providers are expected to utilize industry standards for submissions utilizing the HIPAA 5010 837 and CMS 1450 and 1500 formats as well as nationally recognized coding including, but not limited to, revenue and/or DRG, ICD-10-CM, HCPCS and CPT-4 codes. We recognize that such codes are subject to changes or additions as updates made by the issuing entity. HIPAA 5010 837 submissions must include all required segments and fields as required in the HIPAA 5010 837 companion guide including complete care provider segments that apply to the service.

In addition, the care provider will obtain a valid assignment of benefits and a release of records signature. All claims submitted must include a signature assigning benefits, or indicate “Assignment on File”; otherwise, we are obligated

to remit payment directly to the subscriber. Balance forward statements, will be returned for itemization of charges.

Required data elements typically include:

- Member’s name/plan ID number;
- Member’s address;
- Member’s gender;
- Member’s date of birth (dd/mm/yyyy);
- Member’s relationship to subscriber;
- Subscriber’s name (enter exactly as it appears on health care ID card);
- Subscriber’s ID number;
- Subscriber’s employer group name;
- Subscriber’s employer group number;
- Rendering care provider or health care professional name;
- Rendering care provider or health care professional’s signature;
- Address where service was rendered;
- Care provider or health care professional’s “remit to” address;
- Phone number of care provider or health care professional performing the service (as stated in your participation agreement);
- Care provider’s or health care professional NPI and federal Tax Identification Number (TIN);
- Referring care provider’s name and TIN (if applicable);
- Taxonomy codes for the rendering care provider and billing care provider;
- Date(s) of service;
- Place(s) of service using CMS codes (for more information go to [cms.hhs.gov](#);
- Number of services (days/units) rendered;
- Current CPT-4 and HCPCS procedure codes, with modifiers where appropriate;
- Current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item);
- Charges per service, member cost share amounts, and total charges;
- Detailed information about other insurance coverage;
- Information regarding job-related, auto or accident information, if available;
- Attach operative notes with *CMS-1500 form* paper claims submitted with modifiers 22, 62, 66 or any other team

surgery modifiers as well as CPT 99360 (care provider standby);

- Retail purchase cost or a cumulative retail rental cost for DME greater than \$1,000;

Additional information and requirements needed for a complete *UB-04 form*:

- Date and hour of admission;
- Discharge 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);
- Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on facility inpatient claims per CMS guidelines;
- Current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on facility inpatient claims per CMS guidelines;
- Current ICD-10-CM procedure codes for inpatient procedures;
- Attending care provider ID;
- All outpatient procedures with the appropriate revenue and CPT or HCPCS codes;
- Specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic) for outpatient services;
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449) submitted on a *UB-04 form*;
- Submit claims according to any special billing instructions that may be indicated in your participation agreement with us;
- On an inpatient facility bill type of 11 times, 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 facility outpatient surgery claims, a nominal monetary amount (\$.01 or \$1.00) must be reported on all other surgical revenue code lines to make sure 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;

Claim Correction/Resubmit

If you need to correct and re-submit a claim, electronic submission through an EDI transaction or the claims app on [Link](#) is preferred. You can mail or fax a new *CMS-1500 form* or *UB-04 form* indicating the correction made. When correcting or submitting late charges on a *UB-04 form* or 837 Institutional claim, resubmit all original lines and charges as well as the corrected or additional information using bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim. Hand corrected claim re-submissions will not be accepted.

Retroactive Eligibility Changes

Unless the member's benefit plan or state law dictates otherwise, eligibility under a benefit contract may change retroactively if:

- We receive information that an individual is no longer a member;
- The member's policy/benefit contract has been terminated;
- The member decides not to purchase continuation coverage; or
- The eligibility information we receive is later determined to be incorrect.

If you have submitted a claim(s) affected by a retroactive eligibility change, claim reconsideration may be necessary. The reason for the claim reconsideration reflected on the EOB or PRA. If enrolled in Electronic Payments and Statements (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.

California Prohibition against Provider Rescission

California law requires that if UnitedHealthcare West was contacted immediately prior to or during the rendering of treatment and the provider relied upon the member's eligibility to treat and the member is later retro-cancelled, the Provider may submit an appeal showing proof that eligibility was obtained and relied upon at the time services were rendered. Failure by the provider to verify eligibility immediately prior to each service date is not subject to this provision. Additionally, each provider must contact UnitedHealthcare West for eligibility. Reliance not made on another provider's eligibility verification, (as an example the facilities verification). Each Provider must contact UnitedHealth West for eligibility.

Commercial Time Limits for Filing Claims (CA)

The claims "timely filing limit" defined as the calendar day period between the claims last Date of Service or payment denial is subject to the California Provider Dispute Resolution by the primary payer and UnitedHealthcare West or its delegate receives the claim.

For purposes of determining when UnitedHealthcare West or the delegated provider received the claim, the date of receipt will be determined by the working day when a claim, by electronic or physical means first delivery to UnitedHealthcare West or the delegated providers specified claims post office box or designated claims processor.

Time Limits for Filing Claims

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

"Date of receipt" means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to UnitedHealthcare's capitated provider for that claim. It is important that each delegated provider date stamp when the claim received.

"Date of Service," for the purposes of evaluating claims submission and payment requirements means:

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

(B) For inpatient services: Utilize the date upon discharge of member from the inpatient facility. However, UnitedHealthcare or the capitated provider, at a minimum, must accept separately billable claims for inpatient services on at least on a bi-weekly basis.

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

Submission of Unlisted Medical or Surgical Codes

Include a detailed description of the procedure or service provided for claims submitted with unlisted medical or

surgical CPT or "other" revenue codes, as well as for experimental or reconstructive services.

Submission of CMS-1500 Form Drug Codes

Include the current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number entered in the 24D field of the *CMS-1500 form* or the LIno3 segment of the *HIPAA 837 electronic form*.

Reporting Requirements for Anesthesia Services

- Report one of the CMS-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) for anesthesia services;
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV1 04 with an "MJ" qualifier in loop 2400 SV1 03. For *CMS-1500 paper claims*, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H;
- When medically directing residents for anesthesia services, report modifier GC in conjunction with the AA or QK modifier;
- When reporting obstetrical anesthesia services, use add-on codes 01968 or 01969, as applicable, on the same claim as the primary procedure 01967;
- When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

Chapter 16: Appeals and Grievances

Care Provider, Member Appeals and Grievance Complaints

We maintain a centralized system of logging, tracking and analyzing issues received from members and care providers and to measure and improve member and care provider satisfaction.

This system operates to assist us in fulfilling the requirements and expectations of our members and our network care providers. In addition, it facilitates compliance with CMS, the NCQA, The Joint Commission, and other accrediting and/ or regulatory requirements. Care provider and member complaints are important to the recertification process because they help us attract and retain care providers, employer groups and members.

All written complaints acknowledged and entered into the complaint database. If a potential quality of care issue identified within the complaint (using pre-established triggers) the case then forwarded to the Quality of Care Department to investigate the care elements. If the complaint involves an imminent and serious threat to the health of the member, the case referred on to the Quality Intervention Services for immediate action. Quality of care complaints and investigation takes place with the identifying and requesting relevant medical records/ information necessary to make a determination. Case review findings reflected in assigned severity levels and data collection codes too objectively and systemically monitor, evaluate and improve the quality and safety of clinical care and quality of service provided to our members.

Complaints received, tracked and trended by care provider and the information utilized at the time of care provider's recertification. An annual analysis of the complaint data performed to identify opportunities for improvement. Members have the right to appeal the determination of any denied services or claim by filing an appeal with UnitedHealthcare West. Timeframes for filing an appeal may vary, depending on the applicable state or federal requirements.

CA Commercial

Members may use a *UnitedHealthcare West Grievance Form* to help state and explain their grievance. Upon the member's request, the medical group/IPA is responsible for helping the member obtain this form. This might include having the form available or accessing the form online to print and give to the member. The medical group/IPA can access the form through our website and by contacting your provider advocate.

We do not delegate authority or responsibility for processing member grievances, appeals or complaints to our network care providers; however, we do require our

network care providers to assist in resolving grievances, appeals or complaints.

Identification of potential moderate and serious quality of care issues require the medical group/IPA to submit a written response that addresses the identified quality of care issue(s); this may also be referred to our Regional Peer Review Committee for further action.

To Obtain a Grievance Form

California Commercial HMO members can access *grievance forms* online. Please direct members to myuhc.com. The form accessible in two places:

From the California member welcome page or, Library tab page, on the left side, and click on Grievance Form.

Medical Group/IPA's Responsibilities Related to Member Grievance and Appeals

Network care providers are required to:

- Immediately, within one hour of receipt, forward all member grievances and appeals (complaints, appeal, quality of care/service concern, whether oral or written) to UnitedHealthcare West for processing at:
 - › Written grievance/appeal—contact information included in the *How to Contact Us* reference table, set forth under the *Expedited Appeals* and *Standard Member Appeals* sections;
 - › Oral grievance/appeal—contact information included in the *How to Contact Us Reference Table*, set forth under the *Expedited Member Appeals* and *Standard Member Appeals* sections.
- Respond to UnitedHealthcare West requests for information relevant to the member's appeal or grievance within the designated timeframe. Care providers must submit the requested information to UnitedHealthcare's request expedited appeals, within two hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Timeframes apply to every calendar day of the year.
- Comply with all final determinations made by UnitedHealthcare West regarding member appeals and grievances.
- Cooperate with UnitedHealthcare West and the external independent medical review organization including but not limited to, promptly forwarding to the external review organization copies of all medical records, and information relevant to the disputed health care service in the medical group/IPA's possession. Any newly discovered relevant medical records or any information in the participating medical group/IPA's possession, requested by external review organization. Care providers must respond to UnitedHealthcare's requests for proof of effectuation (proof of payment (claim) or a copy of the authorization (pre-service) of overturned appeals:

expedited appeals, within two hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Timeframes apply to every calendar day of the year.

- Provide UnitedHealthcare West with proof of effectuation (Proof of payment (claim) or a copy of the authorization (pre-service) within the stipulated timeframes on reversals of adverse determinations. Care providers must respond to UnitedHealthcare's requests for proof of effectuation of overturned appeals: expedited appeals, within two hours, standard appeals, within 24 hours (no exceptions or delays due to weekend or holidays). Timeframes apply to every calendar day of the year.

Care Provider Claims Appeals

Claims Research and Resolution (Commercial in OK & TX)

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

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

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

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

You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). All rework requests need submission, within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines. The most efficient way to submit your requests is through the claims link application on [Link](#), accessed via [UnitedHealthcareOnline.com](#). You can also submit your request to us in writing by using the *Claims Rework Request form* located on [UHCWest.com](#)

Commercial Delegated Provider Payment Dispute Resolution Process (CA)

The Commercial provider payment dispute resolution (PDR) process includes any decisions where a delegated provider appeals the amount paid by the organization.

The following are the regulatory and UnitedHealthcare compliance requirements:

- "Written Acknowledgement" of provider disputes within two working days for electronic submission and 15 working days for paper submission.
- Resolution and a "Written Determination" must be completed within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
- Resolution of a provider dispute or amended provider dispute involving a claim and which is determined in whole or in part in favor of the provider, must include payment of any outstanding monies determined to be due, and all interest and penalties must be paid within five working days of the issuance of the written determination.
- Incomplete provider disputes where additional information has been requested, the provider has 30 working days to submit additional information.
- Late payment on a complete claim for emergent/urgent services shall include the greater of \$15 or 15% per annum for the period of time that the payment is late.
- Late payment on all other complete claims shall include interest at the rate of 15% (0.000411) per annum for the period of time that the payment is late. Penalty for failure to include interest due on a late claim payment shall pay \$10 for that late claim in addition to the required interest payment.
- Quarterly Dispute Resolution Mechanism Reports must be submitted and signed by the Principal Office within 30 days of the close of each calendar quarter.
- Timeliness is measured from the earliest date stamp within your facilities if you are the financially responsible payer through the date the payment check or notice contesting that claim has been mailed.
- Written procedures for Provider Dispute & Resolution must be established which must include; address, directions for submission, timeframe guidelines and phone numbers for inquiries.
- Improvement Action Plans must be submitted when specified.
- Review process requirements are complied with, including; keeping the scheduled assessment appointment, having all claims and supporting documentation ready at the time of the inspection, canceled checks or bank statements, Operational Review

Questionnaire(s) and Attestations signed and are all available for review.

Excluded From the PDR

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

- Instances in which a member has filed an appeal and you have filed a dispute regarding the same issue. In these cases, the member's appeal will take precedence. You can submit a care provider dispute after the member appeal decision made. If you are appealing on behalf of the member, the appeal processes as a member appeal.
- An Independent Medical Review initiated by a member through the Member Appeal Process.
- Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply "good cause" for the delay.
- Any delegated claim issues that are not been reviewed through the delegated payer's claim resolution mechanism.
- Any request for a dispute, which reviews by the delegated medical group/IPA/payer or capitated facility/ care provider and does not involve an issue of medical necessity or medical management.

UnitedHealthcare West Care Providers Rework or Dispute Process Reference Table

Care Provider's State	Contact Information	Notes
Arizona	PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078	<ul style="list-style-type: none"> • First Review: Request for reconsideration of a claim are considered a grievance care providers and health care professionals are required to notify us of any request for reconsideration within one year from the date the claim was processed. • Second Review: Request for reconsideration of a grievance determination also considered a grievance care providers and health care professionals are required to notify us of any second level Grievance within one year from the date the first level Grievance resolution previously communicated to the care provider.
California	UnitedHealthcare West Care Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	<ul style="list-style-type: none"> • UnitedHealthcare of California will acknowledge receipt of the dispute within 15 business days of receipt of the dispute for disputes submitted by paper, and within 2 business days of receipt of the disputes submitted electronically. We will issue a written determination to the care provider within 45 business days. We will return the care provider dispute if additional information is required within 45 business days.
Colorado	Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983	<p>Upon receipt of a dispute, Colorado Resolution Team will:</p> <ul style="list-style-type: none"> • Acknowledge receipt of the dispute within 30 calendar days of the receipt of the dispute; • Conduct a thorough review of the care provider's dispute and all supporting documentation; • Acknowledge receipt, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute; • Process payment, if necessary, within five business days of the written determination; • Reply to the care provider of service within 30 calendar days if additional information is required; • If additional information is required, we will hold the dispute request for 30 additional calendar days.
Nevada	For Medicare Advantage claims: UnitedHealthcare P.O. Box 95638 Las Vegas, NV 89193-5638	<ul style="list-style-type: none"> • A delegated payer processes all Nevada Medicare Advantage HMO claims; therefore, primarily the delegated payer reviews the care provider appeals.
Oklahoma	UnitedHealthcare West Care Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	
Oregon	UnitedHealthcare West Care Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	<ul style="list-style-type: none"> • UnitedHealthcare of Oregon will allow at least 30 calendar days after the action-giving rise to a dispute for care providers and health care professionals and facilities to complain and initiate the dispute resolution process. • We will render a decision on care provider or facility complaints within a reasonable time for the type of dispute. • In the case of billing disputes, we will render a decision within 60 calendar days of the complaint.
Texas	UnitedHealthcare West Claims Department P.O. Box 400046 San Antonio, TX 78229	
Washington	UnitedHealthcare West Care Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764	<ul style="list-style-type: none"> • UnitedHealthcare of Washington will allow at least 30 calendar days after the action-giving rise to a dispute for care providers and health care professionals and facilities to complain and initiate the dispute resolution process. • We will render a decision on care provider or facility complaints within a reasonable time for the type of dispute. • In the case of billing disputes, we will render a decision within 60 calendar days of the complaint.

Chapter 17: Fraud, Waste and Abuse

The purpose of UnitedHealthcare's 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.

- Payment Integrity functions 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.

Please report to us immediately if you identify compliance issues, or potential fraud, waste, or abuse, so that we can investigate and respond appropriately. For contact information see; [How to Contact Us](#) in Chapter 1.

UnitedHealthcare expressly prohibits retaliation if a report 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 Fraud, Waste and Abuse (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 their code of conduct, or see online at; [UnitedHealth Group's \(UHG's\) Code of Conduct](#).

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

Fraud, Waste, and Abuse and General Compliance Training:

Provide Fraud, Waste, and Abuse (FWA) and General Compliance training.

Effective Jan 1, 2017, CMS has amended the regulations to mandate only the use of CMS published training materials for FDRs of a contracted Medicare plan sponsor. FDRs cannot alter the published CMS training material content; however, CMS will allow FDRs to download CMS training material and add content and topics specific to your organization.

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

The training materials for CMS Parts C and D FWA and General Compliance training module are available on the CMS Medicare Learning Network® at [CMS.gov](#).

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, applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and sub delegates who involved in or responsible for the administration or delivery of UnitedHealthcare MA and Part D benefits or services.

What You Need to Do

- Make sure that potential employees are not excluded from participating in federal health care programs 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 to verify that checks in completion, requested by UnitedHealthcare or CMS.

Examples of Potentially Fraudulent, Wasteful, or Abusive Billing (Not an inclusive list)

- **Back filling:** Billing for part of the global fee before the claim is received for the actual global code;
- **Billing for services not rendered:** Billing for services or supplies that were not provided to the member;
- **Billing for unauthorized services or equipment:** Billing for ancillary, therapeutic or other services without a required physician's order;
- **Billing while ineligible:** Billing for services after care provider's license has been revoked/restricted or after 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 submission 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;

Prevention and Detection

Potential FWA 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 Site](#)

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

Prospective Detection:

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

Retrospective Detection:

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

Improvement 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 improvement action plan if a care provider fails to comply with our billing guidelines or performance standards. We monitor the improvement action plan to confirm implemented effectively, and to help ensure any billing or performance problems 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 treatment, consultation, or waiving copayments and deductibles to motivate members to receive services from a care provider. Care providers who violate this law fined—up to \$10,000 for each wrongful act. Fines assessed for up to three times the amount claimed. Violators excluded from participating in Medicare and Medicaid programs.

Allowable Gratuities: Items or services offered free to members must be worth less than \$10 and total less than \$50 per year per beneficiary. You must never give cash or gift cards to members.

Glossary

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

Accreditation: Recognition processes for network care providers when they meet certain standards, such as quality.

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

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

Adjudication: A process determined with proper payment amount on claim.

Ambulatory Care: Healthcare 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: Facility licensed by state where 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: Healthcare services ordered by a care provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal: 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 rendered. Presently referenced as prior authorization, term previously used precertification.

Authorized Care Provider: Care provider that meets UnitedHealthcare licensing and certification requirements and authorization given 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: A health care item or service covered under a health insurance plan.

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

Care Provider: Person who provides medical or other health care services (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: Documentation of the services during course of visit to health care provider, that occurred.

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

Center for Medicare & Medicaid Services (CMS): Federal agency located within the U.S. Department of Health and Human Services.

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

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

UHC/Provider 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: Services included in members benefit plan are medically necessary with covered services

changing periodically and mandated by federal or state legislation.

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

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

Deductible: Amount a member owes for health care services the health insurance or plan covers, before the health insurance or plan begins to pay.

Delivery System: Mechanisms of delivery to a patient by health care provider. Examples include, but are not limited to, health care facilities, provider offices, and home health care.

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

Disallow Amount: Network care provider medical charges not permitted to receive payment from the health plan and cannot bill the member. Examples are:

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

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

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

Disenrollment: Covered services from a Contractor for member's eligibility discontinued.

Division of Financial Responsibility (DOFR): Participation agreement matrix specifies the financial responsibility of UnitedHealthcare and medical group/IPA or facility for Covered Services.

Durable Medical Equipment (DME): Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. Equipment is also 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): Member's health records in the electronic version.

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

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

Expedited Appeal: Oral or written request by a member or member's personal representative received by UnitedHealthcare. The request is for 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.

Explanation of Payment EOP: If a care provider submits a claim within timely filing guidelines, the care provider should receive an Explanation of Payment (EOP).

Fee for Service: Services paid for to health care providers (like an office visit, test, or procedure).

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

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 Plan Employer Data and Information Set (HEDIS): Set of standardized measures developed by NCQA. Originally, the design was for HEDIS to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS 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.

HIPAA: Health Insurance Portability and Accountability Act

Home Health Care (Home Health Services): Medical care services in the home provided by a visiting nurse. These services include recovering patients, aged homebound patients, or patients with a chronic disease or disability.

Managed Care: Managed care is a system designed to help 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 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) plans.

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

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function;
- 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-efficient 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 his or her physician;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency of demonstrated value; and
- No more 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.

National Provider ID (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 provider agrees to file claims and handle other paperwork for

UnitedHealthcare member. A network provider accepts the negotiated rate as payment in full for services rendered.

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

- **Non-network care provider:** A non-network care provider is a UnitedHealthcare-authorized hospital, institutional care provider, physician, or other provider that furnishes medical services (or supplies) to UnitedHealthcare members without an agreement and does not accept the UnitedHealthcare allowable charge or file claims for UnitedHealthcare members. A non-network care provider may only charge up to 15% above the UnitedHealthcare allowable charge.
- **Network 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. Care providers may seek payment of applicable copayments, cost-shares and deductibles from the member. Under the UnitedHealthcare outpatient prospective payment system, all Medicare network care providers must by law, also participate in UnitedHealthcare for inpatient and outpatient care.

Nurse Practitioner: A registered nurse who has graduated from a program preparing registered nurses for advanced or extended practice, and 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.

Partial Risk: Under a partial risk contract, the facility also receives capitation for institutional services rendered to their assigned members.

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

Primary Care Provider (PCP): A physician chosen by or assigned to a patient and both provides primary care and acts as a gatekeeper to control access to other medical services. Other care 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 a mandatory process where health care providers seek clinical assessment prior to rendering services as required by UnitedHealthcare policy.

Provider Group: Partnership, association, corporation and other groups of providers

Provider Manual: This document referred to as a care provider manual or guide. In addition, 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.

Regional Quality Oversight Committee (RQOC): The Committee activities carried out in collaboration with the West RQOC to avoid duplication of effort. The Senior Medical Director, a physician licensed in CA, chairs the CA-QIC. The committee meets at least quarterly and reports to the UHC of CA BOD and, as needed, to the West RQOC.

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 applied that pays after the primary insurance benefit.

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 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 West contracted provider, as stated in the health care provider's agreement with us.

Shared Risk: Under a shared risk arrangement, the medical group/IPA receives capitation for professional services rendered to its assigned members.

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 providing protection against catastrophic or unpredictable losses, purchased by

employers who have decided to self-fund their employee benefit health plans, but do not want to assume 100% of the liability for losses arising from the plans.

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

Subscriber: Individual with coverage or owns a current insurance policy.

Supplemental benefits: Supplemental insurance includes health benefit plans specifically designed to supplement UnitedHealthcare West Standard benefits.

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

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

UnitedHealthcare West Assisted Living Plan: A Medicare Advantage Institutional Special Needs Plan benefit plans that;

- 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;
- Issued by UnitedHealthcare West Insurance Company or by one of UnitedHealthcare West's affiliates; and offered through our UnitedHealthcare West 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 West Nursing Home Plan: A Medicare Advantage Institutional Special Needs Plan benefit plans that;

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

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

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

Waste: The overutilization of services or other practices that directly or indirectly, result in unnecessary costs to a health care benefit program. Waste not considered 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 his or her employer for the tort of negligence.

Working Day: means Monday through Friday, excluding recognized federal holidays.

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

