Contract year 2021 Medicare Advantage Private Fee-For-Service (PFFS) plan

Terms and conditions of payment

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Terms and conditions of payment

Introduction

UnitedHealthcare® MedicareDirect is a Medicare Advantage Private Fee-For-Service (PFFS) plan offered by UnitedHealthcare Insurance Company, a division of UnitedHealth Group. UnitedHealthcare MedicareDirect allows members to use any care provider, such as a physician, health professional, hospital or other Medicare care provider in the United States who agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the care provider is eligible to provide health care services under Medicare Part A and Part B (also known as "Original Medicare"), or is eligible to be paid by UnitedHealthcare MedicareDirect for benefits that are not covered under Original Medicare.

Centers for Medicare & Medicaid Services (CMS) regulations state that if you have an opportunity to review these terms and conditions of payment and you treat a UnitedHealthcare MedicareDirect member, you will be "deemed" to have a contract with us. Section 2 of this document explains how the deeming process works. The rest of this document contains the contract that the law allows us to deem to hold between you (the care provider) and UnitedHealthcare. Any care provider in the United States who meets the deeming criteria in Section 2 becomes deemed to have a contract with UnitedHealthcare for the services furnished to the UnitedHealthcare MedicareDirect member when the deeming conditions are met. Prior authorization, prior notification or referrals are not required as a condition of coverage when medically necessary, plan-covered services are furnished to a member. However, a member or care provider may request an advance organization determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Advance organization determination is described in Section 7.

When a care provider is deemed to accept UnitedHealthcare MedicareDirect's terms and conditions of payment

A care provider is deemed by law to have a contract with UnitedHealthcare when all of the following 3 criteria are met:

- The care provider is aware, in advance of furnishing health care services, that the patient is a member of UnitedHealthcare MedicareDirect. All of our members receive a member ID card that includes the UnitedHealthcare MedicareDirect plan name that clearly identifies them as PFFS members. The care provider may verify member eligibility online or by phone:
  - **Online:** Use the eligibilityLink tool on Link. Sign in to Link by going to UHCprovider.com and clicking on the Link button in the top right corner. Learn more at UHCprovider.com/eligibilityLink.
  - **Phone:** Call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday.

- The care provider either has a copy of, or has reasonable access to, our terms and conditions of payment (this document). The terms and conditions are available at UHCprovider.com/plans > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit. The terms and conditions may also be obtained by calling Provider Services at 877-842-3210 from 7 a.m.–7 p.m. Central Time, Monday–Friday.

- The care provider furnishes services to a UnitedHealthcare MedicareDirect member that are covered by the plan.

If all of these conditions are met, the care provider is deemed to have agreed to UnitedHealthcare MedicareDirect's terms and conditions of payment for that member, specific to that visit. For example, if a UnitedHealthcare MedicareDirect member shows you a member ID card identifying themselves as a member of UnitedHealthcare MedicareDirect and you provide services to that member, you will be considered a deemed care provider specific to that visit. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (as outlined later in this section).

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Please note: A decision to treat one plan member does not obligate you to treat other UnitedHealthcare MedicareDirect members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

If you do not wish to accept UnitedHealthcare MedicareDirect's terms and conditions of payment, then you should not furnish services to a UnitedHealthcare MedicareDirect member, except for emergency services. If you furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Care providers furnishing emergency services will be treated as non-contracting (i.e., non-deemed) providers and paid at the payment amounts they would have received under Original Medicare.

Care provider qualifications and requirements

In order to be paid by UnitedHealthcare MedicareDirect for services provided to one of our members, you must:

- Have a National Provider Identifier (NPI) number in order to submit electronic transactions to UnitedHealthcare MedicareDirect, in accordance with Health Insurance Portability and Accountability Act (HIPAA) requirements
- Be licensed or certified by the state and furnish services to a UnitedHealthcare MedicareDirect member within the scope of your licensure or certification
- Provide only services that are covered by our plan and are medically necessary according to Medicare definitions
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider, such as a hospital, skilled nursing facility or home health agency)
- Have not opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services
- Not be on the United States Department of Health and Human Services (HHS) Office of Inspectors General excluded and sanctioned provider lists
- Not be included on the CMS preclusion list
- Not be a federal health care provider, such as a Veterans' Administration provider, except when providing emergency care
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members. Please note that you are subject to laws applicable to persons or entities receiving federal funds, and must notify all subcontractors that they are also subject to these laws.
- Agree to cooperate with UnitedHealthcare MedicareDirect to resolve any member grievances involving the care provider within the time frame required under federal requirements
- Agree to abide by our appeal and grievance procedures. To obtain a copy of our procedures, please call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday. You can also access the appeal and grievance procedures at UHCprovider.com/plans > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Tools & Resources > Medicare Advantage Non-Contracted Provider Dispute and Appeal Rights.
- For facilities that are hospitals, home health agencies, skilled nursing facilities or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (see Section 11 for specific requirements)
- Agree to collect from the member their cost share amount as identified in the member's Evidence of Coverage. Please note that balance billing is prohibited.
- Agree to accept the terms and conditions of payment outlined in this document and provide services to a UnitedHealthcare MedicareDirect member
- Agree to bill UnitedHealthcare MedicareDirect directly for reimbursement

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All eligible physicians, facilities and other health care professionals who render services to UnitedHealthcare MedicareDirect members must accept our payment plus the member's applicable cost sharing as payment in full. Physicians, hospitals and other health care professionals who render services to UnitedHealthcare MedicareDirect members must adhere to all industry standards, as well as state and federal requirements.

Payment to care providers

Plan payment

UnitedHealthcare MedicareDirect reimburses deemed care providers the amount they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services minus any member-required cost sharing, for all medically necessary services covered by Medicare.

We will process and pay clean claims within 30 calendar days of receipt. If a clean claim is not paid within the 30-calendar-day time frame, we will pay interest on the claim according to Medicare guidelines. Section 5 of this document has more information about prompt payment rules. Payment to care providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. For more information about our payment methodology for all care provider types, go to UHCprovider.com/plans > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit > Private-Fee-For-Service (PFFS) Reimbursement Guide.

Services covered under UnitedHealthcare MedicareDirect that are not covered under Original Medicare, such as annual physical exams, routine foot care and routine vision and hearing exams, are reimbursed as described in the Service Categories in the Reimbursement Guide. For more information, go to UHCprovider.com/plans > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit.

For more detailed information about our payment methodology for all care provider types, go to UHCprovider.com/plans > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit > Private-Fee-For-Service (PFFS) Reimbursement Guide.

Deemed care providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

Member benefits and cost sharing

Members are responsible for paying their cost share amount. Care providers should collect the applicable cost share from the member at the time of service when possible. You can only collect from the member the appropriate UnitedHealthcare MedicareDirect copayments or coinsurance amounts as described in these terms and conditions. After collecting the member's cost share, you should bill UnitedHealthcare MedicareDirect for covered services. Section 5 of this document provides instructions for how to submit claims to us. Please note, however, that UnitedHealthcare MedicareDirect may not hold members accountable for any cost sharing (deductibles, copayments or coinsurance) for Medicare-covered preventive services that are subject to zero cost sharing.

If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a state Medicaid program), then the care provider cannot collect any cost sharing for Medicare Part A and Part B services from the member at the time of service when the state is responsible for paying such amounts (nominal copayments authorized under the Medicaid state plan may be collected). Instead, the care provider may only accept the Medicare Advantage plan payment (plus any Medicaid copayment amounts) as payment in full or bill the appropriate state entity.

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For more information about covered benefits, plan payment rates and member cost sharing amounts under UnitedHealthcare MedicareDirect, please call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday. Please be sure to have the member's ID number when you call.

UnitedHealthcare MedicareDirect follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by UnitedHealthcare MedicareDirect, unless specified by the plan. Information about obtaining an advance coverage determination can be found in Section 7. UnitedHealthcare MedicareDirect does not require members or care providers to obtain notification/prior authorization or referrals from the plan as a condition of coverage. There are no notification/prior authorization rules for UnitedHealthcare MedicareDirect members.

Please note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including PFFS plans. All cost sharing is the member's responsibility.

DMEPOS Competitive Bidding Program

The DMEPOS Competitive Bidding Program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while helping to ensure beneficiary access to quality items and services.

Under the program, a competition among suppliers who operate in a particular competitive bidding area is conducted. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the single payment amount.

Round 1 2017, Round 2 Recompete and the National Mail-Order Recompete competitive bidding contracts expired on Dec. 31, 2018. Round 2021 of the program is scheduled to begin on Jan. 1, 2021, and will extend through Dec. 31, 2023.

On Oct. 27, 2020, CMS announced the single payment amounts for the following product categories included in Round 2021:

- Off-the-shelf (OTS) back braces
- OTS knee braces

CMS is consolidating the competitive bidding areas (CBAs) included in Round 1 2017 and Round 2 Recompete by conducting Round 2021 in the same geographic areas for a total of 130 CBAs. The CBAs are identified by counties and ZIP codes. A CBA is an area where only the DMEPOS Competitive Bidding Program contract suppliers may furnish competitively bid lead and non-lead items to beneficiaries unless an exception is permitted by regulations. CBAs are based on metropolitan statistical areas (MSAs) that include major cities and their surrounding suburban areas.

For the list of CBAs, visit dmecompetitivebid.com/cba.

UnitedHealthcare MedicareDirect PFFS plan members cannot be required to obtain the DMEPOS competitive-bid items only from contract suppliers. Members will continue to have access to deemed suppliers in CBAs who (1) agree to accept the plans' terms and conditions of payment, which, in this case, reflects the new FFS Medicare payment

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amounts for DMEPOS competitive-bid items, and (2) have met Original Medicare accreditation requirements for the DMEPOS supplies.

For additional information about the program, visit the DMEPOS Competitive Bidding home page at cms.hhs.gov/DMEPOSCompetitiveBid/.

Prohibition of balance billing members

A care provider may collect only applicable plan cost sharing amounts from UnitedHealthcare MedicareDirect members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to UnitedHealthcare MedicareDirect members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by UnitedHealthcare MedicareDirect, insolvency of UnitedHealthcare MedicareDirect, and/or breach of these terms and conditions, shall a deemed care provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, copayments or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

Filing a claim for payment

- You must submit a claim to UnitedHealthcare MedicareDirect for Original Medicare covered services within the same time frame you would have to submit under Original Medicare, which is within 1 calendar year after the date of service.
- Failure to submit claims on time may result in nonpayment. Per Medicare regulation 42 CFR 424.44, for services furnished on or after Jan. 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.
- Prompt payment: UnitedHealthcare MedicareDirect will process and pay clean claims within 30 calendar days of receipt. If a clean claim is not paid within 30 calendar days, UnitedHealthcare MedicareDirect will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. UnitedHealthcare MedicareDirect will process all non-clean claims and notify care providers of the determination within 60 calendar days of receiving such claims.
- Submit claims using the standard CMS-1500 form, CMS-1450 (UB-04) form or appropriate electronic filing format.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT® Codes, Healthcare Common Procedure Coding System (HCPCS) codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.
- Clean claims: A completed clean claim must include the following information:
  - Member name
  - UnitedHealthcare MedicareDirect identification number
  - Date(s) of service
  - Procedure, service, supply and National Drug Codes (NDC)
  - Diagnosis code(s) to the highest level of specificity
  - Care provider's billing name and address
  - Care provider's tax ID number (TIN), unique physician identification number (UPIN) or Social Security number
  - National Provider Identifier (NPI) number (for more information about NPI numbers, see "Your Medicare NPI

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number" on page 8)
  - Days/units of service
  - Place of service
  - Total dollar amount billed
- Other documentation may also be required depending on the care provider type and services billed on a specific claim.
- Interim rate letters: For facilities not paid under Prospective Payment System (PPS) methodology, UnitedHealthcare MedicareDirect must have an interim rate letter on file for any date(s) of service for which services were rendered to a member. Fax letters and updates to Reimbursement Services at 866-943-9811.
- Coordination of benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual. Care providers should identify primary coverage and provide information to UnitedHealthcare MedicareDirect at the time of billing.

Where to submit a claim

- UHCprovider.com and Link: Link is the gateway to UnitedHealthcare's online tools for care providers. To sign in to Link, go to UHCprovider.com and click on the Link button in the top right corner. On Link you can:
  - Submit claims
  - Check patient eligibility and benefits
  - Check claims status and submit reconsideration requests
  - Watch on-demand videos through UHC On Air

  If you have questions or need help using Link, go to UHCprovider.com/link or call the UnitedHealthcare Connectivity Help Desk at 866-842-3278, option 1, from 7 a.m.–9 p.m. Central Time, Monday–Friday.

- For electronic claim submission, UnitedHealthcare MedicareDirect accepts electronic transactions from multiple clearinghouses for our PFFS plan. Using Electronic Data Interchange (EDI) for all eligible UnitedHealthcare transactions can help your organization improve efficiency, reduce costs and increase cash flow. Go to UHCprovider.com/edi to get started with electronic transactions. We recommend that you contact your clearinghouse to determine their available connectivity to UnitedHealthcare. To submit claims through EDI, please use payer ID 87726. Learn more at UHCprovider.com/edi.

  To avoid processing delays, you must validate the appropriate UnitedHealthcare MedicareDirect Payer ID number with your clearinghouse or refer to your clearinghouse's Published Payer Lists. Using a clearinghouse may help ensure that EDI requirements outlined in HIPAA are met. For more information about Electronic Payments & Statements, go to UHCprovider.com/eps or call the UnitedHealthcare Connectivity Help Desk at 866-842-3278, option 5.

  For information about receiving your provider remittance advice (PRA) electronically, go to UHCprovider.com/edi > EDI 835: Electronic Remittance Advice (ERA), or call 800-842-1109, option 4.

- For paper claim submissions, submit completed, hard copy CMS-1500 or CMS-1450 (UB-04) format claims to:
  UnitedHealthcare MedicareDirect
  P.O. Box 31353
  Salt Lake City, UT 84131-0353

  If you need help submitting claims or have billing questions, call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday.

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Claim status

Care providers can find out why a claim was adjudicated either by checking its status using the claimsLink tool on Link or by reading the PRA that accompanies each claim payment. The PRA also includes additional information or instructions related to denied claims. If you have questions about your claim status or the PRA, call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday.

Resubmitting claims

There is a different process for resubmitting previous claims containing the same information versus resubmitting previous claims with new information. If the claim information has not changed, you can resubmit a hard copy by mail, electronically using EDI or online using the claimsLink tool on Link.

- Mail: Send the claim to:
  UnitedHealthcare MedicareDirect
  P.O. Box 31353
  Salt Lake City, UT 84131-0353

- EDI: Use Payer ID 87726
- Online: Go to UHCprovider.com/claimsLink.

If new information or further documentation has been added, a paper claim needs to be mailed and stamped with "Corrected Claim" or "Resubmission." Do not use Link or EDI to resubmit a claim with new information.

Resubmissions versus reconsiderations

There is a difference between resubmissions and reconsiderations. Resubmissions are submitted when more information is needed to process a claim and make a determination. For example, additional information may be requested on a PRA. Reconsiderations are filed by providers after a claim determination has been made and the provider disagrees with the payment decision. Reconsiderations are the first step in the provider dispute resolution process.

Your Medicare NPI number

CMS, and many state Medicaid agencies, require an NPI number to be included on all electronic and paper claim submissions. To avoid payment delays or denials, include a valid NPI number on all UnitedHealthcare MedicareDirect claims submitted for processing.

In addition to the NPI number, it's also important to continue to submit a tax identification number (TIN). Please continue to submit complete claims to comply with clean claim billing requirements. If you have not yet applied for and received your NPI number, please do so immediately at nppes.cms.hhs.gov/NPPES/Welcome.do.

Maintaining medical records and allowing audits

Deemed providers should maintain timely and accurate medical, financial and administrative records related to services they render to UnitedHealthcare MedicareDirect members. Unless a longer time period is required by applicable statutes or regulations, the care provider should maintain such records for at least 10 years from the date of service.

Deemed providers must provide UnitedHealthcare MedicareDirect, HHS, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with federal and state privacy laws. Such records will primarily be used for CMS audits of risk adjustment data upon

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which CMS capitation payments to UnitedHealthcare MedicareDirect are based. Care providers are required to furnish member medical records without charge when the medical records are required for government use.

UnitedHealthcare MedicareDirect may also request records for activities in the following situations:

- To conduct audits of risk adjustment data; determinations of whether services are covered under the plan, are reasonable and medically necessary; and whether the plan was billed correctly for the service
- To investigate fraud and abuse
- To make advance coverage determinations

UnitedHealthcare MedicareDirect will not use these records for any purpose other than the intended use. Care providers will not be reimbursed for furnishing the member medical records. UnitedHealthcare MedicareDirect will not use medical record reviews to create artificial barriers that would delay payments to care providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

Getting an advance organization determination

Care providers or members may choose to obtain a written advance coverage determination (known as an organization determination) from us before furnishing services to confirm whether the service will be covered by UnitedHealthcare MedicareDirect. To obtain an advance organization determination, care providers should call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday. UnitedHealthcare MedicareDirect will make a decision and notify you and the member within 14 calendar days of receiving the request, with a possible (up to) 14-calendar-day extension either due to the member's request or UnitedHealthcare MedicareDirect justification that the delay is in the member's best interest.

In cases where you believe that waiting for a decision within this time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, care providers should call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday. We'll notify you of our decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14-calendar-day extension either due to the member's request or UnitedHealthcare MedicareDirect's justification that the delay is in the member's best interest.

Members can also ask for coverage decisions for medical care using the following methods:

- Call: 866-579-8774, TTY 711, 8 a.m.–8 p.m. local time, 7 days a week
- Fax: 888-950-1170
- Mail:
  UnitedHealthcare Customer Service Department (Organization Determinations)
  P.O. Box 30770
  Salt Lake City, UT 84130-0770
- Online: myUHCMedicare.com

In the absence of an advance organization determination, UnitedHealthcare MedicareDirect can retroactively deny payment for a service furnished to a member if we determine the service was not covered by our plan or was not medically necessary. However, care providers have the right to appeal our decision by submitting a waiver of liability (promising not to bill the member regardless of the outcome). See the Federal regulations at 42 CFR Part 422, subpart M, or Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

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Care provider payment dispute resolution process

If you believe the payment amount you received for a service is less than the amount described in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process. To file a dispute with UnitedHealthcare MedicareDirect, send a written dispute to:

UnitedHealthcare MedicareDirect – Payment Disputes
P.O. Box 30997
Salt Lake City, UT 84130-0997

Please be sure to include a completed "Non-Contracted Provider Claim Payment Dispute Request Form," which is available at UHCprovider.com/plans > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Tools & Resources > Medicare Advantage Claim Payment Dispute Request Form for Non-Contracted Care Providers.

Additionally, please provide appropriate documentation to support your payment dispute, such as a PRA from a Medicare carrier. Claims must be disputed within 120 calendar days from the PRA notification date. Please note that in cases where we re-adjudicate a claim (for instance, when we discover that we processed it incorrectly the first time), you have an additional 120 calendar days from the date you are notified of the re-adjudication in which to dispute the claim.

We will review your dispute and respond to you within 30 calendar days. If we agree with the reason for your payment dispute, we'll pay you the additional amount you're requesting, including any interest that is due. We'll inform you in writing if our decision is unfavorable and no additional amount is owed.

Member and care provider appeals and grievances

UnitedHealthcare MedicareDirect members have the right to file appeals and grievances with UnitedHealthcare MedicareDirect when they have concerns or problems related to coverage or care. Members may appeal a decision made by UnitedHealthcare MedicareDirect to deny coverage or payment for a service or benefit that they believe should be covered or paid. Members should file a grievance for all other types of complaints, such as dissatisfaction with any aspect of the operations, activities or behavior of the plan or its delegated entity.

A care provider who is providing treatment may, upon notifying the member, appeal pre-service organization determination denials to the plan on behalf of the member. The provider may also appeal a post-service claim denial as an authorized representative or by a signed waiver of liability (promising not to bill the member regardless of the outcome). If you appeal on your own right, you agree to abide by the statutes, regulations, standards and guidelines applicable to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance.

In addition to the member's care provider, any individual (e.g., relative, friend, advocate, attorney, etc.) may appeal organization determinations on behalf of the member as a representative and appeal post-service organization determinations (e.g., claims) using the member appeal process.

To learn more about the appeals and grievance process, go to UHCMedicareSolutions.com > Shop for a Plan > Resources > Medicare Advantage Plan Resources > > Medicare Advantage and Special Needs Plan Information and Forms > Other Resources and Plan Information > Medicare Advantage (no prescription drug coverage) Appeals and Grievances. You can also call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday for more information about appeals and grievance policies and procedures.

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Quality Improvement Organization (QIO) complaint process

If the member is concerned about the quality of care they've received, they can file a complaint with the local Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). The QIO is an entity paid by CMS to review medical necessity, access to care, appropriateness and quality of certain medical care and services provided to Medicare beneficiaries by practicing physicians and other health care professionals. The QIO review process is designed to identify and eliminate any improper practices.

Providing members with notice of their appeals rights – requirements for hospitals, skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs) and home health agencies (HHAs)

Hospitals must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including complying with the Medicare regulatory time frames for delivery. For copies of the notice and additional information regarding IM notice and delivery requirements, click here.

Hospitals must also provide a Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries. The MOON is a standardized, written notice explaining that a Medicare beneficiary, including Medicare Advantage beneficiaries enrolled in PFFS plans, is receiving outpatient observation services, and is not an inpatient. The MOON must include the reasons the individual is an outpatient receiving observation services and the implications of receiving such services. Hospitals and critical access hospitals (CAHs) must deliver the MOON no later than 36 hours after initiation of observation services. For copies of the notice and the notice instructions, click here.

SNFs, HHAs and CORFs must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, about their right to appeal a termination of services decision by complying with the requirements for providing the Notice of Medicare Non-Coverage (NOMNC), including complying with the Medicare regulatory time frames for delivery. For copies of the notice and the notice instructions, click here. As directed in the instructions, the NOMNC should contain UnitedHealthcare MedicareDirect contact information somewhere on the form (such as in the additional information section on page 2 of the NOMNC).

Hospitals, HHAs, CORFs or SNFs must provide members with a detailed explanation on behalf of the plan if a member notifies the QIO that the member wishes to appeal a decision regarding a hospital discharge (Detailed Notice of Discharge) or termination of HHA, CORF or SNF services (Detailed Explanation of Non-Coverage) within the time frames specified by Medicare regulation. For copies of the notices and the notice instructions, click here (Hospital Discharge Appeal Notices) and here (Medicare Advantage Expedited Determination Notices).

Uncollectible accounts (bad debt)

Care providers must make reasonable and customary collection efforts before categorizing a patient account as uncollectible (bad debt). Charges for non-covered services are not eligible for bad debt reimbursement. No less than 120 days from the date the member received the first bill for the claim in question, and up to 12 months after that, care providers may submit a request for reimbursement of the applicable portion of the bad debt. The bad debt submittal form, which is available at UHCprovider.com/plans > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Tools and Resources > UnitedHealthcare MedicareDirect (PFFS) Uncollectible Amounts (Bad Debt) Submittal Form, must be completely filled out, listing only the amount of cost sharing for covered services assessed under the member's UnitedHealthcare MedicareDirect benefit plan that could not be collected from the

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member, net of any partial amount(s) collected. Please note that documentation of billing and collection efforts may be requested during processing.

The bad debt submittal form should be mailed to:

UnitedHealthcare MedicareDirect
P.O. Box 31353
Salt Lake City, UT 84131- 31353

A completed form will be processed within 30 days of receipt unless additional information or verification has been requested. If payment or a request for additional information has not been received within 30 days, care providers may call Provider Services at 877-842-3210, 7 a.m.–7 p.m. Central Time, Monday–Friday.

Need additional information or have questions?

For inquiries related to member eligibility, benefits, copayments and claims status, call Provider Services at 877-842-3210 or use Link, your gateway to UnitedHealthcare's online tools. Learn more and sign in at UHCprovider.com/link.

UnitedHealthcare MedicareDirect encourages care providers to verify the member's eligibility before providing services.

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