univera HEALTHCARE

Participating Provider Manual

Provider.UniveraHealthcare.com

UN-144

Univera Healthcare
Participating Provider Manual

Section 1: Introduction

Revised September 2024

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1.1 About the Manual

Univera Healthcare's *Participating Provider Manual* is a reference and source document for physicians and other providers who participate with Univera Healthcare. This manual clarifies and supplements various provisions of a provider's participation agreement. In the event of a conflict between the provisions of this manual and a provider's participation agreement with Univera Healthcare, the participation agreement controls.

The *Participating Provider Manual* contains relevant program policies and procedures with accompanying explanations and exhibits. Univera Healthcare encourages providers to give this document to staff who perform the administrative, billing, and quality assurance functions in their organizations. It is essential that they understand Univera Healthcare's programs and the procedures Univera Healthcare has established for effective implementation and operation. Univera Healthcare updates this manual as needed.

Representatives of the Provider Relations department are also available to provide on-site training at provider offices. For more information, visit our website (see below) or call Customer Cares (see the *Contact List* in this manual for addresses and telephone numbers).

Provider.UniveraHealthcare.com/resources/management/staff-training

1.2 About Univera Healthcare

Health Plan Description

Univera Healthcare is a nonprofit health plan serving members across western New York's eight-county region. Univera Healthcare is part of a family of companies that finances the delivery of vital health care services to approximately 1.5 million people across upstate New York. Univera Healthcare offers an array of product options designed to fit people's lives better. It also offers valuable health-related resources that members use every day, such as cost-saving prescription drug discounts and member discounts and programs.

More information is available at Provider.UniveraHealthcare.com. See the *Administrative Information* section of this manual for information about the website.

Our mission is to improve the health of our members and communities served by:

Providing access to affordable, effective health care services;

Being responsible stewards of our communities' health care premiums and health care resources;

Seeking ways to continually improve the health and health care of the residents of the communities we serve.

Health Plan Responsibilities

In interacting with participating providers, Univera Healthcare's responsibilities are set forth in individual providers' participation agreements.

Below are some of Univera Healthcare's responsibilities:

- Determining enrollment status and eligibility for covered services.
- Arranging for utilization management decision-making that 1) is based only on appropriateness of care and service and existence of coverage; 2) does not specifically reward practitioners or other individuals for issuing denials; and 3) does not offer financial incentives for utilization management decision-makers to encourage inappropriate underutilization.
- Providing and administering grievance and appeal processes for members and providers and offering information on how to access the process.
- Promptly paying clean and uncontested claims for covered services to eligible members in accordance with the time frames required by law and in accordance with the terms of the providers' participation agreements.

- Compensating participating physicians and other providers directly, consistent with the reimbursement methodologies described in participation agreements.
- Maintaining and ensuring access to all appropriate records relating to Univera Healthcare performance which an authorized representative of the local Department of Social Services, New York State Department of Health or any other authorized governmental agency may require.

Code of Conduct

Univera Healthcare maintains a Code of Business Conduct (the Code) prepared with the advice and assistance of legal counsel and approved by the Board of Directors. The Code is a formal statement of the corporation's commitment to the standards and rules of ethical business conduct. It applies to employees, directors, officers, contractors, and others with whom Univera Healthcare does business. In addition to being committed to upholding the rules set forth in the Code, Univera Healthcare is committed to conducting all activities in accordance with applicable laws and regulations.

Providers may obtain a copy of the applicable Code on our website (see below) or by requesting a copy afrom Customer Care (see the *Contact List* in this manual for Univera Healthcare addresses and telephone numbers).

News.UniveraHealthcare.com/compliance

Prohibition on Restricting Provider Discussion with Members

As mandated by New York State Public Health Law, Univera Healthcare will not, by contract, written policy, or written procedure, prohibit or restrict any provider from:

Disclosing to any subscriber, enrollee, patient, designated representative or, where appropriate, prospective enrollee, any information that such provider deems appropriate regarding a condition or a course of treatment of an enrollee including the availability of other therapies, consultations, or tests, or the provisions, terms, or requirements of Univera Healthcare's products as they relate to the enrollee, where applicable, regardless of benefit coverage limitations.

Filing a complaint or making a report or comment to an appropriate governmental body regarding the policies or practices of Univera Healthcare when the provider believes that the policies or practices have a negative impact on the quality of, or access to, patient care.

Advocating to Univera Healthcare on behalf of the enrollee for approval or coverage of a particular treatment or for the provision of health care services.

In addition, nothing in Univera Healthcare's agreements with providers is intended to, or shall be deemed to, transfer liability for Univera Healthcare's own acts or omissions, by indemnification or otherwise, to a provider.

Business Continuity

Univera Healthcare is responsible for creating and maintaining business continuity plans for all of its business units. In the event of a business interruption, we have plans designed to allow us to continue operations of critical business functions, such as claims processing, utilization management, and provider relations. We accomplish this in part by:

- Adopting a communication plan to ensure that Univera Healthcare employees receive emergency notifications and instructions via a variety of sources, including in-building announcements, telephone, and email contact, toll-free numbers, and websites
- Relocating impacted business units to designated recovery locations.
- Using redundant processing capacity at other locations.
- Designing our technology and systems to support the recovery process for critical business functions.
- Using business and technology teams that are responsible for activating and managing the recovery process.
- Rehearsing our incident response and recovery procedures and testing those procedures on a regular basis.

In the event of a business interruption impacting Univera Healthcare, its communities, and/or key stakeholders, all business units directly or indirectly involved in ensuring notification to providers will assess the impact, develop the message, obtain executive approval, and deploy the message to providers. Information may include any claims submission changes including the elimination of referrals and authorization requirements, if necessary, and anticipated changes to the payment cycle. Routine updates will also be available on Univera Healthcare's website, Provider.UniveraHealthcare.com.

1.3 Univera Healthcare Products

Univera Healthcare offers its members various kinds of health care coverage, ranging from managed care to indemnity, and including Medicare supplemental coverage and Medicare Advantage health benefit programs.

Below are brief definitions of the various types of health benefit programs. At the end of this section of the manual is a chart (*Product Portfolio*) showing which programs fall into which category. Please note that some program types may include parts of more than one category (e.g., health savings account).

Note: Univera Healthcare also provides administrative services only (ASO) for some employer groups. While the product may carry the same name as one of the commercial products in the *Product Portfolio* at the end of this section, the employer group may modify the benefit design. Example: An employer group may add preauthorization requirements to an indemnity benefit plan.

Health Maintenance Organization (HMO)

The HMO is the most restrictive type of health benefit program. There are normally no out-of-network benefits except for emergencies or if there is no provider in the needed specialty within the network. (In the latter instance, preauthorization from Univera Healthcare is required.)

Members must select a primary care physician (PCP) to coordinate all their care, including referrals to specialists (if required). Many services require preauthorization. This type of plan provides comprehensive benefits, including coverage for routine/preventive care for children and adults. There are normally no deductibles to be met before benefits begin. Member cost-sharing consists of copayments (flat dollar amounts per visit) and/or coinsurance (percentage of Univera Healthcare's allowed amount). The member has no other financial liability unless he or she has self-referred (if PCP referral is required) or sought services that are not covered. (See the information on patient financial responsibility in the *Administrative Information* section of this manual.)

Point-of-Service (POS)

Members with point-of-service coverage must also select a PCP and get referrals to specialists (if required), but they have the option to seek care on their own without a referral. They can also go out of network for services and still have a level of coverage. Again, member cost-sharing consists of copayments and/or coinsurance, both of which are higher for out-of-network care. In addition, if members go out of network, they could also be liable for charges beyond the in-network benefit.

Preferred Provider Organization (PPO)

In a PPO health benefit program, the member does not have to select a PCP or get a referral to see a specialist. Some services require preauthorization. While the program covers in-network and out-of-network services, the member's cost-sharing is higher for out-of-network care. For many services, the member must meet a deductible before coverage begins. Once this occurs, the member is responsible for only copayments and/or coinsurance (depending on the service), unless he or she has gone to an out-of-network provider. In this case, in addition to higher copays/coinsurance, the member could be liable for charges beyond Univera Healthcare's in-network benefit.

Exclusive Provider Organization (EPO)

An EPO health benefit program works much like a PPO. The difference is that there are no out-of-network benefits except for emergencies or if there is no provider in the needed specialty within the network. In the latter case, the member must have preauthorization from Univera Healthcare before the Plan will cover the out-of-network service.

Indemnity

Most indemnity health benefit programs include coverage for both inpatient and outpatient services. Coverage levels may vary depending on the program, or even on the specific health care service. The member must meet a deductible before coverage begins for most services. Members with this type of coverage do not have to select a PCP or get a referral. Some programs may have more limits than others (in other words, some services may not be covered at all). Others may include optional riders that include preauthorization requirements.

There are no restrictions on where members may seek care. However, if they receive care for covered benefits from participating providers, they are responsible only for their contractual cost-sharing amounts. If they receive care from non-participating providers, they could be liable for charges beyond Univera Healthcare's payment to non-participating providers.

Consumer-Driven or High-Deductible Health Plans (CDHPs/HDHPs)

Consumer-driven or high-deductible health plan products encourage members to act as consumers when spending their benefits dollars, much as they do when making any other purchasing decision. They normally have high deductibles, meaning that the member is

financially responsible until reaching an annual upper limit, at which time plan coverage begins. This feature makes the premiums for these programs more affordable for employer groups and individuals.

Health Savings Accounts (HSAs)

One type of consumer-driven health plan incorporates a health savings account. A health savings account, or HSA, is an alternative funding arrangement for traditional health insurance. It is a savings account that offers a different way for consumers to pay for their health care. HSAs enable members to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis.

In order for a member to take advantage of an HSA, the member must be covered by a high-deductible health plan (HDHP). The federal government sets the requirements for the HDHP paired with an HSA option. The member is responsible for the deductible and can pay it with funds from the HSA. Members with these accounts may also have a debit card that can be used to purchase health care with funds from the HSA.

Employer groups who purchase a product with an HSA option for their employees cannot require the employee to open an HSA. Therefore, it is important not to make assumptions that the patient has one of these accounts from which to pay his or her deductible and other out-of-pocket expenses (provided there is an adequate amount in the account).

Special Programs for Low-Income Uninsured

Univera Healthcare offers a special program that provides basic coverage at lower cost to the member. It has specific eligibility criteria that the prospective member must meet. The program is designed to help fill the gap for people not qualified for government-sponsored programs. The special program follows HMO guidelines. Members with this coverage must have an assigned primary care physician. This means that, with few exceptions, there are no out-of-network benefits except for emergency services. There are no out-of-network benefits except in the case of emergencies or if there is no provider in the needed specialty within the network. In the latter case, the member must have preauthorization before Univera Healthcare will cover the out-of-network service.

Healthy NY

New York state has a program for low income uninsured persons called Healthy NY. The product information is listed in the Product Portfolio included in this section under New York State Government Programs. There are no out-of-network benefits for Healthy NY products, except for emergency services, unless authorized by Univera Healthcare.

Medicare Supplements

These programs supplement a member's Medicare Part A and Part B coverage. The Centers for Medicare & Medicaid Services (CMS) designs the benefits for Medicare supplements. Univera Healthcare offers several supplements, all of which are indemnity supplements.

Medicare Advantage Programs

A Medicare Advantage program is an alternative to a Medicare supplement. In a Medicare Advantage program, the federal government pays Univera Healthcare a certain amount for each member in the program. Rather than billing Medicare, providers bill Univera Healthcare as primary payor for services rendered to a Medicare Advantage program member. Univera Healthcare, in turn, pays the provider directly according to the negotiated fee schedule.

Medicare Advantage programs follow guidelines of the particular benefit design, such as HMO or PPO. In addition, providers must comply with other requirements specific to these programs. Please see the *Medicare Advantage Programs* section for additional information on these requirements.

Dual Special Needs Plan (D-SNP)

D-SNP is a type of MA plan that is specifically designed to integrate and coordinate care for beneficiaries who are eligible for both Medicare and Medicaid Managed Care (MMC) coverage. We currently offer a Highly Integrated Dual Eligible (HIDE) plan that offers additional benefits beyond what traditional Medicare and Medicaid covers.

D-SNP programs follow guidelines of the particular benefit design, such as HMO. In addition, providers must comply with other requirements specific to these programs. Please see the D-SNP section for additional information on D-SNP.

1.4 Commitment to Members

Customer Care

Providers may tell members who have any questions or concerns about their coverage to contact Customer Care. (The telephone number for Customer Care is listed on the member's ID card.) Providers may also contact Univera Healthcare with questions and concerns. (See the *Administrative Information* section of this manual for Univera Healthcare requirements for confirming an established relationship with the member.)

Univera Healthcare also encourages members to contact Customer Care if they are dissatisfied with any aspect of their care or coverage. If a complaint cannot be resolved immediately on the telephone, a Customer Care Advocate will assist the member, his/her designee, or his/her provider in initiating an appeal or grievance. For information about the grievance and appeals process, see the *Benefits Management* section of this manual.

Privacy and Confidentiality

Univera Healthcare has established procedures for compliance with all federal and state statutes, regulations and accreditation standards governing the use, protection and dissemination of medical records and protected health information, including medical records, claims, benefits, surveys, and administrative data. Univera Healthcare utilizes protected health information and data to assist in the delivery of health care, to compensate providers, and to measure and improve care.

Univera Healthcare recognizes that an individual who submits or authorizes his or her health care provider to submit, medical and dental claims information for processing and payment has an expectation that such information, to the extent it identifies the individual, will not be disclosed in any manner that violates federal or state law or regulation.

Univera Healthcare affords members the opportunity to authorize or deny the release of identifiable protected health information. By law, a member must provide a special authorization for Univera Healthcare to release protected health information, including mental health, substance use, abortion, sexually transmitted diseases, genetic testing, and HIV/AIDS-related information. Members may authorize the release of some or all of their protected health information by completing an authorization form.

For those members who lack the ability to give authorization, Univera Healthcare will obtain authorization from a legally designated, qualified person, such as the member's legal guardian or person with the member's power of attorney.

Confidentiality of behavioral health and substance use information requires each health care provider to develop policies and procedures to ensure confidentiality of mental health and substance use-related information. Provider policies and procedures must include 1) initial and annual in-service education of

staff and contractors, 2) identification of staff allowed to access and the limits of such access, 3) procedures to limit access to trained staff, including contractors, 4) the protocol for secure storage, including electronic storage, and 5) procedures for handling requests for behavioral health and/or substance use information protocols to protect persons with behavioral health and/or substance use disorders from discrimination.

A copy of Univera Healthcare's Privacy Notice is available upon request from Customer Care, as is Univera Healthcare's overall privacy policy.

Member Rights and Responsibilities

Univera Healthcare's members have certain rights and responsibilities, as outlined below. These are also available on our website, Provider.UniveraHealthcare.com/resources/member-rights. Many of them involve responsibilities, as well as rights, of the practitioners providing service.

Members have the right to:

- Receive all the benefits to which they are entitled under their contract.
- Receive quality health care through their providers in a timely manner and in a medically appropriate setting.
- Receive considerate, courteous, and respectful care.
- Be treated with respect and recognition of their dignity and their right to privacy.
- Information about services, staff, hours of operation, practitioners and providers, their benefits, including access to routine services, after-hours and emergency services, as well as their rights and responsibilities.
- Participate in decision-making with their physician about their health care, regardless of a member benefit.
- Obtain complete, current information concerning a diagnosis, treatment, and prognosis from a provider in terms that they can reasonably be expected to understand. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member's behalf.
- Refuse treatment as allowed by law and be informed by their physician of the medical consequences.
- Refuse to participate in research.
- Right to a second opinion.
- Confidentiality of medical records and information, with the authority to approve or refuse Univera Healthcare's disclosure of such information, to the extent protected by law.
- Receive all information needed to give informed consent for any procedure or treatment.
- Access to their medical records as permitted by New York state law.

- Express concerns and complaints about the care and services provided by physicians and other providers and have Univera Healthcare investigate and respond to these concerns and complaints.
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Care and treatment without regard to age, race, color, sex or sexual orientation, religion, marital status, national origin, economic status, or source of payment.
- Voice complaints or appeals about care the organization provides and recommend changes in benefits and services to staff, administration and/or the New York State Department of Financial Services or Department of Health, without fear of reprisal.
- Formulate advance care directives regarding their care. Members can obtain a Health Care Proxy form by contacting Univera Healthcare, or by downloading the forms from our website, UniveraHealthcare.com.
- Contact one of Univera Healthcare's service departments to obtain the names, qualifications and titles of providers who are responsible for their care.
- Make recommendations regarding Univera Healthcare's members' rights and responsibilities.

Members have the responsibility to:

- Be an active partner in the effort to promote and restore health by:
    - openly sharing information about their symptoms and health history with their physician.
    - listening and asking questions during or after visits.
    - becoming informed about their diagnosis, recommended treatment, and anticipated or possible outcomes.
    - following the plans of care they have agreed to (e.g., taking medicine, making, and keeping appointments).
    - returning for further care if any problem fails to improve; and
    - accepting responsibility for the outcomes of their decisions.
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals.
- Have all care provided, arranged, or authorized by the member's primary care physician (PCP), where applicable.
- Inform their PCP if there are changes in their health status, where applicable.
- Obtain services authorized by their PCP, where applicable.
- Share with their PCP any concerns about the medical care or services that they receive, where applicable.
- Permit Univera Healthcare to review their medical records in order to comply with federal, state, and local government regulations regarding quality assurance and to verify the nature of services provided.
- Respect time set aside for their appointments with providers; give as much notice as possible when an appointment must be rescheduled or cancelled.

- Understand that emergencies arise for the providers and that their appointments may be unavoidably delayed as a result.
- Respect staff and providers.
- Follow the instructions and guidelines given by the providers.
- Show their member card and pay visit fees to the provider at the time the service is rendered.
- Become informed about Univera Healthcare's policies and procedures, as well as the office policies and procedures of their providers, so that they can make the best use of the services that are available under their contract.
- Abide by the conditions set forth in the member contract.
- Inform the plan (or, if coverage is under an employer group, or was obtained through the NYS Exchange, the Group or NYS, respectively) of changes in their residence, telephone, or other information affecting their health care.

Member Surveys

Univera Healthcare conducts member satisfaction surveys at least annually. The surveys assess member satisfaction with the care and services members receive. The surveys are used to identify opportunities for improvement. They may also be used to measure the success of any actions that are taken to improve the care and services members receive.

1.5 Product Overviews

The chart on the following pages represents a brief overview of each type of health benefit program described previously in this section.

Product Portfolio
Univera Healthcare

Product Type	***Product referred to as:***
HMO (Health Maintenance Organization) ▪ Managed care product. ▪ Primary care provider (PCP), referrals and preauthorizations may be required (see *Benefits Management* section of this manual). ▪ Must use participating (in-network) providers. ▪ Provides comprehensive benefits, including coverage for routine/preventive care for children and adults. ▪ First dollar coverage through copayments and/or coinsurance (no deductibles). ▪ Multiple copayment options available.	▪ Univera Healthcare HMO ▪ Univera Senior Choice
POS (Point of Service) ▪ Provides in-network and out-of-network coverage. ▪ PCP and preauthorization may be required for highest level of coverage (similar to HMO). ▪ Member decides at "point of service" whether to coordinate care through PCP. If the member chooses not to coordinate care, there is increased cost-sharing for out-of-network coverage. ▪ First dollar in-network coverage through copayments and/or coinsurance (no deductibles).	▪ Univera POS Select

PPO (Preferred Provider Organization)
▪ No PCP required.
▪ Some services require precertification or preauthorization.*
▪ In-network and out-of-network coverage.
  ○ In-network – participating providers must be used.
  ○ Out–of-network – non-participating providers may be used, but higher cost sharing.
▪ Typically, deductible must be met, then copayment/coinsurance.
▪ Multiple copayments, coinsurance, and deductible options available, providing a range of benefit levels from which to choose.
***Preauthorization requirements for ActiveUnivera, valUcare and valUcare Plus mirror those of the HMO products.**
	▪ *ActiveUnivera
	▪ *valUcare
	▪ Univera PPO
	▪ Univera Access
	▪ Univera Preferred Access
	▪ Univera Clear Options
	▪ Univera Signature PPO

Product Type	***Product referred to as:***
EPO (Exclusive Provider Organization) for Direct Pay Members ▪ No PCP required. ▪ Some services require precertification or preauthorization.* ▪ In-network coverage only. ▪ In-network – participating providers must be used. ▪ Out–of-network – not covered ▪ Typically, deductible must be met, then copayment/coinsurance. ▪ Multiple copayments, coinsurance, and deductible options available, providing a range of benefit levels from which to choose. ▪ Premium assistance may be available for those who qualify. Must apply through healthbenefitexchange.ny.gov. ***Preauthorization requirements for the direct pay metal plans mirror those of the HMO products.** **+ Lower cost-share options available for those who qualify**	▪ Platinum Standard ▪ Platinum Select ▪ Gold Standard ▪ Gold Select ▪ Advantage Gold ▪ Silver Standard+ ▪ Silver Select+ (See HDHP section below) ▪ Advantage Silver (See HDHP section below) ▪ Bronze Standard (See HDHP section below) ▪ Bronze Select (See HDHP section below) ▪ Bronze Secure Plus ▪ Base
Indemnity ▪ No PCP or referrals required. ▪ Some groups may require preauthorizations. ▪ Deductible must be met first, then coinsurance applies. ▪ Comprehensive (hospital, physician, ancillary) coverage. ▪ Typically includes an out-of-pocket maximum. ▪ Prescription coverage (if included) is generally the same as the medical – deductible, then coinsurance or copayment). ▪ Participating providers accept our payment plus member cost-sharing as payment in full. ▪ Some services are not covered if rendered by a non-participating provider.	▪ Classic Univera Traditional ▪ Classic Univera Comprehensive
Consumer-Driven or High-Deductible Health Plan (HDHP) - Health Savings Account Qualified Plans (HSA) ▪ High deductible must be met before most services are covered. ▪ Lower premiums. ▪ More member responsibility. ***Preauthorization requirements for ActiveUnivera, valUcare and valUcare Plus mirror those of the HMO products** ****These products and all Native-American products have different versions that have associated cost-share reduction levels which do not qualify for a health savings accounts.**	▪ ActiveUnivera HDHP ▪ valUcare HDHP ▪ Silver Select** ▪ Advantage Silver ▪ Bronze Standard HAS ▪ Bronze Select**

Product Type	***Product referred to as:***
Medicare Supplements ▪ Pays after Medicare. ▪ Government-structured benefit package.	▪ A, B, C, F, F+, N
Medicare Advantage ▪ Providers submit claims directly to Univera Healthcare. ▪ Univera Healthcare pays as primary. ▪ Includes all Medicare benefits plus preventive care and other value-added benefits. ▪ Highest level of benefit for services from participating providers. ▪ PCP and referrals required for HMO and HMO-POS products. ▪ Precertification requirements. ▪ To qualify, members must have Medicare Parts A and B, and not be in treatment for end stage renal disease.	▪ Univera Medicare PPO ▪ Univera SeniorChoice HMO

New York State Government Programs
▪ PCP required.
▪ Some services require precertification or preauthorization
▪ In-network coverage only
  ○ In-network – participating providers must be used.
  ○ Out–of-network – not covered
▪ Typically, deductible must be met, then copayment/coinsurance.
 	
***Marketplace Facilitators or Community IPA/Navigators are available to help prospective members with eligibility and enrollment.**
 	
Plan mirrors the Gold Standard benefits per requirements by the NYS Department of Financial Services
*Preauthorization requirements for Healthy New York EPO mirror those of HMO products.
	▪ Essential Plan (no PCP required)
	▪ Child Health Plus*
	▪ Medicaid Managed Care*
	▪ Univera Healthcare MyHealth℠ * (Erie county)
	▪ Univera Healthcare MyHealth Plus ℠ ** (Erie county)
	▪ Healthy NY EPO (no PCP required)
	▪ **HARP=Health and Recovery Plan // No facilitators for this product

Product Type	***Product referred to as:***
Dual Special Needs Plan (D-SNP) ▪ Members have a single ID card covering both Medicare Advantage and Medicaid benefits, as well as other value-added benefits. ▪ Providers submit claims directly to Univera Healthcare for all covered services; Univera Healthcare will process Medicare as primary and Medicaid secondary. ▪ Highest level of benefit for services from participating providers. ▪ PCP required. ▪ Preauthorizations may be required. ▪ To qualify, members must have Medicare Parts A and B, have full dual status (QMB plus SLMB plus FBDE**)** be a resident in approved counties and enrolled in Medicaid Managed Care product, including Health and Recovery Plan, with our Health Plan.	▪ Univera Medicare Dual (HMO D-SNP)

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Participating Provider Manual

Section 2: Administrative Information

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2.1 Contacting Univera Healthcare

Univera Healthcare employs individuals trained to perform specific services and support specific provider needs. The following *Contact List* includes telephone numbers, fax numbers, addresses, web page addresses, and email addresses of the Univera Healthcare departments and other agencies with which providers most often interact.

Contact List

Name	Comments
Univera Healthcare Online	Website: Provider.UniveraHealthcare.com This website provides a variety of information: ▪ Registration can be completed online. ▪ Update practice information. ▪ Request a claim adjustment. ▪ Request a preauthorization. ▪ View fee schedule information. ▪ View pharmacy information. ▪ View medical and administrative policies. **Note:** Registration is required for the majority of services listed above. For assistance with registering, please visit: Provider.UniveraHealthcare.com/resources and click on Frequently Asked Questions.
Customer Care, most products	Questions about claims, member benefits and eligibility, etc. Telephone: 1-866-265-5983 ▪ Monday through Thursday: 8 a.m. to 5 p.m. ▪ Friday: 9 a.m. to 5 p.m. ▪ Closed daily from noon - 1 p.m.
Customer Care Dual Special Needs Plan (D-SNP)	Telephone 1-866-862-7087
Customer Care, SSA HealthChoice	Questions about claims, member benefits and eligibility, etc. Telephone: 1-866-265-5983

Name	Comments
24-Hour Nurse Call Line	Resource for information about chronic conditions and other health-related information. ▪ Telephone: or 800-348-9786 ▪ TTY: 1-800-421-1220
Behavioral Health Preauthorizations	Mental health and substance use services when applicable (mandates, laws, and select products apply). Requests and medical records may be submitted via CareAdvance Provider® tool online at: Provider.UniveraHealthcare.com/authorizations Note: For urgent requests, call Medical Intake with the case number to expedite. Commercial Lines of Business ▪ Telephone: 1-800-363-4658 Government Programs (MyHealth℠, MyHealth Plus℠, Child Health Plus) and Essential Plan ▪ Telephone: 1-844-694-6411
Behavioral Health Concurrent Review	Government Programs (MyHealth℠, MyHealth Plus℠, Child Health Plus) and Essential Plan Medical records may be submitted via the SDS Provider Submission Portal. To register, go to Provider.UniveraHealthcare.com/authorizations/sds-portal
Behavioral Health Advocate	Available to assist members/member advocates or providers who have received a denial of services. The advocate can assist with understanding clinical criteria, and/or filing an appeal or grievance for the denied service. For commercial, Medicare, or Exchange members ▪ Telephone: 1-844-809-7518 For Medicaid, Child Health Plus, Essential Plan or HARP members ▪ Telephone: 1-844-635-2662
CAQH (Council for Affordable Quality Healthcare)	For practitioner credentialing ▪ Website: caqh.org/ucd.php ▪ Telephone: 1-888-599-1771
Case Management	To make referrals ▪ Email: Case.management@univerahealthcare.com

Name	Comments
(Medicare, Commercial, and Exchange members)	▪ Telephone: 1-877-222-1240 ▪ Fax Number: 1-877-243-6819
Case and Disease Management (Government Programs)	To refer members of Child Health Plus or Univera Healthcare MyHealth℠ for case or disease management ▪ Email: Case.management@univerahealthcare.com ▪ Telephone: 1-877-222-1240
Care Management – Behavioral Health (Commercial products)	To make referrals: Behavioral Health is available Monday through Friday from 8 a.m. to 5 p.m. If you call after-hours, leave a voice message on the confidential voice mail and your call will be returned the next business day. ▪ Email: Case.management@univerahealthcare.com ▪ Telephone: 1-877-222-1240
Claim Status, most products, paper	Submit Claim Status Request form to Customer Care, most products, above
Claim Status, most products, web-based	wnyhealthenet.com Registration required for use
Claim Status, Univera PPO, Univera Traditional, 4Front, SSA HealthChoice	Call appropriate Customer Care number for these products
Claims Submission, Electronic	See EDI Solutions below
Claims Submission, Paper	Univera Healthcare PO Box 211256 Eagan, MN 55121
CompassionNet	Case management for children with life-threatening illnesses ▪ Telephone: 1-800-308-3914
Credentialing (Credentialing/re-credentialing questions only)	▪ Email: Credentialing.univera@univerahealthcare.com ▪ Fax: 1-800-293-1691
Treasury Operations (Address to return overpayments)	Univera Healthcare Claim Refunds Department 116250 PO Box 5211 Binghamton, NY 13902

Name	Comments
Departmental Appeals Board (HHS) (Medicare Advantage only)	Department of Health & Human Services Departmental Appeals Board, MS 6127 Medicare Appeals Council Cohen Building, Room G-644 330 Independence Avenue, SW Washington, DC 20201
Disease Management/ Member Care Management/ Chronic Care Management	To make referrals ▪ Email: Case.management@univerahealthcare.com ▪ Telephone:1-877-222-1240 ▪ Fax Number: 1-877-243-6819
EDI Solutions	Electronic transactions including claim submittal edi.solutions@univerahealthcare.com
HIV Counseling & Testing	NYSDOH Program ▪ Telephone: 1-800-541-AIDS
Inpatient Admissions (Hospital or Skilled Nursing Facility)	Facility must notify Univera Healthcare ▪ Telephone: 1-800-926-2357 ▪ Fax: 1-877-203-9401
Livanta	Medicare Appeals ▪ Telephone: 1-866-815-5440 ▪ TTY: 1-866-868-2289 ▪ Fax Number: 1-855-236-2423
Medical Director	Call Customer Care
Medical Policy Coordinator	Questions and comments on medical policies and protocols Call Customer Care.
Medical Specialty Drug	Go to Provider.UniveraHealthcare.com/authorizations/request-authorizationto view the Medical Specialty Drug Prior Authorization list, obtain prior authorization forms, and specialty pharmacy information. Prior Authorization requests and medical record submission may be submitted via CareAdvance Provider online at: Provider.UniveraHealthcare.com/authorizations Medical Specialty Drug Fax Number: 1-800-306-0188 **Also refer to Pharmacy Section 5.6 in the Provider Manual**

Name	Comments
Medicare Appeals (For members or designee, and MDs and DOs)	Medicare Appeals SeniorChoice/Medicare PPO P.O. Box 546 Buffalo, NY 14221-0546 Physicians call Customer Care. Members call the number on their member card.
Member Eligibility Phone Line, most products	Automated phone line ▪ Telephone: 1-866-265-5983
Member Eligibility most products, Web-based	Registration required wnyhealthenet.com
Member Eligibility, Univera PPO, Univera Traditional, 4Front, SSA HealthChoice	Call the appropriate Customer Care number for these products
Member Grievances	Available to Medicaid Managed Care/HARP members only. ▪ Telephone: 1-800-650-4359
Membership, Prospective	For non-members who want to ask questions about joining Univera Healthcare ▪ Telephone: 1-716-857-4480 ▪ Telephone: 1-800-336-2014
National Provider Identifier (NPI) Enumerator	NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 ▪ Email: customerservice@npienumerator.com ▪ Telephone: 1-800-465-3203 ▪ TTY 1-800-692-2326
Other Party Liability/ Coordination of Benefits	For Worker's Comp, No Fault, and to discuss primacy and review coordination of benefit claims Call the appropriate Customer Care number.

Name	Comments
Pharmacy Help Desk	To assure our members have access to safe, effective drug therapy, and to protect against inappropriate use and waste, prior authorization and step therapy are required on select prescription medications Ways to request approval, tips, and policies can be found here Provider.UniveraHealthcare.com/authorizations/prescriptions- Pharmacy Help Desk (all except Med D): ▪ Telephone: 1-800-724-5033 or 1-800-499-1275 ▪ TTY: 1-800-662-1220 Medicare Part D: ▪ Telephone: 1-877-883-9577 ▪ Prior Authorization: 1-800-363-4658 Fax prior authorization forms: ▪ 1-800-956-2397
Preauthorization for Univera Healthcare Products	Requests and medical records may be submitted via CareAdvance Provider online at: Provider.UniveraHealthcare.com/authorizations Note: For urgent requests, call Medical Intake with the case number to expedite ▪ Telephone: 1-800-363-4658
Preauthorization, Imaging Studies (CT, MRI, MRA, PET, nuclear cardiology)	Preauthorization requests for imaging studies (CT, MRI, PET, nuclear cardiology), may be submitted through eviCore Healthcare at: ▪ Website: evicore.com ▪ Telephone: 1-888-333-9036 Monday through Friday, 7 a.m. to 7 p.m. ▪ Fax Number: 1-888-785-2487 (special form required for fax)
Privacy Questions and Complaints	For information about our privacy practices or concerns, or to call, mail or email a privacy complaint: Mailing address: Privacy Officer 333 Butternut Drive Dewitt, NY 13214-2313 ▪ Email: privacy.officer@univerahealthcare.com ▪ Call Customer Care or Provider Relations ▪ Privacy Hotline: 1-866-584-2313

Name	Comments
Provider Advocacy Unit	Professional provider concerns, including appeals regarding contractual/administrative issues that do not result in an out-of-pocket member expense. ▪ Mailing address: PAU, PO Box 4717, Syracuse, NY 13221 ▪ Telephone: 1-866-265-5983 ▪ Fax Number: 1-315-671-6656
Provider File Maintenance	To update provider information, use our online form or fax/mail form. In addition, providers can send us changes by email or fax on company letterhead ▪ Fax Number: 1-716-857-4578 ▪ Website: WNY.Provfile@univerahealthcare.com
Quality Measurement Department	Questions and comments on medical record documentation standards/reviews ▪ Telephone: 1-800-768-8177 ▪ Fax Number: 1-844-324-9012
Referrals (If Required)	Representatives available Monday through Thursday, 8:30 a.m. to 5 p.m., Friday, 9 a.m. to 5 p.m. Medical records may be submitted via the Smart Data Solutions (SDS) Provider Submission Portal. To register, go to Provider.UniveraHealthcare.com/authorizations/sds-portal ▪ Telephone: 1-800-363-4658 ▪ Fax Number: 1-800-245-3370
Referrals, web-based	To obtain or track referrals (if required). Registration required. ▪ Website: wnyhealthenet.com
Risk Adjustment Coding	Univera Healthcare Risk Adjustment Program Operations 205 Park Club Ln Buffalo, NY 14221 ▪ Telephone: 1-585-530-5542 ▪ Fax Number: 1-844-826-8779
Smoker's Quitline, New York State	New York state smoking cessation resources ▪ Website: www.nysmokefree.com ▪ Telephone: 1-866-NY-QUITS (1-866-697-8487)

Name	Comments
Specialty Pharmacies (Refer to Pharmacy section 5.5 for additional information)	Accredo Specialty Pharmacy * For patient-administered & provider-administered medications ▪ Telephone: 1-866-413-4137 ▪ Fax Number: 1-888-773-7386
	AllianceRx Walgreens Pharmacy * ONLY for provider-administered medications ▪ Telephone: 1-866-435-2171 ▪ Fax Number: 1-866-435-2173
Taxonomy (To select appropriate taxonomy)	To view a complete list of taxonomy codes, go to the following website: wpc-edi.com/codes/taxonomy
Univera Healthcare Web Security Help Desk	Telephone: 1-800-278-1247 ▪ Monday through Thursday: 8 a.m. to 4:30 p.m. ▪ Friday: 9 a.m. to 4:30 p.m.
WNY HealtheNet System Administrator (PCI)	Telephone: 1-877-895-4724 ▪ Monday through Friday, 7 a.m. to 7 p.m. *(end)*

2.2 Obtaining Member Information from Univera Healthcare

The privacy rights of members are very important to Univera Healthcare, as is its relationship with participating physicians and other health care providers. Univera Healthcare has procedures in place to ensure that only properly authorized parties have appropriate access to members' protected information. In addition, Univera Healthcare has implemented a process that places extra emphasis on protecting confidential patient information.

> **Note:** For more information about Univera Healthcare policies regarding privacy and confidentiality, see the *Introduction* section of this manual.

When a physician or other health care provider calls Univera Healthcare requesting information about a member, the provider will be required to answer a few questions before Univera Healthcare will release the information.

- First, the participating provider must confirm their identity by supplying a provider identification number.
- Next, the provider must confirm their relationship with the member by supplying the member's full name and member ID number. If the provider is unable to provide the member ID number, the provider must supply at least one of the following, **in addition to the member's name:**
  - Patient birth date
  - A claim number or authorization number
  - Patient address
  - Name of primary physician (when applicable)

  Note: If the member is a Univera Healthcare employee (or dependent of a Univera Healthcare employee), the provider must supply the subscriber ID.

If neither the provider's identity nor the provider/patient relationship can be confirmed, Univera Healthcare will not release patient information.

2.3 Univera Healthcare Connectivity

Website

Univera Healthcare's website, UniveraHealthcare.com, carries up-to-date information for members and providers.

The material presented on the Provider pages of the website is also available by calling Customer Care (see *Contact List*).

> **Note:** In case of a discrepancy between any materials presented on the website and the up-to-date version of that material on file at Univera Healthcare, the latter version controls.

Menu Options on the Provider Home Page

Some of the menu options such as those listed below are available on the provider home page of the Univera Healthcare website are discussed in sections of this *Participating Provider Manual*:

Eligibility & Benefits, Claims & Payments, Authorizations, Policies & Guidelines, Resources

Online Services: WNY HealtheNet

Local physicians and other providers who access the Internet in the office may obtain member eligibility and benefit information about Univera Healthcare benefit packages through WNY HealtheNet. Providers must ***register*** to access this information.

WNY HealtheNet is an online community health information network established through the collaboration of Univera Healthcare, BlueCross BlueShield of Western New York, Independent Health, the Catholic Health System, ECMC, Kaleida Health, and Roswell Park Cancer Institute. The WNY HealtheNet website contains member information for several WNY Health Insurers.

Providers who have registered for WNY HealtheNet can access information about Univera Healthcare benefits packages regarding member eligibility, claim status, referral inquiries, referral requests and authorizations.

To register for WNY HealtheNet:

1. On the Univera Healthcare website, select the Provider option or go directly to, wnyhealthenet.com
2. Click on the WNY HealtheNet link on the provider page.
3. Click on the Sign-Up tab.
4. Follow the instructions to access the online Request Form.
5. Complete the forms and submit as instructed.
6. A representative from HealtheNet PCI will contact an applicant within five business days to provide further instructions and schedule training.

See paragraphs headed *Member Eligibility Internet Inquiry: WNY HealtheNet* for instructions about checking member eligibility using WNY HealtheNet.

Note: For questions or problems while using WNY HealtheNet, call the WNY HealtheNet System Administrator. (Telephone numbers are listed in the *Contact List*.)

Providers who register have access to:

- Benefits and Eligibility
- Claim Status
- Referral Request
- Referral Inquiry
- Authorization Inquiry
- Manage Staff Access

Electronic Billing

Univera Healthcare is compliant with guidelines from the Centers for Medicare & Medicaid Services (CMS) regarding the HIPAA EDI Transaction and Code Set regulation and is prepared to receive HIPAA-compliant transactions. Contact *eCommerce* for detailed information about electronic billing.

Hospital Comparison Tool

Univera Healthcare makes available through its website a hospital comparison tool. An online tool compares the performance of selected hospitals on more than 175 procedures and medical conditions. Univera Healthcare offers access to the hospital comparison tool as a benefit to its members and providers.

The tool allows the user to obtain an independent comparison of hospitals within a specific geographic area by procedure or diagnosis. Users may create a personalized report that compares hospital performance based on information hospitals provide to CMS, state health departments or local agencies. Use of the hospital comparison tool is completely anonymous.

The generated reports provide an analysis of patients hospitalized for certain conditions, including the number of patients treated at each hospital (patients/year), the percentage of patients who developed problems (complications), the percentage of patients who died (mortality), the average number of days people stayed in each hospital (length-of-stay), and the average price the hospital charged.

2.4 Determining Member Eligibility for Benefits

Before providing services, it is important to determine financial responsibility by verifying whether the patient has coverage for the service or should be treated as private pay. Participating providers may check member eligibility through the WNY HealtheNet website, or by calling Univera Healthcare. Providers must be registered to access this information through HealthNet. For registration information, see the paragraphs above under *Online Services*.

Member cards also contain valuable information, but it is still important to verify benefits before providing services.

Member Cards

Each subscriber is assigned an identification (ID) number, and each member is eligible to receive his or her own card. Each of Univera Healthcare's health benefit programs has its own unique member card.

What to Look for on the Member Card

Member cards carry vital information to assist providers in doing business with Univera Healthcare. Provider offices should copy the front and back of the member cards, as both sides contain important information, including information providers need to submit claims and coordinate patient care. While our cards differ from product to product, there are some standard elements:

- Logo - The Univera Healthcare logo is on all Univera Healthcare plan identification cards.
- Rx logo – The Rx logo indicates that the member either has prescription drug coverage through Univera Healthcare's pharmacy benefit manager (see the *Pharmacy Management* section of this manual) or is eligible for the Rx Value-Add Prescription Drug Discount Program.
- Product Name – If present, the name of the health benefit program.
- Plan type (POS, HMO, EPO, PPO or fee for service).
- Subscriber Name – This is the name of the person holding the policy. If the patient is a covered dependent of the subscriber, the patient's name may not be on the card.
- Identification Number (ID#) – The identification number is that of the subscriber. It is required on all claims.
- Copayment or coinsurance amount(s).
- Deductible and out-of-pocket maximum information (in- and out-of-network).
- Instructions for emergency care.
- Telephone numbers.
- Address for submitting claims.
- Health plan website address.
- QR code that links the member to the Benefits Details page of the Univera Healthcare website. The member will be prompted to sign in to view their benefits and cost share.

- Members who are part of a self-funded group have the following verbiage included on the back of their member card: “This coverage is self-funded. Univera Healthcare provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Member Eligibility Telephone Inquiry

The Member Eligibility Phone Line makes available to providers information about eligibility, copayments, and primary care physician assignments for members of selected Univera Healthcare benefit packages. An automated telephone system, the Member Eligibility Line is accessible 24 hours a day, seven days a week. Information is updated daily.

To access the Member Eligibility Phone Line:

1. Using a touch-tone phone, dial the number of the Member Eligibility Phone Line (listed on the *Contact List*).
2. Enter your Provider Number, followed by the pound (#) sign.
3. Enter the member’s ID number. The system will list options for obtaining information about the member’s benefits, including:

   - Office and specialty copays
   - Primary care physician
   - Pharmacy coverage
   - Out-of-network coverage

   Note: Providers may also obtain the same information and more by contacting the Customer Care Department during normal business hours (listed on the *Contact List*). Be ready to provide the member’s ID number, name, date of birth, date of service/admission, and diagnosis.

Member Eligibility Internet Inquiry: WNY HealtheNet

Providers may check member eligibility through the Internet-based system, WNY HealtheNet, but ***must be registered to use the system***. For registration information, see the paragraphs headed *Online Patient Information System: WNY HealtheNet*.

1. Visit wnyhealthenet.com. Select Login. The system will display the Disclaimer screen.
2. Click on I Agree. The system will display the login screen.
3. Enter Username and Password. The system will display the WNY HealtheNet Introduction screen, with a menu that includes the option, Eligibility and Benefits. The system displays an inquiry screen.
4. a. In the field listing the participating plans, select Univera Healthcare.

   b. In the member information fields, supply two types of patient information, e.g., the patient’s first and last name, birth date, Univera Healthcare member ID number, or Social Security Number.

   c. In the field, Eligibility Date, enter the date of the service that will be or has been provided to the member.
5. The system displays a screen showing the benefits this member was eligible for on the given date.

Note: For questions or problems while using WNY HealtheNet, contact the WNY HealtheNet System Administrator. (Telephone numbers are listed in the *Contact List*.)

2.5 Univera Healthcare Publications

Participating Provider Manual

Univera Healthcare's *Participating Provider Manual* is an extension of the Univera Healthcare contract for physicians and other providers who participate with Univera Healthcare. The manual is intended to clarify various provisions of a provider's participation agreement.

Provider Newsletter and eAlerts

Univera Healthcare's provider newsletter, *Examiner*, is an electronic publication that is issued and posted to the website on a monthly basis. The newsletter is designed to keep participating providers and their office staff apprised of developments in Univera Healthcare policies and products.

Each month, an eAlert that links to the newsletter is emailed to providers who have opted in to receive the publication electronically. To opt-in, providers must go to the website (see below) and select *Sign Up* in the "Opt in to stay informed!" tile. The newsletter email notification will only be sent to those who have completed the opt-in process.

- Provider.UniveraHealthcare.com/resources/news

Periodically, we also issue bulletins via email "eAlerts." Once opted in to receive the *Examiner* newsletter electronically, providers will also receive general informational bulletins electronically.

If the provider's office does not have access to the Internet, they can receive a paper copy of the newsletter or bulletins via traditional mail. To request a paper copy, please contact Customer Care.

Ad Hoc Communications

As needed, Univera Healthcare sends written notifications to participating providers regarding new and revised policies and procedures and other information of value. Univera Healthcare issues bulletins, letters and other notices in instances when notification is required outside the normal newsletter schedule, or when the information affects only a small, specific audience of providers.

2.6 Provider Office Environment

Office Site Review

Univera Healthcare may conduct site reviews of the office locations of physicians and other health care providers, including but not limited to, when there are member complaints.

An office site review may include, but is not limited to, assessments of patient safety and privacy, office operations and confidentiality, appointment availability and accessibility, security of pharmaceuticals and prescription pads, and office record maintenance.

Univera Healthcare will conduct a site visit upon receiving formal or informal complaints from two or more members within 12 months. A complaint may, but will not always, pertain to physical appearance, handicap access, waiting room or exam room space. The areas to be reviewed include *but are not limited to,* facility and environment, office operations, pharmaceuticals and office record maintenance. All applicable site visit standards must be met.

Wheelchair Accessibility

As part of the Office Site Review, Univera Healthcare reviewers gather information to better serve members with disabilities. This information does not affect a provider's credentialing status. Accessibility information is included in the Univera Healthcare provider directories.

HIPAA Compliance

> **Note:** This section gives a general overview of HIPAA requirements. For information about Univera Healthcare compliance with HIPAA standards on privacy and confidentiality, see the *Introduction* section of this manual. For information regarding HIPAA-compliant availability of eligibility, claims, and referral information, see paragraphs about Member Eligibility, Remote Access Inquiry, Online Inquiry Systems, as well as referral and preauthorization information in the *Benefits Management* section of this manual. For information about Univera Healthcare compliance with HIPAA standards on electronic submission of claims, see the *Billing and Remittance* section of this manual.

HIPAA, the Health Insurance Portability and Accountability Act of 1996 was designed to improve the efficiency and effectiveness of the health care system. It includes administration simplification provisions that required the U.S. Department of Health and Human Services to adopt national standards for electronic health care transactions. Recognizing that advances in electronic technology could erode the privacy of health information, Congress incorporated into HIPAA provisions that mandate the adoption of federal privacy protections for individually identifiable health information. This information is referred to as Protected Health Information or PHI.

The HIPAA Privacy Rule provides standards for the protection of PHI in today's world where information is broadly held and transmitted electronically. HIPAA's privacy rule requires that health care providers and other specified entities ("covered entities") take certain actions to maintain confidentiality.

Some of these actions are:

- Notifying patients about their privacy rights and how their PHI can be used.

- Adopting and implementing privacy procedures.
- Training employees to understand privacy procedures.
- Designating a Privacy Officer responsible for seeing that privacy procedures are adopted and followed.
- Securing patient records containing PHI so they are accessible only to specified individuals.

Who Must Comply

The following individuals and organizations must comply with the HIPAA standards. They are referred to as "covered entities:"

- Health care providers who electronically conduct the financial and administrative transactions listed under *Applicable Transactions*, below.
- Health Plans such as Univera Healthcare and Medicare and Medicaid, employer plans under the Employee Retirement Income Security Act (ERISA), Indian Health plans, and self-administered plans (except those with fewer than 50 participants).
- Health care clearinghouses.
- Business associates of any of the covered entities, even if a third party, conduct the specified transactions on their behalf.

Applicable Transactions

All covered entities that conduct any of the following standard transactions are required to use HIPAA-compliant electronic language and codes:

- Health care claims or equivalent encounter information.
- Health care payment and remittance advice.
- Coordination of benefits.
- Health care claim status.
- Enrollment and disenrollment in a health plan.
- Eligibility for a health plan.
- Health plan premium payments.
- Referral certification and authorization.

Compliance Dates

Covered entities had until April 14, 2003, to comply with the act's privacy regulations. Covered entities were to have complied with HIPAA standards for electronic submission (ANSI 837) by October 16, 2003, subject to fine, although a one-year delay was granted to "small" organizations.

Updating Practice Information

To comply with applicable laws and to keep our provider directory and claims system information current, Univera Healthcare requires that providers submit the following information when: (a) the provider enters into a participating provider arrangement with us; b) at least thirty (30) days prior to termination of their participation agreement with us; c) when there are material changes to the below information previously provided to us; and d) at any other time (including upon our request) determined appropriate by provider or any state or federal regulatory agency:

- Provider name

- Provider tax ID
- Provider NPI
- Provider taxonomy codes
- Payment address
- Directory Listing: that is, provider address, phone number, fax number and, for primary care providers who participate in managed care products, languages spoken and whether the practice is accepting new patients (open or closed)
- Service addresses
- Changes in coverage arrangements
- When one or more practitioners join the group practice
- When one or more practitioners leave the group practice
- Provider specialty
- Provider digital contact information

To notify Univera Healthcare of such changes, complete a *Practitioner Demographic Changes* form, indicating what information has changed. The form is available on our website (see below), or by contacting Customer Care. We encourage providers to complete the form and submit it electronically, which will ensure that we receive and process updates in a timely manner. Instructions are included on our website. When submitting the form online, we don't require a provider signature on the form because of the provider's secure sign-on to our provider portal. Providers may mail or fax the completed form using the return information included at the bottom of the form if they are unable to submit the form electronically.

- Provider.UniveraHealthcare.com/resources/management/practice-info

Note: Providers also may notify Univera Healthcare of changes in practice information by submitting a letter on office letterhead specifying what the changes are. Letters also should be faxed or mailed to Provider File Maintenance.

If a practitioner who is not already participating is joining a currently participating group practice, Univera Healthcare also requires that provider to complete an *Application for Practitioner Enrollment* form. This form is available at:
Provider.UniveraHealthcare.com/contact/join-our-network/participating-provider.

Required Annual Certifications and Attestations for Provider Practices

Univera Healthcare complies with the annual attestation and certification requirements of New York state and other regulatory bodies, including, but not limited to:

- Cultural Competency Training Attestation
- Dual Special Needs Plan Model of Care Training Attestation
- Provider Directory Attestation
- Office of the Medicaid Inspector General Medicaid Certification

Compliance with all required attestations and certifications is mandatory under the terms of your participation agreement with the Health Plan. Retain proof of completion for all required training to provide upon request. Please visit our provider portal, Resources > Attestations and Certifications for more information and to complete and submit annual required documentation for your practice (Secure login required).

Closing/Opening a Practice

In signing a participation agreement with Univera Healthcare, a participating physician agrees to accept as patients those members who elect to receive care from the physician, or those whom Univera Healthcare assigns to the physician. Providers are responsible for assessing practice capacity; if the physician's practice is at capacity, the physician may close their practice to new managed care patients.

However, a participating physician shall not close or reopen their practice to new patients without giving Univera Healthcare 90-day prior written notice. In all cases, a participating physician shall continue to permit a current patient who has other health coverage to designate the physician as their PCP in the event the patient chooses to enroll as a member of Univera Healthcare.

Access to Care

Univera Healthcare has established appointment availability standards to provide reasonable patient access to care. In addition, physicians who participate in Univera Healthcare's managed care programs are required to advise Univera Healthcare in writing of covering participating physician arrangements or changes to those arrangements, including situations in which physicians in the same office are covering for each other.

See the *Quality Improvement* section of this manual for additional information about Univera Healthcare's requirements for accessibility, including access to after-hours care.

Member Payments

Except in limited circumstances (see paragraphs headed *Charges for Photocopying Medical Records* and *Patient Financial Responsibility Agreement*), Univera Healthcare participating providers may not charge and/or collect a deposit from, or seek any form of reimbursement from, a Univera Healthcare member, or persons acting on the member's behalf, other than those permitted below:

Charges Permitted

Participating providers may collect applicable copayments, coinsurances, or unmet deductibles associated with covered services.

> **Note**: Cost-sharing information (copayments, coinsurance and deductibles) for specific member contracts is available via the website inquiry methods. Providers may also call Customer Care for this information.

Charges Not Permitted

Participating providers cannot:

- Bill a managed care member for services above the applicable co-pay, except in limited circumstances, including but not limited to non-covered services. In these circumstances, the member may be asked to pay for the full charge at the time the services are rendered.

- Charge a member when the member is covered by two health plans. For example, if Univera Healthcare is primary and a balance remains after Univera Healthcare has reimbursed its allowed amount for covered services, providers must bill the secondary carrier.
- Charge a member for administrative fees, such as completing claims forms or triplicate prescriptions that are standard overhead costs. Providers may bill a member if the member fails to show up for an appointment, but only if this policy is prominently displayed in the office and communicated to the physician's patients. Univera Healthcare does not pay for missed appointments.

Patient Financial Responsibility Agreement

Univera Healthcare encourages participating providers to ascertain, prior to providing services to a Univera Healthcare member, whether those services are covered under the member's health benefit program. (See previous paragraphs for information about determining member eligibility.) This is important because, as stated above, participating providers may not charge or collect a deposit from, or seek any form of reimbursement from, a Univera Healthcare member, or a person acting on the member's behalf, other than the permitted copayments, coinsurances, or deductibles associated with covered services. Providers must notify the member in writing prior to providing a service that is uncovered informing the member that they will be liable for payment.

In situations where a member does not have a valid referral, or the member's eligibility for requested **outpatient** services cannot be determined because Univera Healthcare's member eligibility systems are not available, participating providers may elect to have the member complete and sign a *Patient Financial Responsibility Agreement*. (A sample form is available on the website or from Customer Care.)

Having the member sign the form may allow the provider to bill the member for services that Univera Healthcare did not cover because:

- The managed care member self-referred for the service, or
- The services were **not a covered benefit** under the member's benefit package, or
- The services were not within the scope of the provider's participation agreement, or

Once a member has signed a *Patient Financial Responsibility Agreement*, the provider should keep the form on file.

No Surprise Act

Based on their insurance product coverage, Univera Healthcare's members are protected from balance billing, also referred to as a "surprise bill", under both federal No Surprise Act, which is included under the federal Consolidated Appropriations Act of 2021, and New York Financial Services laws.

A surprise bill is a bill for non-emergency health care services received by: (1) an insured for non-participating physician services in an in-network participating hospital or ambulatory surgical center when a participating physician is unavailable, or an out of network physician renders services without the insured's knowledge, or when unforeseen medical circumstances arise; (2) an insured when a participating physician refers the insured to an out of network provider without the insured's consent; (3)

an uninsured or self-insured patient for services rendered by a physician in a hospital or ambulatory surgical center when the required disclosure is not made.

Surprise Bill Scenarios

A referral to a nonparticipating provider occurs when:

- the health care services are performed by a non-participating provider in the participating physician's office or practice during the course of the same visit;
- the participating physician sends a specimen taken from the patient in the physician's office to a non-participating laboratory or pathologist; or
- for any other health care services when referrals are required under the insured's contract.

2.7 Medical Records

Univera Healthcare requires that participating provider medical records be kept in a manner that is current, detailed, organized, that complies with all state and federal laws and regulations, and that is accessible by the treating provider and Univera Healthcare. To support this requirement, Univera Healthcare has established Medical Record Documentation Standards. Information regarding these standards is included in the *Quality Improvement* section of this manual.

For medical record requests related to Medicare Advantage members, please see the *Medicare Advantage* section of this manual.

Access to Medical Records

By Univera Healthcare

A participating physician or other provider must maintain medical records and provide such medical, financial and administrative information to Univera Healthcare, as it may reasonably require compliance with applicable laws, rules, and regulations.Participating physician offices must:

- Maintain medical records in a manner that is individualized, current, organized, detailed, and confidential.
- Make records available to Univera Healthcare staff for review when requested.
- Make records available upon request of the NYS Department of Health, the Center for Medicare & Medicaid Services or a local Department of Social Services (Medicaid only).
- Provide copies of patient charts to Univera Healthcare without cost, per the provider's participation agreement.

  Note: Medical record documentation auditing and reporting are part of "health care operations" as defined by HIPAA and thus do not require patient authorization for release of protected health information. For information about HIPAA, see the paragraph headed HIPAA Compliance that appears earlier in this section of the manual.

  According to the New York State Department of Health, New York State patient consent requirements are stricter than those found in the Health Insurance Portability and Accountability Act. Therefore, participating providers are required, as part of their participation agreements with us, to obtain patient authorizations or consents from our members directly. Offices obtain these authorizations as part of their routine administrative business practices. If this is not a routine part of your practice, please obtain such authorizations or consents for release of patient records if you have not already done so. For more information regarding privacy rule language, please visit http://www.hhs.gov/ocr/privacy.

By Members

Members have the right to see their medical records. Univera Healthcare's member handbooks state that any requests for medical records should be directed, in writing, to a member's physician. Each member age 18 or over, or an emancipated minor, must sign his or her own written request.

Charges for Photocopying Medical Records

Subject to the terms of a provider's participation agreement, a participating provider may not charge Univera Healthcare or the Department of Health for photocopying a patient's medical record. New York State Public Health Law Article 1, Title 2, Section 18 (2.e) states that providers may impose reasonable charges when a patient (*subject*) requests copies of their medical records, not to exceed 75 cents per page. However, members may not be denied access to their records due to inability to pay.

Advance Care Directives

Univera Healthcare encourages providers to discuss with members end-of-life care and the appointment of an agent to assume the responsibility of making health care decisions when the member is unable to do so. Information for members about advance care planning is available on the website.

Univera Healthcare's Medical Records Documentation Standards state that medical charts must include documentation indicating that adults age 18 years and older, emancipated minors, and minors with children have been given information regarding advance directives. See the *Quality Improvement* section of this manual for additional information about this requirement and about advance care directives.

Note: Treatment decisions may not be conditional on the execution of advance directives.

2.8 Telehealth and Telemedicine

Note: Some temporary contingencies and cost-share waivers are in place related to telehealth and telemedicine services to help ensure that our members have access to the care and services that they need during the COVID-19 public health emergency. Some services are being covered on a temporary basis and may not be covered after the emergency has ended. Please refer to our website, Provider.UniveraHealthcare.com/coronavirus, our corporate medical policy, ***Telehealth and Telemedicine (1.01.49),*** *corporate administrative policy* ***AP-22 Telemedicine and Telehealth****, and our provider communications for additional information.*

Univera Healthcare covers telehealth and telemedicine services, including services via a telemedicine vendor, in accordance with the member's benefit plan. In accordance with New York State regulations, coverage may not be excluded for services delivered via telehealth. Coverage may be subject to member cost-sharing, as long as it is at least as favorable to the member as the cost-sharing established for the same service when not delivered via telehealth. Coverage may also be subject to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when rendered on a face-to-face basis.

The patient must provide consent prior to the telehealth services being rendered and this should be documented in the medical record.

Please refer to the member's benefits for specific contract benefits and limitations, including member cost-sharing responsibility (e.g., copay, deductible) before rendering telehealth and telemedicine services. Coverage varies by line of business, and coverage limits apply just as they do for similar services provided in a face-to-face setting.

Providers rendering telehealth/telemedicine services must use HIPAA-compliant telecommunication systems/devices. Univera Healthcare does not consider the following telecommunication systems HIPAA-compliant, including but not limited to, FaceTime, Skype, texting, and social media. **Please refer to the following link for Notification of Enforcement Discretion for telehealth remote communications during the COVID-19 public health emergency:**

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

"*Telehealth*" includes a broad range of electronic information and communication technologies that support and promote long-distance health care services by a health care provider, including the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of a patient. Telehealth offers a convenient way for a health care provider to deliver health care services without travel logistics or other barriers.

"*Telemedicine*" is a subset of telehealth that uses interactive telecommunication devices between a patient and a health care professional for the purpose of delivering clinical health care services, including the assessment, diagnosis, and treatment of the patient. Interactive telecommunication devices consist of equipment capable of transmitting two-way video, or telephone, real-time (**synchronous**) communications between a patient (originating site) and health care professional (distant site).

"*Store and forward technology*" refers to the asynchronous, electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site.

"Remote patient monitoring" (telemonitoring), is the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an originating site and transmit it to a telehealth provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. Such conditions include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Remote patient monitoring shall be ordered by a physician, a nurse practitioner, or a midwife.

There are many types of telemedicine, telehealth, and remote patient monitoring (telemonitoring) services available, and additional services are emerging or under development.

Telehealth and telemedicine services using a **synchronous (real-time)** telecommunications system to substitute for an in-person encounter are considered **medically appropriate** when services are telecommunicated from an originating site to a distant site, when the patient is present and participating in the visit, and when benefits are available in accordance with the member's subscriber contract.

Examples of such services include, but are not limited to:

- Office or other outpatient visits.
- Individual psychotherapy or psychiatric diagnostic interview examination.
- Pharmacologic management.
- Individual and group medical nutrition education; and
- Individual and group diabetes self-management training services.

The use of **asynchronous (e.g., store and forward)** telecommunication systems are considered **medically appropriate** when:

1. The use of the telecommunication system addresses a care access issue within the designated population; and
2. The medical literature on the use of the asynchronous technology has demonstrated favorable impacts on health outcomes for a specific patient population (e.g., acute illnesses in the pediatric age group); and
3. The telecommunication system can provide clear audio and video communication with a digital camera with attachments designed to capture pertinent clinical findings, such as an electronic stethoscope, to assess ear, nose, throat, skin, and eye conditions, and
4. The clinical evaluation occurs and is communicated back to the patient within the same business day.

When the originating site is a personal originating site (e.g., the patient's home or worksite), subsequent ongoing care by a provider for long-distance relationships is considered **medically appropriate** only if there are arrangements for handling emergency situations locally that are consistent with established local care practice.

For Medicaid Managed Care members, telemedicine via audio-only telephone communication, facsimile machine, or electronic messaging alone, is not covered under telehealth. **Please refer to the New York State Medicaid Update, March 2020 Volume 36 - Number 4, for telephonic communication services effective March 13, 2020, during the current state of emergency only.**

- https://www.health.ny.gov/health_care/medicaid/program/update/covid_speced.htm#v36no09

Effective June 25, 2021, and through the end of the Federal Public Health Emergency for COVID, based on New York State Department of Health guidance, in addition to the telehealth modalities set forth in Section 2999-cc of the Public Health Law, reimbursement shall be made for telehealth services provided by use of telephone and other audio-only technologies. For reimbursement purposes, the use of telehealth must be appropriate to meet a patient's health care needs and be within the provider's scope of practice.

- Telehealth Services.pdf (ny.gov)

Billing Information for Telehealth Services

Modifiers

The appropriate modifier (95, GQ, or GT) should also be used, when applicable.

Modifier	Description	Note/Example
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system	**Modifier 95** may only be appended to the specific services listed in Appendix P of the AMA's CPT® code book. The CPT codes listed in Appendix P are for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio-visual telecommunication system.
GT	Via interactive audio and video telecommunication systems	**Modifier GT** is only for use with those services provided via synchronous audio and video for which modifier 95 cannot be used.
GQ	Via asynchronous telecommunications system	**Modifier GQ** is used for services delivered via an asynchronous telecommunications system.* *During the COVID-19 public health emergency, New York state has re-purposed this modifier to identify Medicaid covered services performed via audio only (telephone).

Modifier G0 (zero) may also be reported for telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke.

Place of Service (POS) Coding

- Services billed on a form CMS-1500 should be reported using POS 02.
- During the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services has instructed providers to use modifier 95 plus the POS code where the provider is located. For example, POS 11 should be reported when the provider is office-based and POS 12 when the provider is home-based. The New York State Department of Health allows any applicable telehealth modifier to be reported.
- Services billed on a form UB-04 should be reported using revenue codes 780 – 789, along with the applicable CPT/HCPCS code and modifier, if appropriate.

Virtual Provider Networks

- **Telemedicine Services via MDLIVE®:** We encourage all Univera Healthcare members to seek care from their in-network medical or behavioral health care provider. But, for members who are unable to conduct a visit with their provider via telehealth, Univera Healthcare partners with MDLIVE, an independent company, to offer members access to a medical or behavioral health telemedicine visit 24 hours a day, seven days a week. MDLIVE can be used for acute, non-emergency conditions.

Univera Healthcare
Participating Provider Manual

Section 3: General Provider Information

Revised September 2024

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3.1 Provider Support

Univera Healthcare has staff dedicated to assisting providers in doing business with us.

Customer Care

Univera Healthcare encourages providers to use its online inquiry selections whenever possible. When online inquiry is not possible, providers may call the Customer Care department whenever they have questions. (Customer Care telephone and fax numbers are listed on the *Contact List* in this manual.)

Customer Care representatives can answer most questions a provider may have and, in situations where they can't provide an answer, they will direct a provider to the appropriate department. Call Customer Care to inquire about:

- Member eligibility and benefits
- Copayment and coinsurance information
- Referral and preauthorization status
- Claim inquiries
- Medical policies
- Request for claims adjustment
- Request for appeal
- Coordination of Benefits (COB)
- Univera Healthcare printed materials such as provider bulletins, provider newsletter or provider manual
- Any other provider-related issue

Provider Relations

Provider Relations Representatives are liaisons between provider offices and Univera Healthcare.

Provider Relations representatives:

- Facilitate establishing contracts with individual providers
- Hold orientation sessions for participating providers and staff
- Educate providers on Univera Healthcare policies and protocols
- Answer provider inquiries regarding provider participation agreements, reimbursement, incentive programs, etc.
- Assist providers with other complex problems or concerns
- Train office staff on use of available electronic tools
- Visit provider sites
- Host provider seminars

Contact information for Provider Relations representatives is available on Univera Healthcare's website or from Customer Care. To access, go to Provider.UniveraHealthcare.com/contact, then click *Provider Relations Representative*. This will display a complete list of Provider Relations representatives. Find the representative corresponding to the provider's service area.

Provider Advocate Unit

Univera Healthcare has a Provider Advocate Unit (PAU) to address grievances and appeals submitted by physicians (MDs and DOs) and facilities for services they have rendered. The PAU is responsible for administering a process designed to provide a reasonable opportunity for a full and fair review of an initial coverage decision. The goal is to improve service and response to providers who disagree with Univera Healthcare's decisions.

Issues that qualify for submission of a grievance include those related to:

- Referral/authorization process, not related to a medical necessity decision
- Administrative or medical policy changes/implementations
- Timely filing claims submission guidelines
- Benefit/contract coverage, not related to a specific member's care
- Claims payment disputes
- Fee schedule allowance/reimbursement
- Coding validation audits
- Scope of practice denials
- Retrospective or Inpatient versus Outpatient Denials

To submit a grievance, a physician should submit the Provider Request for Grievance or Appeal form available on the Plan website at Provider.UniveraHealthcare.com/resources/forms. Select the *Request for Grievance or Appeal Form* in the Benefits Management section. The physician may submit written comments, documents, or other information to support their position regarding the dispute.

The physician should submit the grievance within 90 calendar days of the date the physician received notification of the initial decision or administrative policy change or implementation, unless otherwise stipulated in the individual physician's participation agreement. Univera Healthcare will conduct a full review of the documents, *excluding any aspects of medical necessity*. Univera Healthcare may request medical records if needed to reach a determination.

Facility Appeal Time Frames

For an inpatient or inpatient vs. observation stay, retrospective denials have 30 days (or as defined in the Facilities contract) from the initial determination date to file a level 1 appeal. If applicable per the Facility contract a level 2 appeal may be filed within 30 days (or as defined by the Facility contract) of the level 1 appeal review.

For questions about the Provider Advocate Unit and the grievance process, contact Customer Care. (The Customer Care telephone numbers are on the *Contact List* in this manual.)

Provider Satisfaction Surveys

Univera Healthcare conducts hospital, physician, and provider office manager satisfaction surveys at least annually. The surveys assess satisfaction with Univera Healthcare and are used to identify opportunities to improve Univera Healthcare services to the provider community and to members. Univera Healthcare develops action plans based on survey results and assesses these plans to determine effectiveness.

3.2 National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that Health and Human Services (HHS) adopt a standard unique identifier for each individual health care provider, to be used with all payers. (For information about HIPAA, see the *Administrative Information* section of this manual.)

National Provider Identifier Required on All Standard Transactions

Effective May 23, 2008, each provider must include the NPI on all claims, electronic or paper in order to be paid.

ONLY NPIs are accepted on standard transactions (837, 835, 270/271, 276/277, 278), including both electronic and paper claims. Any transaction submitted without the NPI will be returned. Provider numbers used for billing prior to the implementation, such as Univera Healthcare assigned numbers, are no longer accepted. (See the *Billing and Remittance* section of this manual for information on claim submittal.)

How to Obtain an NPI

The Centers for Medicare & Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign the unique identifiers. **Health plans are not responsible for the assignment of provider NPIs.**

It does not cost anything to apply for, or receive, an NPI, but **every provider must have one**. When applying for an NPI, providers must have their taxonomy codes available. (See below for additional information on taxonomy.)

Providers must apply for an NPI with the NPI Enumerator. The NPI Enumerator may be contacted by toll-free telephone, via the Internet or by U.S mail. Contact information is included on the *Contact List* in this manual. Look for *NPI Enumerator* on the alphabetical listing.

Taxonomy Codes

Taxonomy codes, also known as specialty codes, identify a provider's specialty category. A practitioner may have one National Provider Identifier (NPI) with multiple taxonomy codes, depending on the specialties in which he or she practices. It is suggested that a practitioner select the simplest, most generic taxonomy code to describe their specialty.

To view a list of taxonomy codes, please visit the Washington Publishing Company website at http://wpc-edi.com/codes/taxonomy.

Please note that all claims must be submitted with taxonomy codes. Failure to include taxonomy codes on claims may result in incorrect payments.

Share NPI with Univera Healthcare and Billing Agency

Providers must supply NPI information to Univera Healthcare. Those who have not already done so should contact Provider Relations. Offices that use a billing agency need to share NPI information with the agency. Univera Healthcare has communicated with vendors to ensure compliance with the requirements, as specified in the Trading Partner Agreement between the vendor and Univera Healthcare.

3.3 Credentialing and Recredentialing

This section of the manual summarizes Univera Healthcare's credentialing and recredentialing policies. Copies of the complete policies are available under the Contact Us tab on the Provider homepage of our website or are available upon request from Customer Care. (Customer Care contact information is on the *Contact List* in this manual.

Overview

Providers who participate in Univera Healthcare's managed care and Medicare Advantage programs must meet Univera Healthcare's credentialing requirements. Univera Healthcare credentials primary care physicians, most specialty physicians, certain other health professionals and specific types of facilities.

Univera Healthcare does not currently credential the following specialty physicians:

- Anesthesiologists who provide only basic anesthesia services. (Anesthesiologists who provide pain management services must be credentialed.)
- Emergency Room (ER) physicians
- Hospitalists
- Locum Tenens
- Pathologists
- Certified Diabetic Educator (affiliated with Physician Group or Hospital)
- Registered Dietician (affiliated with Physician Group or Hospital)
- Licensed Master Social Worker (LMSW) and Licensed Creative Arts Therapist (LCAT)
- Nurse Practitioners*, Certified Registered Nurse Anesthetists, Physician Assistants

*Select nurse practitioners may qualify to be credentialed as independently practicing providers. Please refer to Provider.UniveraHealthcare.com/policies/view to review the requirements and/or criteria to be credentialed as an independently practice Nurse Practitioner. Univera Healthcare is responsible for assuring the provision of accessible, cost-efficient, quality care to its members. To that end, Univera Healthcare's Credentialing Committee reviews the credentials of all providers who apply for participation. The Credentialing Committee is composed of community providers, Univera Healthcare Medical Directors, and other such members as Univera Healthcare may appoint, who as a peer group is responsible for the review of all practitioner credentials and the review of all credentialing and recredentialing policies.

> **Note:** Univera Healthcare will not credential a trainee who does not maintain a separate practice from their training practice. Nor does Univera Healthcare credential providers who practice on a limited permit. Univera Healthcare may not require credentialing of a provider who practices exclusively within an inpatient setting or freestanding facility, and who supplies health care services to a Univera Healthcare member only due to the member being treated at the facility.

Univera Healthcare makes credentialing decisions without regard to the applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients in whom the provider specializes. Univera Healthcare does not discriminate against providers who serve high-risk populations or who specialize in treating costly conditions.

> **Note:** Univera Healthcare reserves the right to disapprove credentials in accordance with federal and state law and regulation.

The applicant has the burden of providing complete information sufficiently detailed for the Credentialing Committee to act. An applicant has the right upon request to be informed of the status of their application. The method of communication used by the applicant will determine the method of response. (For example, a phone inquiry will receive a phone response; a letter inquiry will receive a response by letter.)

A provider may not serve members of Univera Healthcare's programs that require providers to be credentialed until the provider is notified of Univera Healthcare's credentialing approval and execution of a participating provider agreement by both the provider and Univera Healthcare. Until a provider has received such an approval in writing and a participating agreement has been executed by both parties, they are not a member of the network. Providers are recredentialed at least every 36 months.

Provider's Right to Review Credentialing Information

A provider has the right to review certain information Univera Healthcare uses when credentialing them. The information available for review is that obtained from primary source organizations such as the National Practitioner Data Bank, state licensing boards, medical professional insurance carriers and hospitals. Any provider wishing to review their personal information obtained from these primary sources must submit a signed (original signature of requestor), written request to the Credentialing Department. (Credentialing Department contact information is included in the *Contact List* in this manual.)

The provider has the right to correct erroneous information submitted by another party. The provider must notify Credentialing Staff in writing within 30 days of discovering the erroneous information. Univera Healthcare will include the explanation and/or correction as part of the provider's application when it is presented to the Credentialing Committee for review and recommendation.

Web-based System for Submitting Credentialing Information

Overview

Univera Healthcare participates in a web-based system that providers must use to submit credentialing and recredentialing information. The system incorporates a nationwide universal credentialing application offered through the Council for Affordable Quality Healthcare (CAQH). Called *CAQH ProView*, the system enables a provider to complete their credentialing application online, store the information in a database they control and can update, and authorize participating health plans to view the data. In addition to physicians, this policy applies to all non-physician health care providers for whom Univera Healthcare has credentialing responsibilities, including:

- Acupuncturists
- Applied Behavioral Analysts
- Audiologists
- Certified Diabetic Educators
- Chiropractors
- Dentists *(specializing in oral maxillofacial surgery)*
- Enterostomal Therapists
- Genetic Counselors
- Licensed Clinical Social Workers
- Marriage & Family Therapists
- Massage Therapists
- Mental Health Counselors
- Midwives
- Occupational Therapists
- Optometrists
- Pharmacists
- Physical Therapists
- Podiatrists
- Specialty Nurse Practitioners
- Primary Care Nurse Practitioners
- Psychologists
- Registered Dieticians
- Speech and Language Pathologists

Note: For more information about the CAQH system, contact CAQH, Credentialing or Provider Relations. (For CAQH and Univera Healthcare contact information, see the *Contact List* in this manual.)

Among the requirements of the credentialing process, physicians and non-physicians must:

- Maintain a practice within Univera Healthcare's service area
- Demonstrate attainment of Univera Healthcare's specialty-specific requirements by providing copies of all applicable certificates regarding training, licensure, specialty certification and medical professional liability insurance
- Possess and maintain medical professional liability insurance at all times in amounts specified by Univera Healthcare. The provider must have a certificate of medical professional liability insurance that names the provider, documents the limits of liability, and specifies the effective date and the expiration date
- Possess and maintain a valid state license and current registration at all times.
- Possess and maintain a valid Drug Enforcement Agency (DEA) Certificate at all times, if applicable to the provider's specialty
- Be a member in good standing with a Health Plan-affiliated Article 28 or Article 40 facility, if applicable. Exemptions to this requirement may be available upon request. All providers are required, by contract, to notify Univera Healthcare of any changes in their privilege status
- Authorize release of information
- Provide and update on an ongoing basis historical information regarding physical or mental capacity impairments; criminal charges or convictions; loss, limitation, or restriction of license; loss or limitation of DEA certification; loss or limitation of privileges in a hospital, facility, or managed care organization; professional disciplinary actions; or medical professional liability claims, among other information
- Permit a site review of their office, if requested. See the paragraph headed *Office Site Review* in the *Administrative Information* section of this manual
- Provide 24-hour coverage. In a managed care plan or a plan with managed care features, primary care physicians and specialists must provide continuous care of their patients through on-call coverage arrangements with other participating credentialed providers. See the paragraph regarding *Access to Care* in the *Administrative Information* section of this manual

Practitioner Credentialing

1. When a physician or other health care practitioner is a first-time applicant for participation with Univera Healthcare, Univera Healthcare will send the practitioner an enrollment form that the practitioner must complete and return. The enrollment form includes a place for the practitioner to enter their CAQH number, which is required to initiate the credentialing process.
2. The practitioner is required to authorize Univera Healthcare to view information available online through CAQH ProView.
    a. If the practitioner seeks to participate with another health plan that participates with the CAQH system, the practitioner may authorize that plan to view their information, thus eliminating the need to complete another credentialing application.

b. Routinely, CAQH will ask the practitioner to update their information as necessary. A practitioner may also contact CAQH to update the information at any time.
c. As required by Chapter 551 amendments to Public Health Law 4406-d(1) and Insurance Law 4803(a), Univera Healthcare will respond to a credentialing application within 60 days of receipt of the completed application. Univera Healthcare follows all applicable managed care legislation for any provider's credentialing application that is pending for more than 60 days. This includes notification to a provider when additional time is needed to complete processing of the application. Credentialing staff cannot process an incomplete application. If any information is missing, the practitioner will be notified as soon as possible, but no more than 60 days from receipt of the application.
d. Credentialing staff shall notify the individual practitioner and/or the IPA(s)/Delivery System(s), if applicable, of the credentialing decision made by the committee within 30 days.

Note: Practitioners must continue to notify Univera Healthcare directly in writing of changes to information, such as remit address, tax ID, etc. to keep claims processing systems accurate. This is done using the *Practitioner Demographic Changes form*, available on the website or by calling Customer Care.

Emergency Credentialing

Univera Healthcare may offer emergency credentialing to physicians or other health care practitioners in unique situations or where there is an urgent need for patients to access certain practitioners. A Univera Healthcare Medical Director will review all requests for emergency credentialing to determine whether approval should be granted. Emergency credentials, if granted, expire after 60 days.

Practitioner Recredentialing

Univera Healthcare may recredential practitioners at any time, but in no circumstances less frequently than every 36 months. When a practitioner is due for recredentialing, Univera Healthcare will use the CAQH application if the practitioner has reviewed, updated, and re-attested to the data in their application within the last 60 days. If the on-line application has not been refreshed recently, Univera Healthcare will contact the practitioner to request that the practitioner review, update, and re-attest to their CAQH application data.

Credentialing and Recredentialing Facilities

This section of the manual provides a brief overview of Univera Healthcare's facility credentialing process. For more information, call the Credentialing Department. (Credentialing Department contact information is on the *Contact List* in this manual.)

Univera Healthcare is committed to providing quality care and services to its members. To help support this goal, Univera Healthcare credentials and re-credentials health delivery organizations with which it contracts. Health delivery organizations (as listed below) requesting participation in Univera Healthcare's provider network shall be required to meet established credentialing criteria based on service type. Univera Healthcare will not contract with health delivery organizations that do not meet the criteria for that provider type. Univera Healthcare staff will review health delivery organizations at least every 36 months. Univera Healthcare will credential only licensed, regulated facilities.

Each health delivery organization must meet the criteria listed below. In situations where an organization does not meet the criteria, Univera Healthcare may reconsider the organization for participation following an on-site review.

A. Acute General Hospitals. Must provide inpatient, outpatient and emergency services and must have:

- Operating License and Certificate
- Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or American Osteopathic Association (AOA); DNV Healthcare Inc. (DNVHC); and Centers for Medicare & Medicaid Services (CMS)
- Medicare Certification as issued by CMS
- Medicaid Certification as issued by the Department of Health, Education and Welfare
- Certification from the Office of Mental Health for Acute Care General Hospitals with Mental Health Services
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare

B. Home Health Agencies, including Certified Home Health Agencies and Licensed Home Care Services Agencies. At a minimum, an agency must make available the services of registered and licensed practical nurses, certified home health aides, as well as occupational, physical and speech therapists. The agency also must have:

- Operating License and Certificate
- Medicare and/or Medicaid Certification
- Accreditation by JCAHO or the Accreditation Commission for Healthcare (ACHC): Organizations not accredited are requested to submit their most recent Department of Health Survey
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare

C. Skilled Nursing Facilities. At a minimum, the facility must provide discharge planning services; nursing supervision and services by registered or licensed practical nurses, nurse's aides and occupational, physical and speech therapists; routine medical supplies; and semi-private room and board. At minimum, the facility must have:

- Operating License and Certificate
- Medicare and Medicaid Certification
- Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Continuing Care Accreditation Commission (CCAC). Organizations that are not accredited are requested to submit their most recent Department of Health Survey
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare

D. Freestanding Surgical Centers/Ambulatory Care Organizations. At a minimum, the facility must have:

- Operating License and Certificate
- Medicare and Medicaid Certification
- Accreditation from a recognized accrediting body [e.g., JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC)
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare

E. Freestanding Dialysis Center. At a minimum, the facility must provide evaluation, intensive outpatient treatment and be medically supervised by a participating physician. At a minimum, the facility must have:

- Operating License and Certificate
- Medicare and Medicaid Certification
  (i) for NY facilities, certification from OASAS to provide services defined in 14 NYCRR 819.2(a)(1) and Part 817 and 820(ii) For out-of-state facilities, licensure from a similar state agency or accreditation from the Joint Commission as an alcohol, substance use, or chemical dependency treatment program to provide the same level of treatment
- List of qualified individuals providing stated services
- Certificate of Insurance

F. Substance Use Treatment Centers. At a minimum, the facility must provide evaluation, intensive outpatient treatment and be medically supervised by a participating physician. The facility must have:

- Operating License and Certificate
- Certification from NYS Office of Alcoholism and Substance Abuse Services (OASAS)
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare
- List of qualified individuals providing services and a statement of their credentials

Note: When credentialing OMH-licensed, OMH-operated and OASAS-certified facilities, Univera Healthcare will accept OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors, or agents of such providers. Univera Healthcare will collect and accept program integrity-related information as part of the credentialing process. Univera Healthcare requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in Medicare or Medicaid programs.

G. Community Mental Health Centers. At a minimum, the facility must provide evaluation, short-term treatment, and medical management services. The facility must have:

- Operating License and Certificate
- Medicare and Medicaid Certification
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare
- List of qualified individuals providing services and stated credentials

Note: When credentialing OMH-licensed, OMH-operated and OASAS-certified facilities, Univera Healthcare will accept OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors, or agents of such providers. Univera Healthcare will collect and accept program integrity-related information as part of the credentialing process. Univera Healthcare requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in Medicare or Medicaid programs.

H. Inpatient Substance Use Facilities. At a minimum, the facility must have:

- Operating License and Certificate
- Medicare and Medicaid Certification
- Certification from NYS Office of Addiction Services and Supports (OASAS)
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare

- JCAHO Accreditation

I. Inpatient Mental Health Facilities. At a minimum, the facility must have:

- Operating License and Certificate
- Medicare and Medicaid Certification
- Certificate of Insurance: general and medical professional liability insurance in amounts specified by Univera Healthcare
- JCAHO Accreditation
- Certification from Office of Mental Health (OMH)

J. Freestanding Sleep Study Centers. At a minimum, the facility must have:

- Operating License and Certificate
- Medicare and Medicaid Certification
- Accreditation from American Academy of Sleep Medicine (AASM)
- Certificate of Insurance; general and medical professional liability insurance in amounts specified by Univera Healthcare

K. Freestanding Urgent Care Centers. At a minimum, the facility must have:

- Joint Commission (JCAHO) accreditation or in process of achieving accreditation from JCAHO, an on-site review may be required, OR
- Article 28 operating license and certificate issued by NYSDOH, OR
- Accreditation by a recognized accrediting body (i.e. Urgent Care Center Accreditation (UCCA), American Academy of Urgent Care Medicine (AAUCM), AND
- Independently practicing Nurse Practitioners must be credentialed, AND
- All employed practitioners must be credentialed by Univera Healthcare and all Nurse Practitioners supervised by an on-site credentialed physician must be registered by Univera Healthcare and all must maintain current, unrestricted licensure and be in good standing with state and federal bodies
- Medicare and/or Medicaid certification
- Certificate of Insurance; general and medical professional liability insurance in amounts specified by Univera Healthcare
- Current unrestricted licensure of providers and Nurse Practitioners

L. Mental Health Residential Treatment Facility

- Operating License and Certificate
- Medicare and Medicaid Certification
- (i) For New York facilities, the facility must be either a “residential treatment facility for children and youth” as defined in Mental Hygiene Law 1.03(33), or a facility that is part of a comprehensive care center for eating disorders identified in accordance with Public Health Law Article 27-J
  (ii) For out-of-state facilities, licensure, or certification in that state to provide the same level of treatment
- Certificate of Insurance

M. Substance Use Disorder Residential Treatment Facility

- Operating License and Certificate
- Medicare and Medicaid Certification

- (i) For New York facilities, certification from OASAS to provide services defined in 14 NYCRR 819.2(a)(1) and Part 817
  (ii) For out-of-state facilities, licensure from a similar state agency or accreditation from the Joint Commission as an alcohol, substance use or chemical dependency treatment program to provide the same level of treatment
- List of qualified individuals providing the services
- Certificate of Insurance

N. New York State Operated Centers

- OMH self-certifies its state-operated programs. OMH will provide New York State Operated Centers with a letter and corresponding list of such certified programs to eliminate the need for proof of licensure, certificate of need information or certification.
- New York State provides malpractice coverage. New York state operated centers are run by the state of New York and therefore, the state of New York is liable for claims arising out of New York State Operated Centers and/or its employees' performance pursuant to Section 8 of the New York State Court of Claims Act.

Univera Healthcare will conduct an on-site review if the above criteria are not met. On-site reviewers will verify that the organization:

- Has a current, active Quality Management Program
- Has a current, active Policy and Procedure Manual
- Holds Quality Management meetings appropriate to the organization
- Has indicators in place to address the measurement, action, and frequency of reports/monitoring
- Monitors/reports member complaints and takes appropriate action
- Performs outcome studies
- Demonstrates that the individual member's plan of care corresponds to that prescribed by the member's physician

Univera Healthcare also conducts an interview with the organization's Director of Quality Program at the time of the on-site visit.

3.4 Registering Non-Credentialed Providers

Certain providers who elect to participate in Univera Healthcare's network are not subject to credentialing but must, instead, be registered with Univera Healthcare. Currently, this group includes:

- Anesthesiologists who provide only basic anesthesia services. (Anesthesiologists who provide pain management services must be credentialed.)
- Emergency Room (ER) physicians
- Hospitalists
- Locum Tenens
- Pathologists
- Certified Diabetic Educator (affiliated with a Physician Group or Hospital)

- Registered Dietician (affiliated with a Physician Group or Hospital)
- Licensed Master Social Worker (LMSW) and Licensed Creative Arts Therapist (LCAT)
- Nurse Practitioners*, CRNA, Physician Assistants
  **Not practicing independently*

Procedures

1. An anesthesiologist, ER physician, hospitalist, pathologist, nurse practitioner (not practicing independently), CRNA, PA, CDE, RD or locum tenens who wants to participate must contact Univera Healthcare through Customer Care. (For Univera Healthcare addresses and phone numbers, see the *Contact List* in this manual.)
2. After discussion with an appropriate individual in the Network Management Department, the provider must complete the *Application for Practitioner Enrollment* (available on Univera Healthcare website or from Customer Care) and attach:
   - A W-9 form
   - A signed agreement signature page
   - A signed copy of their license or registration
   - A copy of the face sheet from the applicable medical professional liability insurance policy
   - If applicable, a copy of their DEA registration
3. The provider must submit the enrollment form and materials using one of the methods indicated at the end of the form.

Registering Nurse Practitioners and Physician Assistants

Univera Healthcare requires that nurse practitioners (NP) (unless credentialed as a Psychiatric, Women's Health or Primary Care Nurse Practitioner) or physician assistants (PA) be registered with Univera Healthcare so that NPs and PAs may be appropriately reimbursed for treating members. Where required, an NP agreement must be provided to Univera Healthcare. The supervising physician of a PA must attest to being such on the registration form(s).

Sixty (60) days before an NP can begin billing under their own provider ID, the NP or the collaborating physician must register the collaborating agreement with Univera Healthcare by following these procedures. In the same time frame, a PA/CRNA who wishes to bill under their own provider ID must:

1. Complete an *Application for Non-Physician Health Care Practitioner* available on Univera Healthcare's website or from Customer Care.
2. On the form, enter the required information for the NP/PA and the collaborating/supervising physician whom the NP/PA will be supporting.

   Note: To register collaborating/supervising agreements/relationships with additional physicians, attach a separate sheet. Include on that sheet the name of each additional physician and the other information specified in the Physician Information section of the form.
3. Attach photocopies of:

a. Proof of medical liability insurance in amounts specified by Univera Healthcare.
b. A written statement from the collaborating/supervising physician, affirming that they are the collaborating/supervising physician for this NP/PA and, as required for NPs, that the appropriate agreement is in place.

Note: If attaching a separate sheet listing collaborating/supervising agreements with other physicians, include photocopies of the above documents as associated with **each physician listed.**

4. If this NP/PA has not previously registered a collaborating/supervising agreement/relationship with Univera Healthcare, also attach a photocopy of the NP/PA/CRNA's signed professional license or registration.
5. The NP/PA must sign and date the form.
6. Fax or mail the form and its attachments (and the additional sheet and attachments, if necessary) to the attention of Provider Relations. Fax number and address are given at the top of the form.

Registering Licensed Master Social Workers and Licensed Creative Art Therapists

To register a licensed master social worker (LMSW) or licensed creative art therapist (LCAT), Univera Healthcare requires the LMSW/LCAT to enter in a written collaborative arrangement with a supervising provider to offer mental health services, such as psychotherapy. The supervising provider must be a licensed clinical social worker with the "R" designation (LCSW-R), psychologist (PhD) or psychiatrist (MD) who participates with Univera Healthcare.

The collaborative arrangement must address:

- Patient referral and consultation.
- Coverage for emergency absences of either the LMSW or the collaborating provider.
- Resolution of disagreements between the LMSW and the collaborating provider regarding diagnosis and treatment.
- Peer review by the collaborating provider of patient records.

Univera Healthcare also requires the:

- LMSW/LCAT acquire their own unique National Provider Identifier (NPI) number.
- LMSW/LCAT register under the same tax identification number as the supervising provider.
- LMSW/LCAT and supervising provider complete, sign and submit the *Application for Non-Physician Health Care Practitioner* form, which includes the Collaborating Physician Attestation.

Once registered, LMSWs and LCATs currently submitting claims under their individual tax identification number would need to begin submitting claims under the supervising provider's tax identification number.

Notifying Univera Healthcare when an NP/PA/LMSW/LCAT Agreement Ends

To the extent possible, sixty (60) days before an NP/PA/LMSW/LCAT ends an arrangement with a collaborating/supervising physician, the NP/PA/LMSW/LCAT or the physician must notify Univera Healthcare **in writing.**

In the notification, include the NP/PA/LMSW/LCAT's national provider ID (NPI) as associated with the collaborating/supervising physician, the physician's NPI, and the date the arrangement is to end. Mail the notification to Provider File Maintenance at Univera Healthcare. (Univera Healthcare addresses and phone numbers are listed on the *Contact List* in this manual.)

3.5 Provider Termination and Suspension

Univera Healthcare has established a policy that describes the procedures associated with termination and suspension of health care professionals as defined under New York State Public Health Law s. 406-d. The policy is designed to advise providers of all notice and hearing rights afforded by the New York State Public Health Law, the New York State Insurance Law, and the federal Health Care Quality Improvement Act. In cases where a provider has a participation agreement with Univera Healthcare, to the extent that the agreement contains any additional rights with respect to terminations or suspensions not set forth in the policy, such additional rights shall apply as long as they are not contrary to applicable law.

Cases Involving Imminent Harm to Patient Care

When a Univera Healthcare Medical Director or their designee determines, at their sole discretion, that permitting a provider to continue to provide patient care services to members poses a risk of imminent harm to patient care, Univera Healthcare shall:

- Suspend the provider's right to provide patient care services to members as described in the paragraph titled "Suspensions to Conduct Investigations" below.

OR

- Except set forth below, terminate the provider's participation agreement and revoke the provider's credentials, as applicable, without affording the provider a hearing as described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual. If the provider is a physician or dentist and the conduct is related to the physician's/dentist's competence or professional conduct, Univera Healthcare may recommend termination of the physician's/dentist's participation agreement or revocation of the provider's credentials, as applicable, by referral to the Corporate Credentialing Committee. If the Corporate Credentialing Committee agrees to propose to terminate the provider, Univera Healthcare shall afford the provider a hearing as described in "Notice and Hearing Procedures" later in this section of the manual. Notwithstanding the foregoing, where a Plan Medical Director determines in their sole discretion (prior to affording the applicable hearing procedures for a proposed termination) that the provider's failure to act may result in the imminent danger to the health or safety of any individual, Univera Healthcare may terminate the provider's participation subject to the subsequent provision of the applicable hearing procedures for a proposed termination.

Cases Involving Fraud (as defined by the state in which the provider is licensed)

Where there has been a determination of fraud, Univera Healthcare shall:

- Suspend the provider's right to provide patient care services to members as described in the paragraph titled "Suspensions to Conduct Investigations" below

OR

- Except set as forth below, terminate the provider's participation agreement, and revoke the provider's credentials, as applicable, without affording the provider a hearing as described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual. If the provider is a physician or dentist and the conduct is related to the physician's/dentist's competence or professional conduct, Univera Healthcare may recommend termination of the physician's/dentist's participation agreement or revocation of the provider's credentials, as applicable, by referral to the Corporate Credentialing Committee. If the Corporate Credentialing Committee agrees and proposes to terminate the provider, Univera Healthcare shall afford the provider a hearing as described in "Notice and Hearing Procedures" later in this section of the manual. Notwithstanding the foregoing, where a Plan Medical Director determines in their sole discretion (prior to affording the applicable hearing procedures for a proposed termination) that the provider's failure to act may result in the imminent danger to the health or safety of any individual, Univera Healthcare may terminate the provider's participation subject to the subsequent provision of the applicable hearing procedures for a proposed termination.

Cases Involving Final Disciplinary Actions by State Licensing Boards or Other Governmental Agencies

Where a final disciplinary action has been rendered by any state licensing board or other governmental agency that impairs the provider's ability to practice, Univera Healthcare shall proceed in accordance with one of the following, as applicable:

- Suspend the provider's right to provide patient care services to members as described in the paragraph titled "Suspensions to Conduct Investigations" below.

OR

- Except as set forth below, terminate the provider's participation agreement and revoke the provider's credentials, as applicable, without affording the provider a hearing as described in the paragraph titled "Notice and Hearing Procedures" later in this section of the manual. If the provider is a physician or dentist and the conduct is related to the physician's/dentist's competence or professional conduct, Univera Healthcare may recommend termination of the physician's/dentist's participation agreement or revocation of the provider's credentials, as applicable, by referral to the Corporate Credentialing Committee. If the Corporate Credentialing Committee agrees and proposes to terminate the provider, Univera Healthcare shall afford the provider a hearing as described in "Notice and Hearing Procedures" later in this section of the manual. Notwithstanding the foregoing, where a Plan Medical Director determines in their sole discretion (prior to affording the applicable hearing procedures for a proposed termination) that the provider's failure to act may result in the imminent danger to the health or safety of any individual, Univera Healthcare may terminate the provider's participation subject to the subsequent provision of the applicable hearing procedures for a proposed termination.

Termination for Exclusion from Participation in Medicare Programs

If the New York State Office of the Medicaid Inspector General (OMIG) or U.S. Department of Human & Health Services Office of Inspector General (OIG) excludes or terminates a provider from participation in the Medicaid or Medicare program, Univera Healthcare shall, upon learning of such exclusion or termination, immediately terminate the provider's agreement and Univera Healthcare will no longer pay claims for the provider for services rendered to members with that coverage. Unless required by law, the excluded provider will not be afforded a hearing as described in the paragraph entitled "Notice and Hearing Procedures" later in this section of the manual.

Termination for Other Reasons

Where Univera Healthcare proposes to terminate a provider's participation agreement and/or revoke a provider's credentials, as applicable, for any reason other than those described in the previous sections (e.g., failure to comply with Univera Healthcare's utilization management or quality management policies and procedures, failure to satisfy Univera Healthcare's credentialing/peer review/quality review standards), Univera Healthcare shall afford the provider a hearing as described in the following paragraphs.

Univera Healthcare may in its sole discretion, implement an action or range of actions prior to termination including but not limited to: corrective action plans with monitoring as recommended by Quality Management; conditional, time-limited credentialing as approved by the Corporate Credentialing Committee; required continuing medical education; or mentoring by an appropriate peer.

Notice and Hearing Procedures

Any hearing afforded a provider shall be conducted in accordance with Univera Healthcare's *Practitioner Termination and Suspension Policy* as follows:

Notices

Univera Healthcare will send a provider a written notice of any proposed termination. The written notice of proposed termination shall be personally delivered or mailed by U.S. mail with return receipt requested - to the provider. The notice shall include:

1. A written explanation of the reasons for the proposed termination.
2. If appropriate, a statement that the provider has the right to request a hearing before a hearing panel appointed by Univera Healthcare.
3. A summary of the provider's rights at the hearing.
4. A time limit of not less than 30 calendar days within which to submit a written request for a hearing.
5. A time limit for a hearing, which must be held within 30 calendar days after the date of receipt of a request for a hearing, unless the parties agree otherwise.

Hearing Requests

1. Any request for a hearing must be in writing, and be personally delivered, or mailed by U.S. mail with return receipt requested, to the medical director.
2. The provider is entitled to only one hearing.
3. If the provider does not request a hearing in compliance with these rules, a proposed termination will be final, and the provider will have waived any right to a hearing or review under any applicable law.

Notice of Hearing

1. If the provider submits a written request for a hearing in compliance with these rules, Univera Healthcare shall give the provider a "Notice of Hearing." The *Notice* shall be in writing and shall state the place, time, and date of the hearing, which date shall be within 30 days after the date of receipt of the hearing request, unless the parties agree otherwise. The Notice of Hearing shall be personally delivered—or mailed by U.S. mail with return receipt requested—to the provider.
2. The Notice of Hearing shall also state a list of the witnesses, if any, expected to testify at the hearing against the provider and that the right to a hearing will be forfeited if the provider fails to appear at the hearing without good cause. The provider shall also provide a list of witnesses and representatives to Univera Healthcare no less than five (5) business days prior to the scheduled hearing.

Provider's Evidence at the Hearing

1. The Provider has the right to present witnesses at the Hearing. A list on any such witnesses shall be provided to the Plan at least five (5) business days prior to the Hearing.
2. Any materials the Practitioner intends to use as evidence during the Hearing (e.g., relevant medical records, articles from peer-reviewed literature, statements of support from other physicians or providers), must be provided to the Plan at least five (5) business days prior to the Hearing.
3. Practitioner's failure to provide the list of proposed witnesses and/or evidence to be presented at the Hearing may result in exclusion of the witnesses and/or evidence from the Hearing. In the alternative and its sole discretion, the Plan may delay the Hearing by a reasonable time if the witness list and/or evidence is not received within the time frame required; such delay will be communicated to the Practitioner in writing.

Conduct of the Hearing

If the practitioner submits a written request for a hearing in compliance with these rules, Univera Healthcare will appoint a hearing panel composed of three persons as follows: one clinical peer in the discipline and in the same or similar specialty as the practitioner under review and two other persons appointed by Univera Healthcare The hearing panel may consist of more than three persons provided that the number of clinical peers in the panel shall constitute one-third or more of the total membership of the panel.

In its sole discretion, the Plan may appoint a Hearing Officer to facilitate the Hearing. The Hearing Officer will be a Plan employee and not a voting member of the panel. The Hearing Officer ensures the Hearing is conducted with due process, objectivity, impartiality, effectiveness, and consistency.

1. The proponent (Univera Healthcare) leads with:
    a. The timeline of actions, notices, and responses.
    b. The action(s) taken.
    c. Citations to policies, law, precedent, and other rules that justify the action.

2. The respondent (practitioner) follows with:
    a. Rebuttal to being informed in a timely manner of the adverse action, explaining the decision, or clear explanation of how to obtain a fair hearing.
    b. Rebuttal with documents or witnesses to the facts that are the basis of the adverse action.
    c. Proposed alternate penalties or conditions.
3. If one is appointed, the Hearing Officer must make decisions about evidence proposed for admission, identify the accepted evidence, only admit evidence applicable to the charges, decline testimonials and character witnesses, and permit both sides to present a case.
4. The committee must keep a record of the hearing, which includes the recording, transcript, or summary; all admitted exhibits; committee decisions; committee notices; and orders.
5. The practitioner shall be afforded the right to have a record made of the hearing, and the practitioner may obtain a copy of the record of the hearing upon payment of any reasonable charges associated with the preparation and copying of the record.
6. The practitioner may submit a written statement to the hearing panel at the conclusion of the hearing.

Effective Date of Termination

1. If the provider does not request a hearing, the contract termination will become effective 60 days from the date the provider received the original notice of intent to terminate (i.e., written notice of proposed contract termination).
2. If the provider requests a hearing, and the hearing panel upholds the proposed action against the provider's credentials and termination of the participation agreement, the termination will become effective 30 days after the date the provider receives written notice of the hearing panel's decision, or 60 days after the date when the provider received the original notice of intent to terminate (i.e., written notice of proposed contract termination), whichever is later.

Reporting the Results of the Hearing

The decision of the hearing panel shall be reported to the Corporate Credentialing Committee. The minutes of the Corporate Credentialing Committee shall be reported to the board of directors. The hearing panel will render its decision in writing to the practitioner and the panel's written decision shall communicate reinstatement by Univera Healthcare or provisional reinstatement subject to conditions set forth by Univera Healthcare, or termination.

Suspensions to Conduct Investigations

A Univera Healthcare medical director may summarily suspend or restrict a practitioner's clinical privileges for a period not longer than 30 days to conduct an investigation in any case where a Univera Healthcare medical director determines, in their sole discretion, that an Adverse Action may be warranted. Notwithstanding, in the case where a physician or dentist's conduct is related to their competence or professional conduct, a Univera Healthcare medical director may summarily suspend or restrict clinical privileges:

(a) To investigate and determine the need for an Adverse Action for a period not to exceed 14 days, or

(b) Where a Univera Healthcare medical director determines in their sole discretion that the failure to take such action in advance of affording the hearing procedures otherwise applicable to a Proposed Termination may result in the imminent danger to the health and safety of any individual, subject to the subsequent provision of the hearing procedures applicable to the Proposed Termination. Any suspension or restriction of clinical privileges pursuant to this paragraph shall be effective immediately upon notice to the practitioner.

Potential outcomes of such an investigation include Proposed Termination or initiation of a corrective action plan.

Non-Renewal

Upon 60 days' notice to the provider, or as otherwise set forth in a Univera Healthcare provider participation agreement, Univera Healthcare may exercise a right of non-renewal at the expiration set forth in the participation agreement or at the expiration of the credentialing period, whichever is applicable.

No Retaliatory Terminations/Non-Renewals

Univera Healthcare will not terminate or refuse to renew a participation agreement solely because the provider has: (a) advocated on behalf of an enrollee, (b) filed a complaint against Univera Healthcare, (c) appealed a decision of Univera Healthcare, (d) provided information or filed a report to an appropriate governmental body regarding the policies or practices of Univera Healthcare which provider believes may negatively impact upon the quality of, or access to, patient care, or (e) requested a hearing or review.

Reporting to Regulatory Agencies

To the extent required by all applicable state and federal laws and regulations, Univera Healthcare shall report terminations or suspensions for cause of greater than 30 days to the appropriate regulatory agency, including without limitation, the National Practitioner Data Bank, the Healthcare Integrity and Protection

Data Bank, the New York state Department of Health's Office of Professional Medical Conduct, and the New York state Department of Education's Office of Professional Discipline.

The report must include the name, address, profession, and license number of the person being reported. The report shall also include a description of the action taken by Univera Healthcare with the specific reason for and date of the action. A Univera Healthcare medical director will sign the report.

Causes for termination/revocation or suspension of greater than 30 days include but are not limited to:

- Termination of a provider for mental or physical impairment, misconduct, or impairment of patient safety
- Voluntary or involuntary termination to avoid imposition of disciplinary action
- Termination for a determination of fraud or imminent harm to patient care
- Information that reasonably appears to show a professional is guilty of misconduct

Transitional Care

In accordance with applicable state and/or federal law, Univera Healthcare may approve a member to continue an ongoing course of treatment with a provider for a period of up to 90 days after the later of (1) the provider's contractual obligation to provide services to the member terminates; or (2) the date Univera Healthcare provides notice to the member of the provider termination, if the provider fails to timely notify Univera Healthcare prior to such termination. In addition, Univera Healthcare may approve a member to continue with a provider, if the member is pregnant at the time of the provider's disaffiliation, through delivery, including delivery-related post-partum care. A provider whose termination is related to fraud, quality of care or disciplinary action is not eligible to provide transitional care. A provider who is eligible to provide transitional care to an eligible Univera Healthcare member shall accept reimbursement for those transitional care services at the rates of reimbursement that were applicable prior to the start of the transitional period under their now-terminated participation agreement with Univera Healthcare, as payment in full, except for the member's in-network cost-sharing. In addition, such provider shall comply with all Univera Healthcare policies, procedures, and quality standards in the same manner as if the provider's termination had not occurred.

3.6 Provider-Initiated Departure from Univera Healthcare

The term of a provider's participation with Univera Healthcare is specified in the participation *agreement. In a standard participation agreement, the agreement is designed to remain in effect until* either Univera Healthcare or the provider terminates the agreement under the provisions outlined in the agreement.

In addition to the above, Univera Healthcare requires written notification of a provider leaving the network in the following circumstances:

- **Retirement:** Notice is required at least 60 days prior to the date a provider intends to stop seeing patients.
- **Death:** Upon the death of a provider, their representative should notify Univera Healthcare as soon as possible.
- **Practice Closure:** Notice is required at least 60 days in advance, when possible. Otherwise, Univera Healthcare must be notified as soon as possible.

In all of the above circumstances, Univera Healthcare must be provided with contact information for the custodian of the provider's medical records. The above notification and information must be provided in writing either on the provider's practice letterhead or through our online Demographic Changes form.

Re-entry into Univera Healthcare Following Resignation

Providers who wish to be considered for re-entry to the panel of providers permitted to treat Univera Healthcare members must contact the Provider Relations Department to make that request. Univera Healthcare will consider re-admittance based on established policy. Copies of this policy are available on the Plan's website. (For Univera Healthcare address and phone numbers, see the *Contact List* in this manual.)

Notifying Members Following Provider Departure

Univera Healthcare Responsibilities

Within 15 days after receiving notification that a provider acting as a primary care physician will be disaffiliated with Univera Healthcare, or at least 30 days prior to the termination date, Univera Healthcare will send a letter to members under that provider's care. The letter will inform the member of the date on which the provider's contract was/will be terminated, encourage the member to select a new provider and provide notice of the member's right to request transitional care from the provider, if applicable.

Specialist Responsibilities

When an individual specialist physician or a specialty group terminates participation in Univera Healthcare, the specialist or specialty group must notify affected members of the termination at least 30 days prior to the effective date of the termination. In the event an individual specialist is terminated from a specialty

group, the group must notify affected members at least 30 days prior to the effective date of the termination.

“Termination” shall include termination of the agreement between Univera Healthcare and the physician or group for any reason, or any other situation in which the physician or group is no longer available to see an affected member. “Affected members” refers to members enrolled in Univera Healthcare who are receiving ongoing treatment from the specialist physician or specialty group.

3.7 Provider Reimbursement

Reimbursement is based on standard payment methodologies utilized by Univera Healthcare for each provider type and line of business. Specific reimbursement is determined from the member's benefit package, the product lines in which the provider participates, and the terms of the provider's participating provider agreement.

Inquiries regarding the reimbursement terms of a provider's participation agreement should be directed to Provider Relations. (See the *Contact List* in this manual.)

Payment in Full and Hold Harmless

When Univera Healthcare pays a participating provider directly for covered services, the provider must accept the payment as payment-in-full and must agree not to collect from or bill the member for anything except the permitted copayment, coinsurance, and deductible.

Fee Schedule

Univera Healthcare pays a participating provider for covered services provided to members on the basis of a fee schedule pursuant to the terms and conditions of the provider's participation agreement. Reimbursement rates are mailed to non-physician professional providers (e.g., social workers, optometrists, psychologists, etc.) Physician reimbursement schedules are available on our website, Provider.UniveraHealthcare.com. It is very important for providers to register for our website to access fee schedules online.

Univera Healthcare deducts copayments, coinsurance, and deductibles from the amount to be reimbursed, as applicable. These amounts are determined from the member's benefit package, the product lines in which the provider participates, and the terms established in the provider's participation agreement with Univera Healthcare.

Reimbursement of Mid-level Practitioners (NPs and PAs)

Univera Healthcare will reimburse nurse practitioners (NPs) and physician assistants (PAs) (mid-level practitioners) at 85 percent of the physician fee schedule for Evaluation and Management, Medicine, and procedural codes as applicable to all services within the scope of the licensure/registration of the individual NP/PA.

Exceptions to this are immunizations, vaccinations, injectable drugs, laboratory, radiology and supplies, which are reimbursed at 100 percent of the physician fee schedule.

Univera Healthcare reimburses claims submitted by the NP/PA as part of the remittance paid to the associated collaborating/supervising physician.

For additional information regarding submitting claims for services provided by mid-level practitioners, see the *Billing and Remittance* section of this manual.

Univera Healthcare
Participating Provider Manual

Section 4: Benefits Management

Providers who agree to participate with Univera Healthcare have also agreed to cooperate in and comply with the standards and requirements of Univera Healthcare's utilization management (and other) initiatives.

> **Note:** For the purposes of this section of the provider manual, the term "managed care" refers to those products that require the member to select a primary care physician (PCP) to coordinate their care. This may include obtaining authorization for a referral for services that the PCP cannot provide. The types of products that may have this requirement are HMO and point-of-service (POS).

Revised September 2024

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4.1 Utilization Review

> **Note:** This section **does not** apply to the utilization review process for Medicare Advantage products. For information about how Univera Healthcare conducts utilization review - called "organization determination" by the Centers for Medicare & Medicaid Services (CMS) - for Medicare Advantage products, see the *Medicare Advantage* section of this manual.

Univera Healthcare conducts utilization review to determine whether health care services that have been provided, are being provided, or are proposed to be provided to a member are medically necessary. Univera Healthcare has a medical policy defining *Medically Necessary Services*. The policy is available on Univera Healthcare's website or from Customer Care.

For Univera Healthcare MyHealth℠ and MyHealth Plus℠ products, the New York State Department of Health requires the following definition *of Medically Necessary*:

Medically Necessary means health care and services that are necessary to prevent, diagnose, manage, or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote the normal growth and development and prevent, diagnose, treat, ameliorate, or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability.

Univera Healthcare considers none of the following to be utilization review for medical necessity:

- A denial based on failure to obtain health care services from a designated or approved health care provider, as required under a member's contract
- A determination rendered pursuant to the dispute resolution provision of Public Health Law section 2807(c) (3-a)
- A review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedures
- Any issues related to a determination of the amount or extent of payment other than determinations to deny payment based on an adverse determination
- A determination of any coverage issues other than whether health care services are or were medically necessary or experimental/investigational
- A denial due to a contractual exclusion; or
- A denial for failure to obtain preauthorization where required

No Financial Incentives

Univera Healthcare has a process for reviewing health care services to ensure they are evidence based, medically necessary, and being performed at the right level of care by qualified professionals. This process is called utilization management (UM) and it is conducted by licensed health care professionals and practitioners.

UM decision-making is based solely upon the application of nationally recognized clinical criteria, transparent corporate medical policies, and the existence of coverage. Univera Healthcare does not, in any way, encourage decisions that result in underutilization or reward UM decision-makers for denials of coverage or limits on access to care.

Utilization Review Criteria

Medical Necessity Determinations

Univera Healthcare conducts pre-service, concurrent, and post-service reviews to determine whether the services requested are appropriate for the diagnosis and treatment of members' conditions. Medical necessity criteria are selected and/or developed and approved by Univera Healthcare medical management committees with input from participating physicians.

> **Note:** The fact that a provider has furnished, prescribed, ordered, recommended, or approved a service does not make it medically necessary, nor does it indicate that the service is covered.

Clinical Information/Case Documentation

To make an informed clinical decision, Medical Services staff may request copies of select portions of a member's medical record from all sources involved in the member's care (e.g., the member's PCP, a physician specialist, or an institutional or ancillary provider).

If the documentation supplied is insufficient or requires clarification, the Medical Services reviewer, Univera Healthcare Medical Director, or designee may make a request for additional information, either orally or in writing to the requesting provider. If Univera Healthcare does not receive the requested additional information, Univera Healthcare's Medical Director will make a medical necessity determination based on the information available within the applicable time frame. (See the paragraphs entitled *Utilization Review Decision and Notification Time Frames* later in this section of the manual.)

Univera Healthcare will review the clinical information supplied against established clinical review criteria, Univera Healthcare standards, guidelines, and policies; and state and federal laws and regulations.

Refer to the *Billing and Remittance* section of this manual, for additional information about submission of medical records.

Criteria Selection and Application

In performing utilization review, Univera Healthcare utilizes nationally recognized criteria such as InterQual® and Medicare medical coverage guidelines, as well as corporate medical policies and community-based criteria, including New York state's OASAS LOCADTR 3.0 for Substance Use and ASAM (American Society for Addiction Medicine).

Criteria are reviewed with participating providers. Community-based criteria are developed using regional providers, who apply both regional standards of practice and nationally accepted standards. Medical Services reviewers use these standards to evaluate the medical necessity, level of care, and proposed alternative care settings for inpatient and outpatient services. Staff members apply Univera Healthcare medical policies associated with the requested service. (See discussion about medical policies in other sections of this manual.)

Univera Healthcare's medical policies are available through the Provider pages on Univera Healthcare's website. Univera Healthcare's utilization management criteria are available to participating providers, members, and prospective members on Univera Healthcare's website or upon request from Customer Care. (For telephone numbers, see the *Contact List* in this manual.)

Review of New Technology and Local Capacity

Univera Healthcare's mission includes making affordable medical care available as widely as possible throughout the community. Overuse of services and use of unproven technologies affect both cost and quality. Therefore, Univera Healthcare has established a process to review and manage both technology and capacity.

Capacity includes incremental increases in capital equipment (for example MRI scanners), programs (for example, birthing centers), approved technology that is new to the local area (for example, PET scans) and changes in the distribution of services within the service area.

Univera Healthcare will cover new technologies, services, and capacity *only* as approved and reviewed by corporate committees. New or incremental technology, programs or services that have not been reviewed through this process will not be eligible for coverage.

Participating providers who are planning to invest in new technologies, services, and/or added capacity should first verify that coverage will be available the additional service under Univera Healthcare's health benefit programs and that the new technologies, services, and/or added capacity are consistent with Univera Healthcare's position on the community's need for additional capacity.

Types of Utilization Review

All utilization review processes follow the timelines shown on the chart, *UM Initial Determination Timeframes,* located on our website, Provider.UniveraHealthcare.com/resources/forms, in the *Benefits Management* section. The *UM Initial Determination Timeframes* for Behavioral Health is in the Mental Health and Substance Use section. See the paragraphs entitled *Utilization Review Decision and Notification Time Frames* later in this section of the manual. Univera Healthcare's Medical Services staff conducts utilization review to:

- Determine the medical necessity of the services utilizing clinical criteria.
- Determine appropriateness of the level of service and provider of service; and
- Identify and refer potential quality of care issues to the Quality Management Department.

Pre-Service Review

Univera Healthcare's Medical Services staff conducts pre-service reviews on all member services that, according to the individual member's contract, require such determinations before services are rendered.

A participating provider or a member may initiate a pre-service determination request by telephone, web (see Smart Data Solutions (SDS) Provider Submission Portal below), or written request, as directed by the terms of the specific benefit plan and the member contract. The staff will assess services in keeping with established preauthorization processes, the member's contract, and/or approved medical criteria. Cases not meeting criteria or requiring further evaluation are referred to a medical director or other clinical peer reviewer for determination. Licensed health care professionals (e.g., physicians) determine whether services are not medically necessary and/or are experimental/ investigational.

- SDS Portal: Provider.UniveraHealthcare.com/authorizations/sds-portal

If required, a Univera Healthcare reviewer or designee will contact the member and the requesting provider by telephone to notify them of the determination. Univera Healthcare will send a determination letter and/or electronic notice to the member and requesting provider.

Concurrent Review

Univera Healthcare's Medical Services staff conducts concurrent review for select services and may monitor the medical necessity of an episode of care during the course of treatment. Univera Healthcare usually conducts concurrent reviews through telephonic care coordination. Concurrent review is performed for select inpatient and outpatient care. Cases not meeting criteria or requiring further evaluation are referred to a medical director or other clinical peer reviewer for determination. Licensed health care professionals (e.g., physicians) determine whether services are not medically necessary and/or are experimental/ investigational.

If required, a Univera Healthcare reviewer or designee will orally contact the member and the requesting provider by telephone to notify them of the determination. Univera Healthcare will send a determination letter and/or electronic notice to the member and requesting provider.

Post-Service Review

Post-service review is the detailed analysis of an episode of care after the care has been rendered. Univera Healthcare staff may perform post-service review for both inpatient and outpatient services.

Cases not meeting criteria or requiring further evaluation are referred to a medical director or other clinical peer reviewer for determination. Licensed health care professionals (e.g., physicians) will determine whether services are not medically necessary and/or are experimental/ investigational. Written and/or electronic notices of determinations are sent to members and rendering providers.

Urgent Requests

The member or provider may request an urgent/expedited review. An expedited review must be conducted when Univera Healthcare determines, or the provider indicates, that a delay would seriously jeopardize the member's life or health or the ability to attain, maintain or regain maximum function. Univera Healthcare will never deny this request for an urgent/expedited review.

Reconsiderations

Providers may call Univera Healthcare to request a reconsideration of an adverse determination, when the provider recommended a service, but Univera Healthcare made no attempt to discuss the matter with the provider prior to making its decision. Reconsideration of a pre-service or concurrent review determination will take place within one business day of the request. Reconsideration of a pre-service or concurrent review determination will take place within one business day of the request. Reconsideration decisions will be made by a team of peer reviewers who make original determinations.

Reconsideration is a telephonic process initiated through Customer Care. It does not affect the right to appeal. (For example, an appeal may be initiated whether or not there has been reconsideration, or after reconsideration has occurred.)

Utilization Review Decision and Notification Time Frames

Univera Healthcare has established time frames for utilization review that meet state and federal regulations and accreditation standards. Notification to the member and the provider(s) of Univera Healthcare's decision is made in writing and/or electronically and by telephone, as required by regulations. Specific time frames and notification requirements for different types of review are presented in the charts, *UM Initial Determination Time Frames*, available from the Provider page of Univera Healthcare's website, or by contacting Customer Care.

> **Note:** Once Univera Healthcare has all the information necessary to make a determination, Univera Healthcare's failure to make a utilization review determination within the applicable time frame shall be deemed an adverse determination subject to appeal. For appeal information, see the paragraphs under *Utilization Review Appeals and Grievances* later in this section of the manual.

Who Is Notified of Utilization Review Decisions?

If a request for a pre-service or concurrent referral or preauthorization is approved, Univera Healthcare will provide telephonic notice to the requesting provider and member and send written and/or electronic confirmation of the approval to the member, to the requesting provider, and to the providing specialist (or facility). If a pre-service or concurrent authorization is denied, Univera Healthcare will provide telephonic notice and send written and/or electronic notification of the denial to the member and requesting provider. For pre-service denial cases, notice is not given to the proposed specialist or facility (due to HIPAA privacy regulations). For post-service cases, the same written and/or electronic notifications are sent to the same parties as listed above, but no telephonic notification is required.

Written Notice of Initial Adverse Determination

An initial adverse determination is a determination made by Univera Healthcare or its utilization review agent that, based on the information provided, the admission, extension of stay, level of care, or other health care service is not medically necessary or is experimental/investigational and, thus, not covered. Time frames for notification are included in the *UM Initial Determination Timeframes* chart and *Behavioral Health UM Initial Determination Timeframes* document, available on the Provider page of the Univera Healthcare website, or by contacting Customer Care.

All notices of initial adverse determination must include:

- The clinical rationale for the denial, including a reference to the criteria on which the denial was based
- A description of the actions to be taken (e.g., that Univera Healthcare will not provide coverage for the service at issue)
- Instructions for appealing the determination, including information describing the expedited and external appeal processes
- A description of the member's right to contact the Department of Health and/or Insurance Department, depending on the type of product, including toll-free telephone number

- An explanation of the right to external appeal of final adverse determinations
- Instructions for obtaining a copy of the clinical criteria used in making the determination
- A statement regarding the availability of the reviewer to discuss the denial
- A statement that the member's provider has the right to speak with a Medical Director if they have questions regarding the decision
- Instructions about how the member can obtain information about the diagnosis or treatment code related to the case
- A statement that Univera Healthcare will not retaliate or take any discriminatory action if an appeal is filed
- A statement that the notice is available in other languages and format for special needs and information on how to access these formats; and
- Any additional information required by Univera Healthcare to render a decision on appeal

If a member disagrees with a utilization review decision, or if Univera Healthcare does not make the decision within the specified time frame, the member may request an internal appeal. Univera Healthcare has standard procedures for responding to requests for appeals of adverse determinations made by a member, the member's authorized designee or a provider. See the paragraphs under *Utilization Review Appeals and Grievances* later in this section of the manual.

4.2 Medical Policies

Univera Healthcare establishes and uses medical policies as a guide for decisions concerning medical necessity, medical appropriateness, and experimental/investigational procedures in accordance with the member's subscriber contract. Medical policies are developed using an evidence-based review of the scientific literature and Univera Healthcare contractual benefits.

All medical policies currently in effect are available on Univera Healthcare's website (see below), along with an overview of the medical policy development and implementation process. Copies of the overview and of specific policies may also be obtained upon request from Customer Care. In addition, Univera Healthcare monthly supplies highlights of new and revised policies to providers. Questions and comments may be directed to the medical policy coordinator. (For Univera Healthcare address and phone numbers, see the *Contact List* in this manual.)

- Provider.UniveraHealthcare.com/policies/medical

Provider Participation in Medical Policy Development

Univera Healthcare's Corporate Medical Policy Committee meets monthly to discuss and approve medical policies. Univera Healthcare encourages participating physicians to become involved in medical policy development, as follows:

- Participate in the Corporate Medical Policy Committee. For information about how to do so, contact the Regional Medical Director (see *Contact List*)
- Become involved in medical policy development. Each month, Univera Healthcare posts draft medical policies in the Provider section of the Univera Healthcare website (see below) for participating providers' review and comment.
    - Provider.UniveraHealthcare.com/policies/preview-comment

4.3 Primary Care Physicians and Specialists *(Managed Care Only)*

Univera Healthcare requires each member who is covered under a managed care health benefit program to select a primary care physician (PCP) as a condition of membership. A member's PCP is responsible for monitoring and coordinating the member's health care. This may occur either by direct provision of primary care services or through appropriate referrals or preauthorizations that allow the member to receive health care services from other physician specialists and providers when medically necessary. (Referrals and preauthorizations are described later in this section of the manual.) PCPs who participate with Univera Healthcare are expected to maintain a high standard of care and to uphold the commonly accepted professional and ethical standards of the medical field.

PCP Responsibilities

Primary care physicians include doctors in general practice, as well as those specializing in internal medicine, family practice, and pediatrics. In certain situations, a member may select a specialty physician as a PCP. These situations are described later in the paragraph entitled *Use of a Specialist as PCP*.

Primary care physicians:

- Provide all routine and preventive care
- Refer or request preauthorization for members to obtain:
  - Care from participating physicians and other health professionals
  - Laboratory tests, X-rays, and diagnostic tests
  - Inpatient care and treatment
  - Outpatient care and treatment
- Work with specialty physicians and other providers for continuity and coordination of care

A member's PCP—not the PCP's office staff—is ultimately responsible for authorizing all referrals for that member. (See the paragraphs under the heading *Referrals*.) PCPs are also responsible for obtaining all consultation reports, lab tests, and test results, for reviewing and noting the results in the medical record, and for documenting the treatment plan.

If a member is a patient of a behavioral health clinic that also provides primary care services, he or she may select a lead provider at the clinic as a PCP.

For Medicaid Managed Care enrollees, the member's PCP is responsible for conducting Child/Teen Health Program (C/THP) screenings for children and adolescents, and for conducting behavioral health screenings for all members, as appropriate.

The C/THP promotes the provision of early and periodic screening services and well care examinations, with diagnosis and treatment of any health or mental health problems identified during these exams. The C/THP care standards and periodicity schedule are provided by the New York State Department of Health and can be found at: www.emedny.org/providermanuals.

Specialist Responsibilities

A specialist provides services to a Univera Healthcare member for a particular illness or injury, usually upon referral from the member's PCP. A participating specialist is responsible for rendering services to the member as ordered by the PCP and/or reported on a referral form.

Participating specialists must adhere to Univera Healthcare policies and procedures regarding preauthorization requirements for hospital admissions, home health care, durable medical equipment, and other specified medical care and procedures.

Should a specialist determine that a Univera Healthcare member requires services or care in addition to what has been specified by the member's PCP or that is beyond the scope of a referral, the specialist must obtain another referral from the PCP, unless a standing referral has been approved. In addition, there are other exceptions where a provider other than the PCP may refer. These are described later in this section of the manual.

Use of a Specialist as PCP

A member with a life-threatening or degenerative and disabling condition or disease that requires prolonged specialized medical care may receive a referral to a specialist who will be responsible for and capable of providing and coordinating the member's primary and specialty care. This type of referral must be made pursuant to a treatment plan approved by Univera Healthcare, in consultation with the primary care physician, the specialist, and the member. In no event will Univera Healthcare be required to permit a member to elect to have a non-participating specialist as a PCP, unless there is no specialist in the network.

4.4 Referrals **(Managed Care Only)**

When a managed care member requires selected specialty services that their PCP cannot furnish, the PCP may be required to "refer" the member to a participating Univera Healthcare specialist. *(Univera Healthcare also allows participating OB/GYNs to make any referral that a PCP can make.)* The PCP must request a referral and obtain a referral number **before** the specialist provides services to the member. Referral requirements may differ depending on the member's benefit plan. Providers must verify specific referral requirements for individual members.

Who May Request a Referral?

Only the member's PCP, participating OB/GYN or a participating on-call physician may generate or update a referral for a member.

What Services Require a Referral?

Various specialty services provided outside of the PCP's office require a referral. For general referral requirements associated with a specific health benefit package, please visit WNYHealthenet.com, or contact Customer Care.

> **Note:** Univera Healthcare makes coverage decisions based upon the presence of a valid referral, the terms of a member's contract, and medical necessity. The presence of a valid referral does not guarantee payment. Payment is based on the member's contractual benefits in effect at the time of service.

If the Member Self-Refers

On occasion, a member may seek specialty services that require a referral without first contacting their PCP. In that instance, if the member is an HMO member, Univera Healthcare may deny benefits for the services rendered.

A participating specialist must inform a patient who is an HMO member, *prior to treatment,* that the member will be liable for the payment due for these services. A participating specialist may not bill an HMO member for unpaid services provided without a valid referral number, unless the member has signed a *Patient Financial Responsibility Agreement*. A participating specialist who elects to see an HMO member without a valid referral may wish to have the member complete and sign a *Patient Financial Responsibility Agreement.* This is described in the *Administrative Information* section of this manual.

Claims for services rendered to a Univera Healthcare point-of-service (POS) member without a valid referral may be eligible for coverage under the member's out-of-network benefit but may pay at a lower level. Payment will be made if the care provided is medically necessary, and the member will be responsible for any applicable deductibles, coinsurance, and any additional charges in excess of Univera Healthcare's allowance.

Members in Univera Healthcare PPO or indemnity plans do not need a referral for specialty services, but they may need preauthorization for selected services.

Female members in HMO plans may self-refer for OB/GYN care, in accordance with the benefit package. OB/GYN care includes:

- Two routine visits per year
- Care for acute gynecological condition and any follow-up care
- Prenatal care

Medicaid Managed Care members may choose to be seen by their primary care provider or county public health agency for the diagnosis and treatment of tuberculosis. A referral is not required before a Medicaid Managed Care member is seen for diagnosis or treatment of tuberculosis at a county public health agency.

Medicaid Managed Care members may self-refer to participating providers for:

- Obstetrics and gynecology services
- Dental services
- Eye care/vision services
- Family planning
- HIV and sexually transmitted infection screenings
- HIV prevention services
- Mental health and substance use disorder service assessments (this provision does not apply to assertive community treatment, inpatient psychiatric hospitalization, partial hospitalization, or home and community-based services)
- Smoking cessation services
- Maternal depression screenings
- Emergencies

Standing Referrals

Univera Healthcare has a process that allows members who require ongoing care from a specialist to request a standing referral to that specialist. If Univera Healthcare, or the primary care physician in consultation with a Univera Healthcare medical director and the participating specialist, determines that a standing referral is appropriate for a member who requires ongoing care, Univera Healthcare will approve a referral to a specialist.

The referral must be made pursuant to a treatment plan approved by Univera Healthcare, in consultation with the primary care physician and the specialist. The treatment plan may limit the number of visits and/or the period during which treatment is authorized. The specialist must provide regular reports to the member's PCP regarding patient care and status. Univera Healthcare will not be required to permit a member to have a standing referral to a non-participating specialist unless there is no specialist in the network.

Out-of-Network Referrals

If Univera Healthcare's panel of providers does not include a health care provider with the appropriate training and experience to meet a member's particular health care needs, the member's PCP must submit a letter of medical necessity to request service from an out-of-network provider. Univera Healthcare may grant a referral, pursuant to a treatment plan approved by Univera Healthcare's medical staff in consultation with the primary care physician, the non-participating provider, and the member.

In such event, Univera Healthcare will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within Univera Healthcare's provider network. In no event shall Univera Healthcare permit a member to receive services from a non-participating specialist except as approved above.

Referrals to Specialty Care Centers

A member with a life-threatening or a degenerative and disabling condition or disease that requires specialized medical care over a prolonged period of time may receive a referral to an accredited or designated specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by Univera Healthcare, in consultation with the primary care provider, if any, or specialist.

In no event will Univera Healthcare be required to permit a member to receive services from a non-participating specialty care center, unless Univera Healthcare does not have within the network an appropriate specialty care center to treat the member's disease or condition. Services must be provided pursuant to an approved treatment plan, and Univera Healthcare will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within network.

Transitional Care When a Provider Leaves the Network

> **Note:** The transitional care rights described in this section do not apply to patients of a provider who leaves a Univera Healthcare network without a right to a hearing under the provisions of the New York State Public Health Law.

Univera Healthcare will permit a member to continue an ongoing course of treatment with a provider during a transitional period: (i) of up to 90 days from the provider's termination, or (ii) through delivery and any post-partum care directly related to that delivery.

Univera Healthcare will authorize the transitional care described above only if the provider agrees to continue to accept the reimbursement rates in effect prior to the start of the transitional period as payment in full, and to comply with all of Univera Healthcare's policies and procedures, including, without limitation, quality management, utilization management, referral, and preauthorization programs. The provider must also ensure that the member's treatment plan is approved by Univera Healthcare and readily provide medical information related to the member's care.

Transitional Care for New Members

In the following circumstances, Univera Healthcare will permit a new member to continue seeing their previous health care practitioner for a limited time, even if that practitioner is not participating in Univera Healthcare:

- If, on the effective date of enrollment, the member has a life-threatening or a degenerative and disabling disease or condition for which they are in an ongoing course of treatment, they may continue to see a non-participating practitioner who is caring for them, for up to 60 days
- If, on the effective date of enrollment, the member is pregnant, the member may continue to see a non-participating practitioner who is providing care through delivery and any postpartum care directly related to that delivery

How to Request a Referral

Providers may request a referral by computer or telephone. Telephone and computer tools for obtaining information from and providing information to Univera Healthcare are discussed generally in the *Administrative Information* section of this manual.

> **Note:** If the appointment for the specialist will occur within two business days, the provider should call in the referral and speak to a Univera Healthcare representative. The telephone number for referrals is included on the *Contact List* in this manual.

It is important to have all patient identification and referral information readily available before beginning.

Information Needed to Generate a Referral

1. Patient's name
2. Patient's birth date (for accurate identification)
3. Member ID number
4. Specialty provider to whom the member is being referred, including Provider ID
5. Diagnosis, including the ICD-CM code (if available)
6. Time period (duration of referral)
7. Number of visits (required for selected specialties, elective for others)

> **Note:** Non-emergency out-of-area referrals require preauthorization. See the paragraphs on preauthorization below.

Requesting Referrals via Web

A provider may enter patient referral information into the Internet-based system, WNY HealtheNet, and create a referral in real time. (However, the provider *must be registered to use the system*. Registration and access information are included in the *Administrative Information* section of this manual.)

For referral information, from Provider.UniveraHealthcare.com, click *Authorizations*, then click *Referrals*.

Requesting Referrals via Telephone

If the appointment for the specialist will occur within two business days, the provider should call in the referral. The telephone number for referrals is included on the Contact List in the *Administrative Information* section of this manual.

4.5 Preauthorization

Univera Healthcare must review certain services in advance to determine if the services are medically necessary, appropriate for the member, and experimental and/or investigational. Before providing these services, a provider must request authorization from Univera Healthcare, which initiates the review.

Preauthorization requirements differ, depending on the member's benefit plan and the applicable utilization management program. Providers should review the preauthorization guidelines (available on Univera Healthcare's website (see below) or from Customer Care) for specific services that require preauthorization. Providers must call Customer Care to obtain preauthorization requirements for members who are part of a self-funded group. Self-funded coverage is indicated on the back of the member card. Providers should always verify preauthorization requirements for the member's health benefit program, and check benefits and eligibility via one of the methods described in the *Administrative Information* section of this manual.

- Provider.UniveraHealthcare.com/authorizations

For information about how to dispute decisions, see the paragraphs under *Utilization Review Appeals and Grievances*.

Univera Healthcare makes coverage decisions based upon the presence of an authorization, the terms of a member's contract, and medical necessity. The presence of an authorization does not guarantee payment. Payment is based on the member's contractual benefit in effect at the time of service.

Who Can Request a Preauthorization?

Under managed care plans, only the member's PCP (or a specialist with a valid referral from the PCP, if required) may request the required preauthorization.

Under non-managed care plans, the member's PCP or the treating provider may request preauthorization.

How to Request a Preauthorization

It is important to have all patient identification and clinical information readily available before beginning.

Information Needed to Request Preauthorization

1. Patient's name
2. Patient's birth date (for accurate identification)
3. Member ID number
4. Requesting physician
5. Servicing provider
6. Diagnosis, including the ICD-CM code (if available)
7. CPT/HCPCS code
8. Time period
9. Number of visits/quantity requested

Requesting Preauthorization by Telephone

- **Call the number listed under Preauthorization on the *Contact List* in this manual.**
- Inform the representative of the preauthorization request.
- Provide all information requested.
- The representative will enter the preauthorization request and, if required, forward it to a nurse in Univera Healthcare's Medical Services Department for review.
- If provider offices can provide all necessary clinical information over the telephone, they may choose to have the call forwarded to the utilization review nurse or designee for clinical review. Offices also have the option of sending requested clinical documentation electronically to the Utilization Management department for review. Refer to the *Contact List* in this manual.
- Once the utilization review nurse has all the necessary clinical information, a decision will be made by the appropriate level of health care professional within the time frames listed on the chart *UM Initial Determination Time Frames*, available from the Provider page of Univera Healthcare's website, or from Customer Care. (See the paragraphs under the heading, *Utilization Review,* at the beginning of this section of the manual for more detail.)

Requesting Preauthorization Electronically

Provider offices may also request preauthorization via the Univera Healthcare website if the provider is registered for this service. Preauthorization for concurrent services must be done by telephone. Registration information is included in the Administrative Information section of this manual.

Provider offices also may request preauthorization for specific services via CareAdvance Provider®, Univera Healthcare's electronic entry tool for preauthorization.

Special Methods of Requesting Preauthorization for Selected Services

Please note that there are special methods to request preauthorization for Imaging Studies, Physical Therapy, Occupational Therapy, and selected Medical Drugs. See the separate paragraphs below that are devoted to these services.

What Services Require Preauthorization?

Services are subject to preauthorization based on the individual member's contract. See the Prior Authorization Guidelines, available on Univera Healthcare's website or from Customer Care, for preauthorization requirements for most managed care health benefit programs. On the website, go to Provider.UniveraHealthcare.com/authorizations/medCical.

Preauthorization requirements for non-managed care health benefit programs may be listed on the member's ID card.

To determine the benefit requirements for a specific member, inquire through one of Univera Healthcare's member eligibility inquiry systems, explained in the *Administrative Information* section of this manual.

Reversal of Preauthorization Approval

Under New York State law, a managed care organization (MCO) (such as Univera Healthcare) may reverse approval of a preauthorized treatment, service, or procedure when:

- The relevant medical information presented to the MCO or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and
- The relevant medical information presented to the MCO or utilization review agent upon retrospective review existed at the time of the preauthorization, but was withheld from or not made available to the managed care organization or utilization review agent; and
- The MCO or utilization review agent was not aware of the existence of the information at the time of the preauthorization review; and
- Had the MCO or utilization review agent been aware of the information, the treatment, service, or procedure being requested would not have been authorized. This determination is to be made using the same standards, criteria and/or procedures used during the preauthorization review

Univera Healthcare may also reverse or revoke preauthorization when it has determined that:

- There is evidence of a fraudulent request
- The time frame of the authorization has expired
- There is a change in the status of the provider from participating to non-participating (subject to the state laws governing continuity of care)
- There is a change in the member's benefit plan between the approval date and date of service
- There is evidence that the information submitted was erroneous or incomplete
- There is evidence of a material change in the member's health condition between the date the approval was provided and the date of treatment that makes the proposed treatment inappropriate for the member
- The member was not a covered person at the time the health care service was rendered. (Exceptions may apply if the member is retroactively disenrolled more than 120 days after the date of service.)
- The member exhausted the benefit after the authorization was issued and before the service was rendered
- The claim was not timely under the terms of the applicable provider or member contract
- For select drug requests, a duplication of drug therapy can have patient safety, toxicity or treatment concerns
- A new request has been received from the treating physician that requests a change in therapy from a previously approved therapy. The approval for the new therapy will contain language that indicates the approval is for therapy that is taking the place of the previously approved drug therapy

Preauthorization for Imaging Studies

In addition to managed care health benefit programs, many other benefit plans may require preauthorization for selected elective outpatient imaging studies. The list of imaging studies requiring preauthorization is available from Customer Care.

Ordering physicians must request preauthorization for selected imaging studies for those members who require it, **before** sending the member for the study.

Providers may request preauthorization by computer, by fax or by telephone. See the *Contact List* in this manual for the appropriate web address, fax, and telephone number.

Ordering physicians should make certain that all clinical information is available, including:

- Patient's name, date of birth and member ID number
- Ordering provider's name, Provider ID number, fax number and telephone numbers
- Rendering provider's information, including facility name, fax number and telephone numbers
- The CPT code and/or description of the test requiring authorization
- Patient data relevant to the request, such as: signs and symptoms, test results, medications, related therapies, dates of prior imaging studies, etc.

All requests will be reviewed within the appropriate time frame. If a request is approved, the requesting physician will be notified by telephone and in writing, and an authorization number will be provided. The physician should contact the member with the approval and testing schedule. Univera Healthcare also contacts the member by letter.

Preauthorizations for imaging studies are valid for 45 days from the date of approval.

If a request is not approved, then the member and the ordering provider are notified by telephone and in writing. The letter will include the rationale for the decision, as well as information regarding the appeals process.

Claims for imaging services will process according to the member's health benefit program that is effective on the date of service. Failure to obtain preauthorization will likely result in payments being denied, and the member may be held harmless.

Preauthorization for Physical Therapy and/or Occupational Therapy

Providers requesting preauthorization for physical and/or occupational therapy must utilize CareAdvance Provider for services requiring preauthorization, including the following circumstances:

- The request is for additional visits
- The request is for a different diagnosis or to see a different practitioner.
- The request is for direct access (without being referred by a physician)

Additional Visits

If the physical or occupational therapist feels that more visits are warranted, they should request them prior to the last authorized visit, using CareAdvance Provider.

If Univera Healthcare determines that the request for additional visits does not meet Univera Healthcare's criteria, Univera Healthcare will ask the physical therapist or occupational therapist to send all case note documentation, including objective, measurable data, and an updated physician order. Univera Healthcare will review patient progress over the previous two-week interval. The case will be presented to a Univera Healthcare medical director for review. The Medical Director may authorize additional visits or deny coverage for further services.

If treatment is denied, the member or their representative may initiate an appeal of this decision. See the paragraphs entitled *Utilization Review Appeals and Grievances* later in this section of the manual for information about appeals.

Different Diagnosis or Different Practitioner

If a physical therapist or occupational therapist requests another authorization while an earlier authorization is still active (due to a different diagnosis or a different practitioner), Univera Healthcare requires completion of the request via CareAdvance Provider. When the provider calls for the authorization, if the representative finds an authorization still open, they will request that the provider complete the request via CareAdvance Provider.

Direct Access

Physical therapy providers may request their own preauthorization for an initial 10 or 20 visits (depending on the member's contract) over 30 days, in accordance with New York State requirements for direct access to physical therapy. To qualify for a direct access preauthorization, the provider must be in clinical practice for a minimum of three years, must inform the member in writing that insurance may not pay for the therapy and that the member may only be seen for 10 or 20 visits over a 30-day period, whichever comes first.

Medical Drug Preauthorization

Medical drugs are drugs that are administered by a health care provider in the office, at an infusion center, at an outpatient facility or by nurses in home care. Medical drugs are covered under a member's medical benefit. In contrast, prescription drugs are drugs that can be self-administered and are covered under a member's prescription drug benefit.

Some medical drugs may also fall into the category of Medical Specialty Drugs due to limited distribution or other unique characteristics. Medical drugs may be obtained through a contracted specialty pharmacy or purchased by the provider and billed to Univera Healthcare.

Preauthorization is required for some medical drugs. Preauthorization for medical drugs is handled through the Medical Specialty Medication Review Program. Additional information, including preauthorization forms, is available at Provider.UniveraHealthcare.com/authorizations/request-authorization. Review the *Provider-Administered Medical Specialty Drug* lists by line of business or contact Customer Care.

> **Note:** Claims will deny or suspend for review (across all lines of business), provider-administered medications that require preauthorization, unless preauthorization has been obtained.

Refer to the *Pharmacy Management* section of this manual for additional information related to medical drugs including preauthorization requirements, the Medical Specialty Medication Review Program, and Specialty Pharmacy options related to obtaining medical and medical specialty drugs.

4.6 Emergency Care Services (In-Area and Out-of-Area)

A referral is not required for treatment of an emergency medical condition in an emergency room. An **emergency medical condition** is defined as a medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such a person; (d) serious disfigurement of such person; or (e) a condition described in clause (i), (ii) or (iii) of section 1867 (e)(1)(A) of the Social Security Act.

Emergency medical service is defined as a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition; and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

4.7 Inpatient Admissions

Many of Univera Healthcare's health benefit programs require preauthorization/notification for inpatient admissions, excluding maternity and emergency room services. Some health benefit programs do not include a benefit for skilled nursing facilities or inpatient acute rehabilitation. It is important that providers verify eligibility for non-emergency inpatient admissions prior to admitting.

Univera Healthcare may deny claims for services that require preauthorization but that were not preauthorized. For information on how to dispute decisions, see the paragraphs following the heading, *Utilization Review Appeals and Grievances*.

No preauthorization is required before emergency services rendered by a hospital, but hospitals must notify Univera Healthcare of emergency admissions within the following time frames:

- During normal business hours, within 24 hours of rendering services or next business day
- Over a weekend, within 48 hours of rendering services or next business day
- Over a holiday, within 72 hours of rendering services or next business day

For members whose health benefit programs do not require preauthorization for inpatient admissions, Univera Healthcare encourages facilities to notify Univera Healthcare before admitting a member, or within 48 hours of admitting a member for emergency care. This is to coordinate care and facilitate claims processing.

Notifying Univera Healthcare of an Admission

To notify Univera Healthcare of an inpatient admission, facilities may use any of the methods described in the *Administrative Information* section of this manual. Providers should have the following information readily available:

1. Member name and date of birth
2. Member ID number
3. Name of attending physician
4. Name of hospital or facility
5. Date of admission
6. Diagnosis and pertinent medical information

Physician Referrals During Inpatient Stay

In **most** instances, Univera Healthcare does not require physicians to obtain a separate referral for managed care members for inpatient medical care, inpatient consultations, inpatient psychiatric care, or nursing home visits *during* an approved admission. These services are normally considered part of Univera Healthcare's authorization for the admission. However, the attending physician should obtain preauthorization for surgery or other care not defined above.

After Discharge

In addition, depending on the health benefit program, physicians and/or other service providers may need a referral from the member's PCP for continuing care following discharge.

4.7 Site of Service: Inpatient versus Outpatient

Several national standards indicate that many surgical procedures are most appropriately rendered in an outpatient setting such as the outpatient department of a hospital, a freestanding ambulatory surgery center, or a physician's office. Univera Healthcare has established a list of these procedures, available on Univera Healthcare's website or from Customer Care. On the website, go to Provider.UniveraHealthcare.com/authorizations/medical and click *Admission Procedures Now Available*.

Except in special circumstances, these procedures will be covered only when performed in an outpatient setting. Any facility or individual provider who feels that the patient has a special medical condition or complication that requires an inpatient stay for a listed procedure should contact Univera Healthcare for authorization prior to scheduling the procedure.

If a required authorization is not obtained in advance, Univera Healthcare may deny payment for the services.

If the patient is already hospitalized and requires a surgical procedure that is on the Outpatient Procedure List, the procedure is covered as part of the inpatient stay if it is deemed medically necessary that the patient remain hospitalized.

4.8 Care Coordination

One aspect of Univera Healthcare's utilization management function is to coordinate the care of select hospitalized members who are enrolled in specific health benefit programs. The goal is to ensure that the member receives the appropriate level of care while in the hospital and experiences a smooth transition to appropriate post-discharge services (e.g., home care and case and disease management programs).

While hospital medical staff remains responsible for all medical care and treatment decisions, Univera Healthcare staff is available to make timely referral into services and programs that could benefit the patient after discharge, or while still hospitalized.

4.1

4.9 Integrated Case Management

Note: Univera Healthcare follows the Population Health Management (PHM) guidelines for NCQA, which Member Care Management is a part of. This program applies to all Univera Healthcare members unless the member's contract provides otherwise.

Case Management for Government Programs Enrollees

Child Health Plus, Univera Healthcare MyHealth℠ and MyHealth Plus℠ members have access to a dedicated team of care management staff assigned specifically to these government programs.

Population Health Management (PHM)

PHM addresses health at all points on the continuum of care, including the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.

The organization has a comprehensive strategy for population health management (PHM) that addresses member needs in the following areas of focus:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses
- Complex Case Management

Integrated Case Management Programs

Univera Healthcare provides case management services at no additional cost to members. Members benefit from programs that focus on preventive care and management of chronic and complex conditions including mental health and substance use disorders. Provider referrals are welcomed and appreciated. To make a referral, please see the Case Management contact information on the Contact List in Section 2.

Integrated Case Management Program Components

Components

Preventive Health

Focus includes educating members on healthy lifestyles, preventive clinical guidelines and identifying those members with gaps in care as related to the recommended preventive care services. The entire population will receive outreach related to healthy lifestyles and preventive health clinical guideline recommendations. Members that are identified as having a gap in preventive screenings may receive a

targeted outreach encouraging them to act in completing the needed testing/care. Preventive health includes programs and services that provide members with access to a variety of resources such as: health risk assessments, on-line risk reduction programs, on-line educational resources, preventive health reminder mailings, mobile application that includes messaging and educational modules, as well as worksite wellness programs as applicable. As a part of the care continuum, preventive health programs tools are available to case managers to assist with member management.

Chronic Case Management

Members identified with chronic medical and behavioral health conditions will be educated on self-management of their condition, including the importance of adhering to their medication regime and treatment plans, appropriate testing for condition monitoring and symptom management as recommended by clinical guidelines. A primary goal is to promote collaboration with their health care provider while encouraging healthy behaviors and lifestyle choices.

Complex Case Management

The Complex Case Management (CCM) program assists members with catastrophic, chronic and/or behavioral health illness to maintain or improve their health and quality of life. The goal of the program is to provide the tools and resources needed for members/caregivers to develop self-management skills that maximize the members' health, wellness, and quality of life. Case managers provide a means to achieve member wellness and autonomy through advocacy, communication, education, coordination of service resources, and facilitation of solutions. This is accomplished by collaborating with physicians, specialists, community resources, and/or internal resources on behalf of members and their families/caregivers.

Advantages of Integrated Case Management Programs:

Chronic/Disease Case Management

- Free educational information and self-monitoring tools help members manage their own conditions
- Individual instruction and coaching by telephone through a series of scheduled contacts based on a standard curriculum are available to members
- Flexible service hours are offered to meet the member's needs
- Members receive encouragement to adhere to the physician's treatment recommendations regarding medication, physical activity, nutrition, and self-monitoring
- Care management offers links to available community services

Complex Case Management

- Interventions promote compliance with Provider's treatment plan and progress towards meeting goals
- Programs offer care coordination role to physician offices
- Patients can receive interventions as frequently as needed to support the treatment plan
- Care for chronic and high-risk conditions requires appropriate medication adherence; care management addresses concerns of medication costs, increasing opportunities for adherence
- Care management offers links to available community services

Policies and Procedures

- Members who may benefit from case management are identified by their primary care physician or through risk assessment or other internal mechanism
- Each member's Plan of Care is developed in collaboration with the member, the member's physician, an RN case manager, and specialty-care physicians, as appropriate
- Members must meet defined discharge criteria, before case management is discontinued

Procedures

Univera Healthcare's Integrated Case Management Program has established criteria for identifying individuals who may appropriately be considered for care management services. These criteria are available upon request from Customer Care.

Physicians also may refer a member to the Integrated Case Management programs by calling Univera Healthcare's central intake line at 1-800-434-9110 or via email at case.management@univerahealthcare.com. Please provide the following information:

- Member's name and ID number
- Referring physician's name and phone number
- Primary diagnosis
- Anticipated care management needs

Members can self-refer to the programs by calling 1-877-222-1240.

Based on the member-specific information provided, Univera Healthcare will determine which program will best meet the needs of the member. Once the member has been identified, a case manager contacts the member to disclose specific information about the proposed case management services and ensures the member's willingness to participate. Using standard telephone assessment tools, the care manager assesses the member's needs and determines the acuity and intensity of care management services required.

Primary Care providers are informed of members' participation in care management programs when the case is opened, as needed while the case is opened, and when the case is closed, as applicable. The program supports the ongoing communication between the member (or caregiver) and their provider. Care managers work directly with providers to assist members in navigation of the health care system and to support the provider's plan of care as needs are identified. The provider is notified of the member's discharge from the case management program at the time of care closure.

Univera Healthcare conducts quality reviews of cases to ascertain, among other things, the appropriateness and effectiveness of services provided, the timeliness of follow-up, and staff compliance with care management standards.

24/7 Nurse Call Line

The Univera Healthcare 24 X 7 Nurse Call Line is available to all members and includes TDD/TTY and Language Line Services. Registered nurses provide symptom management support and triage information using evidence-based triage protocols. Additionally, it is a resource for referrals to the Integrated Case Management programs. For the 24/7 Nurse Call Line number, see the *Contact List* in Section 2.

Additional Case Management Programs

CompassionNet

CompassionNet is a case management program available for children with potentially life-threatening illnesses and their families, administered by Genesee Region Home Care Association d/b/a Lifetime Care, recently renamed Rochester Regional Home Care and Hospice Care. In late 2019, Rochester Regional Health acquired Lifetime Care and is maintaining the CompassionNet program for seriously ill children and their families.

CompassionNet coordinates the delivery of necessary social and support services with the medical care needed by children diagnosed with potentially life-threatening illness, and their families. CompassionNet does not provide primary care.

To learn more about CompassionNet services or to refer a Univera Healthcare member to CompassionNet, the provider treating the child must contact CompassionNet, part of Lifetime Care at Rochester Regional Health System, at 1-800-308-3914. Learn more at LifetimeCare.org.

For seriously ill children outside of the catchment area for CompassionNet, we recommend connecting with pediatric palliative care specialists in the provider's area.

Case Management for Government Programs Enrollees

Univera Healthcare Child Health Plus, Univera Healthcare MyHealth℠ and MyHealth Plus℠ members have access to a dedicated team of care management staff assigned specifically to these government programs. For referral and contact information, refer to Section 2 of this manual.

Case Management

Case management goes beyond traditional care management and provides a holistic approach in identifying psychosocial, medical, behavioral, or functional issues that may impact the members and their enrolled families. The program manages members who have non-complex and complex case management needs. The Case Manager (CM) coordinates and collaborates with internal care management programs, providers, and community resources to ensure member and family needs are met, and that they have the ability to overcome barriers to receiving health care services. In addition, all members are provided a 24-hour, seven-day per week nursing line to review medical issues and preference-sensitive condition support.

Disease Management

The disease management program provides telephonic outreach, education and support services to those members who are identified as having a chronic condition such as asthma, COPD, diabetes, heart disease and depression to promote member adherence to treatment guidelines. The program spans from early-stage conditions through acute events and severe chronic disease to enhance members' understanding of their condition and encourages positive lifestyle changes to better manage their disease and make informed decisions about their treatment options. The program provides a three-part strategy: first identify individuals with a chronic condition, second, provide targeted information and interventions based on the severity of the illness, and third, work with health care providers to improve chronic conditions. The program includes assistance with medical supplies and community resources to better control the member's condition and avoid complications.

A 24-hour nursing line is available seven days per week to assist members in managing their chronic condition.

Emergency Management

The safety net population often experiences barriers to care and significant risk factors that may limit the ability to access health care services. In addition, many members lack a physician or transportation, which forces them to seek treatment in an emergency room. Univera Healthcare collaborates with facilities to promote early identification of members seeking ER services. The facilities can notify Univera Healthcare by phone or through daily admission reports. This allows the CM to contact the member, educate and coordinate discharge orders, and assist the member in overcoming barriers that may affect their ability to seek follow-up care.

Prenatal Case Management Program (Univera Healthy Baby Connection)

Several major risk factors are associated with poor pregnancy outcomes, including low birth weight and infant mortality (deaths). Some of these risk factors include late or no prenatal care, cigarette smoking, alcohol, and other drug use, being HIV positive, spacing of pregnancies, maternal age, poor nutrition, and socioeconomic status.

The Prenatal Case Management Program emphasizes early identification of pregnant members to improve birth outcomes, case managers assist members in overcoming barriers that impact the frequency of their prenatal care, provide members with relevant pregnancy-related information and link members to available community resources. The program incorporates initiatives to promote and provide incentives for program participation and compliance with prenatal and postpartum care. Prenatal members are screened for depression and other concerns that may relate to poor birth outcomes.

Foster Care Program

Children in the foster care system often present with a variety of medical and behavioral health needs. The children's healthcare system is disjointed and inefficient with a wide range of providers and services that are often uncoordinated. New York State designed a new comprehensive cross-system approach to diminish silos of care and improve health outcomes for children well into adulthood. A case management representative will work with these service providers to ensure collaboration and assist with any gaps in care. The goal of a cross-system approach is to support and intervene with children and their families as a key element of value-based initiatives aimed to limit the prevalence of negative physical, emotional, and social outcomes associated with chronic conditions in adults.

Behavioral Health Case Management Program

The BH care managers have expertise in the management of members with BH needs and manage behavioral health conditions that are identified as appropriate for case management. The BH care managers are part of the Integrated Clinical Case Management program. The BH care managers obtain referrals according to established triggers and investigate the referred member for appropriateness of case management services. Depending on the needs of the member, a case may be managed solely by a BH case manager, receive consultation from a BH case manager, or be co-managed in collaboration with medical case managers.

4.2

4.9 Health and Wellness

Workplace Wellness offers self-serve and direct contact programs and services to Univera Healthcare members in order to foster early identification of an intervention with preventable conditions, encourage healthy behaviors and improve self-care and informed decision making. Univera Healthcare uses a variety of delivery methods (such as face-to-face, online, telephone and print) to deliver the programs described below.

Risk Reduction Programs

Health Risk Assessment

The Health Risk Assessment (HRA) provides the greatest opportunity to identify individuals at an early stage and engage a member prior to an increase in risk level. An HRA is a questionnaire that asks about lifestyle, diet habits and medical history. Adult members complete this questionnaire on the Internet in under 15 minutes. The participant receives interactive personalized recommendations on achievable lifestyle changes to protect and improve their health immediately after completing their HRA.

Eligible patients can access the Health Risk Assessment on Univera Healthcare's website.

New York State Smoker's Quitline

The New York State Smokers' Quitline offers useful and proven resources to help people who want to quit smoking. Call the Quitline at 1-866-NY-QUITS (1-866-697-8487) or visit their website at: www.nysmokefree.com.

Decision Support Tools

Healthwise® Knowledgebase

Healthwise Knowledgebase is an online database containing evidence-based content on over 6,000 topics. The database provides insight on questions regarding health conditions, medical tests, procedures, medications, and everyday health and wellness. Healthwise has a "decision point" feature that helps individuals understand their options and provides information to help them make wise decisions. There are seven opportunities to use Healthwise including:

- Self-care
- Self-triage
- Provider visit preparation
- Self-management of chronic conditions
- Shared decision making
- End-of-life care

The Healthwise Knowledgebase is available to **all** Health Plan members on the Univera Healthcare website. From the Member page, the member must register and login. After login, the member selects *Health and Wellness* from the top menu bar, then selects *Research Health Topics* to begin. Members can search by condition, life stages, wellness, and prevention and more.

Surgery Decision Support

Univera Healthcare offers a surgery decision program to Medicare Advantage, Essential Plan and Commercial Fully Insured members through our partnership with Welvie. This is a self-guided online program designed to help members decide on, prepare for, and recover from surgery. The tool walks members through decision making process, from discussing options with providers to avoiding common problems that can occur after surgery.

Members may register by going to www.welvie.com.

Cost Estimator Tool

Managing the quality and cost of members' health care is important. Univera Healthcare's online treatment cost estimator makes it easy. Members get easy-to-understand estimates based on their current benefit plan and cost-sharing amounts:

- Search from a wide variety of treatments including inpatient services, outpatient services, diagnostics, and office visits
- Estimate treatment costs
- Find out-of-pocket costs
- Sort provider results by cost, distance, and number of treatments

To access the Cost Estimator Tool from the Member page, click Estimate Medical Costs under Member Tools at the bottom of the page. At this point, the member must register and log in.

Worksite Wellness

Univera Healthcare's Worksite Wellness Services are designed to enhance our care coordination approach while motivating members to become more knowledgeable health care consumers. Services are coordinated through employers and accessed by members at their worksites. Services include:

Biometric Screening Solutions

All biometric screening participants receive lifestyle counseling which includes feedback about their results and what, if any, actions they need to take. Those members with abnormal results are sent a follow-up letter reminding them to follow up with their primary care physicians. Members also receive educational materials and are connected to Univera Healthcare's health and medical programs and services.

The following screenings can be provided:

- Blood pressure
- Blood glucose
- Body mass index (BMI)
- Total cholesterol
- Lipid profile
- High-density lipoprotein (HDL)
- Low-density lipoprotein (LDL)
- Triglycerides
- TC/HDL ratio

Health Education Programs

More than 15 education programs are offered covering a wide selection of topics to promote healthier lifestyles. These topics are offered in a one-hour format.

Wellness Videos

Univera Healthcare provides video presentations on a variety of health topics such as stress management and nutrition.

The videos are short, web-based health seminars that provide health information available at no additional cost. These wellness videos are available on the Univera Healthcare YouTube channel.

4.3

4.10 Utilization Review Appeals and Grievances

Note: The following procedures do not apply to Medicare Advantage programs. For appeals and grievance procedures available to members of Medicare Advantage health benefit programs, see the *Medicare Advantage* section of this manual.

The following paragraphs describe:

- The handling of appeals that involve a medical necessity determination (see paragraphs headed *Internal Appeals* and *External Appeals*).
- The review of issues (including quality of care and access to care complaints) not associated with medical necessity or experimental and/or investigational determinations, excluding service requests (see paragraphs headed *First-level Grievance* and *Second-level Grievance*).
- This process is intended to provide a reasonable opportunity for a full and fair review of an adverse determination.

General Policies

- ***Assistance of a designee***. A member may designate a representative (including a lawyer or health care provider) to act on their behalf at any stage of the appeal or grievance process. The designation must be in writing. For the purpose of this policy, any reference to a member includes a member's designated representative if the member has chosen one.
- ***Internal Appeal.*** If a member is not satisfied with a medical necessity determination or an experimental and/or investigational determination of Univera Healthcare, the member may submit an internal appeal. All requirements pertaining to internal appeals are described below.
- ***Expedited Internal Appeal.*** Cases involving the following are subject to an expedited internal appeal:
    - Requests for review of continued or extended health care services
    - Requests for additional services in a course of continued treatment; or
    - Cases (other than retrospective review cases) in which a provider requests an immediate review
- ***External Appeal.*** If a member is not satisfied with an internal appeal determination (the "final adverse determination" for purposes of external appeal), an insured member may submit a request to the New York State Insurance Department for an external appeal. For members in a self-insured plan, external appeals *may* be available as required by the Patient Protection and Affordable Care Act. All requirements pertaining to external appeal are described below.
- ***Level One Grievance.*** If a member is not satisfied with a determination made by or on behalf of Univera Healthcare that does not involve a medical necessity determination or an experimental and/or investigational determination, the member may submit a Level One grievance. All requirements pertaining to Level One grievance review are described beginning on page 37 of this section.

- ***Level Two Grievance.*** If a member is not satisfied with a Level One grievance determination, the member may submit a Level Two grievance. All requirements pertaining to Level Two grievance reviews are described beginning on page 38 of this section.
- ***No Retaliation.*** Univera Healthcare will not retaliate or take any discriminatory action against a member because the member requested an internal or external appeal.
- ***Legal Action.*** The levels of appeal/grievance below should be exhausted before a member can bring legal action against Univera Healthcare.
- ***Automatic Reversal.*** For insured members, Univera Healthcare's failure to render a determination on a *standard appeal* within 60 calendar days from receipt of all necessary information results in a reversal of the initial adverse determination. Failure to render a determination on an *expedited appeal* within two business days from receipt of all information will result in a reversal of the initial adverse determination.

The Appeal Process

Policies

Members have the right to request the identification of all experts whose advice Univera Healthcare obtained in connection with an adverse determination. In addition, if Univera Healthcare upholds a claim denial on appeal, members have the right to request, free of charge, copies of all documents and other information relevant to Univera Healthcare's claim determination. All appeals are thoroughly documented and investigated.

Procedure

1. The member and, in post-service (retrospective) review cases, the member's health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing.
    - The member may make a verbal request by calling the phone number listed on their identification card. Written appeal requests should be submitted to the Advocacy Department, P.O. Box 4717, Syracuse, NY 13221
    - The member has up to 180 calendar days from receipt of the notice of adverse determination to file an appeal
    - The member, the member's health care provider or the member's designated representative has the right to submit written comments, documents, or other information in support of the appeal
2. Univera Healthcare will acknowledge the request for an appeal within 15 calendar days of receipt of the appeal. The acknowledgment will include the name, address and phone number of the person handling the appeal. If necessary, it will inform the member—and in post-service (retrospective) review cases, the member's health care provider—of any additional information needed before a decision can be made.
3. Expedited and standard appeals will be decided by a clinical peer reviewer, provided that any such appeals are reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination
4. In cases where additional information is deemed necessary, the following guidelines will apply.

a. Standard Appeals

- Univera Healthcare will send a letter to the member and their provider requesting and identifying the additional information needed. Univera Healthcare will send this letter within the applicable case time-period but no later than 15 calendar days of receipt of the request for appeal
- If, subsequently, the member and/or their provider provide only partial information to Univera Healthcare, Univera Healthcare will send a letter *to the member and their provider* requesting and identifying the additional information needed. Univera Healthcare will send this letter within five business days of receipt of the partial information

b. Expedited Appeals

- Univera Healthcare expeditiously will request and specify the additional information via phone or fax from the member and their provider followed by written notification to the member and provider

5. When Univera Healthcare reviews a claim on appeal, it will not give any deference to the initial decision. A clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial decision will decide the appeal

   Note: A clinical peer reviewer is defined as a physician who possesses a current and valid non-restricted license to practice medicine or a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification, or registration or, where no provision for a license, certificate, or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the health care provider who typically manages the medical condition or provides the treatment at issue.

Medical Necessity or Experimental/Investigational Appeals

Expedited Appeals

Univera Healthcare will decide appeals involving pre-service (prospective) events within the lesser of two business days or 72 hours of receipt of the appeal. Written notice will follow within 24 hours of Univera Healthcare's determination, but no later than 72 hours of receipt of the appeal request. Univera Healthcare will provide reasonable access to its clinical peer reviewer within one business day of receiving notice of taking the expedited appeal. If the member is not satisfied with the resolution of the expedited appeal, they may file a standard internal appeal or an external appeal.

Univera Healthcare will transmit all information relating to the appeal to the member and the member's provider and will accept by telephone or facsimile information from the member, the member's provider or the member's designated representative relating to the appeal.

Univera Healthcare will handle reviews of continued or extended health care services and additional services rendered throughout the course of continued treatment as expedited appeals.

Pre-Service Appeals

Univera Healthcare will decide appeals involving pre-service (prospective) matters within 30 calendar days of receipt of the appeal request. Univera Healthcare will provide written notice of the determination to the

member (and the member's provider if he or she requested the review) within two business days after the determination is made, but not later than 30 calendar days after receipt of the appeal request.

Post-Service Appeals

For commercial, Child Health Plus and Article 47 products, Univera Healthcare will decide appeals filed post-service (retrospective) within 30 calendar days from receipt of all necessary information, but no later than 60 calendar days after receipt of appeal request. For self-insured products, Univera Healthcare will decide appeals filed post-service within 60 calendar days from receipt of appeal request. Univera Healthcare will provide written notice of the determination to the member (and the provider of service if they requested the review) within two business days after the determination is made, but not later than 60 calendar days after receipt of the appeal request.

Determination upon Appeal

Upon making its determination, Univera Healthcare will send a notice of determination of the internal appeal that will include the following information:

- A clear statement describing the basis and clinical rationale for the denial as applicable to the member
- The titles and credentials of the appeal reviewer
- A clear statement that the notice constitutes a final adverse determination
- Univera Healthcare's contact person and their telephone number
- The member's coverage type
- The name and full address of Univera Healthcare's utilization review agent (which may be Univera Healthcare itself)
- The utilization review agent's contact person and their telephone number
- A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or provider proposed to provide the treatment and the developer/manufacturer of the health care service
- A statement that the member may be eligible for an external appeal and the time frames for requesting an appeal (a copy of an external appeal application is sent to the member with the final adverse determination letter); and
- A clear statement written in bolded text that: the 45-day or four-month (whichever applicable) time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether a second level appeal is requested; and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request an external appeal

Univera Healthcare will treat all requests and discussions as confidential, and no discriminatory action will be taken against any member for filing an appeal. There is a process for both standard and expedited appeals. Appeals are thoroughly reviewed and documented. Univera Healthcare will maintain a file on each appeal that includes the date the appeal was filed; a copy of the appeal, if written; the date upon which the acknowledgment was received, and a copy of the acknowledgment; the appeal determination, including the date of the determination; and the titles of the personnel and credentials of clinical personnel who reviewed the appeal.

External Appeals

A provider can request an external appeal for concurrent or post-service (retrospective) adverse determinations. A provider may **not** request an external appeal pre-service utilization review determination. A provider must use a separate request form (available upon request from Univera Healthcare) to request external appeal. Upon the provider's request, Univera Healthcare will send him/her the request form within three business days. An external appeal may be available for out-of-network denials if the member's attending physician (who must be board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease) submits a statement to Univera Healthcare that the service is materially different from the service approved by Univera Healthcare. The member's physician must also submit two documents from the available medical and scientific evidence that the service is likely to be more clinically beneficial and for which the adverse risk of the requested service would not likely be substantially increased over treatment covered by Univera Healthcare.

An external appeal may also be filed:

1. When the member has had coverage of a health care service denied on the basis that such service is experimental or investigational, **and** the denial has been upheld on appeal **or** both Univera Healthcare and the member have jointly agreed to waive any internal appeal:
    a. **and** the member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health care services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Univera Healthcare or (c) for which there exists a clinical trial
    b. **and** the member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. The physician certification mentioned above will include a statement of the evidence relied upon by the physician in certifying their recommendation,
    c. **and** the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.
2. **or,** when the appeal is related to continued inpatient treatment for substance use.

For self-insured members, under the Patient Protection and Affordable Care Act (PPACA), external appeals are available for denials related to medical necessity and experimental/investigational issues. A self-insured group must NOT be grandfathered from PPACA rules for the external appeal option to apply. External appeals are also available for self-insured members for:

- Rescissions of coverage
- Consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the No Surprises Act

- Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the plan's wellness program
- Whether the plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations

Procedure

1. A provider or a member may submit a request for an external appeal:
   a. For insured members, the provider, effective 7/1/14, has 60 days from the time the provider receives the notice of the final adverse determination to submit the external appeal. For eligible self-insured members, the provider has four months from the time the provider receives the notice of the final adverse determination to submit the external appeal

      In the event that the enrollee (member) has pursued the internal appeal process without notifying the provider, it is possible that the provider would never have received "notice" of the final adverse determination. Under such circumstances, an enrollee whose four-month deadline had expired could revise their time for filing simply by "notifying" the provider of the final adverse determination and asking the provider to request the external appeal on the enrollee's behalf. To protect against this, the member may file an application as explained in *b,* below

   b. A member may file an application for an external appeal by an approved external appeal agent if the member has received a denial of coverage based on medical necessity or because the service is experimental and/or investigational. To be eligible for an external appeal: (a) the member must have received a final adverse determination from Univera Healthcare's internal appeal process, or (b) Univera Healthcare and the member must have agreed jointly to waive the internal utilization review appeal process, **or** (c) the appeal must be related to continued inpatient treatment for substance use.

   c. Univera Healthcare must provide, in writing, information regarding filing an external appeal to the member within 24 hours of the mutual agreement to waive the internal appeal process

2. The member or provider may obtain an external appeal application:
   - For insured members, from the New York State Department of Financial Services at 1-800-400-8882, or its website, dfs.ny.gov/

   or

   - By calling Univera Healthcare at the telephone number listed on the member's Health Plan identification card

   The application will provide clear instructions for completion. A fee of $50.00 may be required to request an external appeal. Univera Healthcare waives the cost to the member for filing an external appeal.

   - For insured members, the provider's application for external appeal must be made within 60 days of the member or provider's receipt of the notice of final adverse determination from Univera Healthcare's appeal process, or within 60 days of when Univera Healthcare and the member and/or provider jointly agreed to waive the internal appeal process. For eligible self-insured members, the application for external appeal must be made within four months of the member or provider's receipt of the notice of final adverse determination from Univera

Healthcare's appeal process, or within four months of when Univera Healthcare and the member and/or provider jointly agreed to waive the internal appeal process

The member may request an expedited external appeal if the member and/or the member's health care provider can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to the member's health.

A member will lose their right to an external appeal if they do not file an application for an external appeal within four months from receipt of the final adverse determination from the internal appeal.

3. The application will instruct the member where to send the external appeal. The member must release all pertinent medical information concerning their medical condition and request for services.
4. An independent external appeal agent approved by the state will review the request to determine if the denied service is medically necessary and should be covered by Univera Healthcare. All external appeals are conducted by clinical peer reviewers. The agent's decision is final and binding on both the member and Univera Healthcare.
   - For standard appeals, the external appeal agent must make a decision within 30 days of receiving the application for external appeal. Five additional business days may be added if the agent needs additional information.
   - If the agent determines that the information submitted is materially different from that considered by Univera Healthcare, Univera Healthcare will have three additional business days to reconsider or affirm its decision. The member will be notified within two business days of the agent's decision.
   - Expedited appeals will be decided within the lesser of seventy-two hours of receipt of the appeal or within two business days of receipt of the information necessary to conduct the appeal. The agent will make every reasonable effort to notify the member and Univera Healthcare of the decision immediately by phone or fax. This will be followed immediately by a written notice.

Appeals Based on Any Reason other than Medical Necessity or Experimental/Investigational Denials (Grievances)

If a member is not satisfied with a determination made by or on behalf of Univera Healthcare that does not involve a medical necessity determination or an experimental and/or investigational determination, the member may submit a grievance.

For example, the grievance procedure would be used to resolve a dispute in which Univera Healthcare decided that the member does not meet the requirements for coverage of a particular service, or that an out-of-area referral was unnecessary. The grievance procedure also applies to complaints involving service quality.

Filing a First-Level Grievance

1. The member or their designee may file a first-level grievance either by telephone, in person or in writing.

- The member may make an oral request by calling the telephone number listed on their identification card. Written grievance requests can be submitted to the address of Univera Healthcare listed on the member's identification card
- A member has up to 180 calendar days from receipt of the decision to file a grievance

Univera Healthcare will acknowledge the request for a grievance within 15 calendar days of its receipt. The acknowledgment will include the name, address, and telephone number of the person handling the grievance. If necessary, the acknowledgment will inform the member of any additional information needed before a decision can be made. The member may submit additional information pertinent to the grievance.

2. When Univera Healthcare reviews a first-level grievance, it will not give any deference to the initial decision. When a member files a first-level grievance, an individual who is not subordinate to the individual who rendered the initial determination will review the grievance. If the first-level grievance involves a clinical matter, a clinical peer reviewer will decide the first-level grievance.

   Univera Healthcare will treat all requests and discussions as confidential, and no discriminatory action will be taken against any member for filing a grievance. There is a process for both standard and urgent grievances. Grievances are thoroughly reviewed and documented. Univera Healthcare will maintain a file on each grievance. The file will include the date the grievance was filed; a copy of the grievance, if written; the date of receipt of and a copy of the acknowledgment; the grievance determination, including the date of the determination; and the titles of the personnel and credentials of clinical personnel who reviewed the grievance.

3. Univera Healthcare will make its determination.

   a. Urgent Grievances

   If a first-level grievance relates to an urgent matter, Univera Healthcare will decide the first-level grievance and notify the member of the determination by phone within 48 hours of receipt of the first-level grievance request. Written notice will follow within 24 hours of Univera Healthcare's determination.

   b. Pre-Service Grievances

   If a first-level grievance relates to a pre-service (prospective) matter, Univera Healthcare will decide the first-level grievance and notify the member of the determination in writing within 15 calendar days or 30 calendar days of receipt of the first-level grievance request.

   c. Post-Service Grievances

   If a first-level grievance relates to a post-service (retrospective) matter, Univera Healthcare will decide the first-level grievance and notify the member of the determination in writing within 30 calendar days of receipt of the first-level grievance request.

   d. Intangible Level 1 Grievances

   Intangible grievances include the following categories:

   - *Clinical Quality of Care*. A clinical quality concern is one that may adversely affect the health and/or well-being of the member. Examples of this may include perceptions of inadequate or inappropriate treatment or failure to diagnose accurately
   - *Access to Care.* Inability to obtain a timely appointment or after-hours appointment

- *Interpersonal Issues.* Interpersonal issues with a provider or their office staff or other complaints against the corporation

All intangibles must be resolved, and the member notified within 45 calendar days after receipt of all information. Univera Healthcare will handle urgent clinical situations expeditiously. Univera Healthcare will notify the member of the results of an expedited review within 72 hours after receipt of all information.

4. Upon making its determination, Univera Healthcare will send a notice of determination of the first-level grievance that will include:
    - The name and title of the reviewer
    - Detailed reasons for the determination, and, if the grievance involves a clinical matter
    - The clinical rationale for the determination, if the determination has a clinical basis, and information about how to file a second-level grievance, including the appropriate form, if applicable

Filing a Second-level Grievance

1. If a member is not satisfied with the resolution of a first-level grievance, the member or their designated representative may file a second-level grievance (available only to fully insured and some self-insured products).
    - A member has up to 180 calendar days from receipt of the first-level grievance determination to file a second-level grievance
    - The member may file a second-level grievance by phone, in person or by writing
2. Univera Healthcare will acknowledge the request for a second-level grievance within 15 calendar days of receipt. The acknowledgment will include the name, address, and telephone number of the person handling the grievance.
    - Univera Healthcare will review the second-level grievance. One or more qualified personnel at a higher level than the personnel who rendered the first-level grievance determination will decide the second-level grievance. If the second-level grievance involves a clinical matter, a clinical peer reviewer will decide the second-level grievance.
3. Univera Healthcare will make its determination.

a. Urgent Grievances

If the second-level grievance relates to an urgent matter, Univera Healthcare will decide the second-level grievance and notify the member of the determination by phone within 24 hours of receipt of the second-level grievance request. Written notice will follow within 24 hours of Univera Healthcare's determination.

b. Pre-Service Grievances

If a second-level grievance relates to a pre-service matter, Univera Healthcare will decide the second-level grievance and notify the member of the determination in writing within 15 calendar days of receipt of the second-level grievance request.

c. Post-Service Grievances

If a second-level grievance relates to a post-service matter, Univera Healthcare will decide the second-level grievance and notify the member of the determination in writing within 30 calendar days of receipt of the second-level grievance request.

d. Intangible Level 2 Grievances

Intangible grievances include the following categories:

- *Clinical Quality of Care*. A clinical quality concern is one that may adversely affect the health and/or well-being of the member. Examples of this may include perceptions of inadequate or inappropriate treatment or failure to diagnose accurately.
- *Access to Care.* Inability to obtain a timely appointment or an after-hours appointment availability.
- *Interpersonal Issues*. Interpersonal issues with a provider or their office staff or other complaints against the corporation.

All intangibles must be resolved, and the member notified within 45 calendar days after receipt of all information. Univera Healthcare will handle urgent clinical situations expeditiously. Univera Healthcare will notify the member of the results of the expedited review within 72 hours after receipt of all information.

4. Upon making its determination, Univera Healthcare will send a notice of determination of the second-level grievance that will include:
   - The name and title of the reviewer
   - Detailed reasons for the determination, and
   - If the grievance involves a clinical matter, the clinical rationale for the determination
5. If an insured member remains dissatisfied with a first-level and/or second-level grievance determination(s), or if they are dissatisfied at any other time, the member may:
   - Contact the New York state Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237, 1-800-206-8125, for managed care products, and/or
   - Contact the New York state Department of Insurance, Consumer Services Bureau, One Commerce Plaza, Albany, New York 12257, 1-800-342-3736

Univera Healthcare
Participating Provider Manual

Section 5: Pharmacy Management

This section includes information about prescription drug benefits as well as information about drugs that are covered as a medical benefit (such as certain injectable and infusion drugs that are administered by a health care practitioner).

Revised September 2024

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5.1 Pharmacy Benefits

Univera Healthcare is committed to effectively managing prescription drug benefit costs and providing members with affordable access to prescription drugs. Pharmacy benefits for many of our members are administered by Univera Healthcare. Providers should direct pharmacy benefit authorizations or inquiries to the Pharmacy Help Desk. The Pharmacy Help Desk telephone numbers and address are listed on the *Contact List* in this manual.

> **Note:** Prescription drug benefits are added to many health benefit programs by way of a rider. Not all health benefit programs include a prescription drug benefit. Member ID cards for programs that include an “Rx” symbol.

> **Note:** Effective April 1, 2023, pharmacy benefits are administered through NYRx, the Medicaid Pharmacy Program, for all Blue Choice Option, HMO Blue Option and Blue Option Plus members. Please visit Medicaid Pharmacy Program (ny.gov) for more information.

5.2 Medication Guides

Univera Healthcare offers a variety of formulary options to members, providers, employers and guests. All formularies include both generic and brand-name medications. The Pharmacy and Therapeutics Committee, composed of practicing community physicians and clinical pharmacists, defines the drugs in each category. The committee meets regularly to review the drugs on the formularies.

Formularies are located at Provider.UniveraHealthcare.com/policies/prescriptions/formularies. Provider offices that do not access the Internet may request paper copies from the Pharmacy Help Desk (see the *Contact List* in this manual).

Three-Tier Drug Plan

This drug benefit design provides three tiers of coverage with a graduating scale of patient copayment/coinsurance based on the tier assignment of the prescribed drug. Select three-tier formularies are closed formularies, which means that not all drugs are part of the formulary. Members play a vital role in controlling the rising cost of prescription drugs, and this three-tier benefit gives them the incentive to make informed decisions about the medications they take.

The three tiers are categorized as:

- **Tier One** - Typically, generic drugs. Generic drugs have the same active ingredients, strength and effectiveness as their brand-name counterparts but at a substantially lower cost. There may be instances where brand-name drugs may be placed in Tier One for clinical reasons.
- **Tier Two** - Typically, brand-name products selected because of their overall value. There may be instances where generic drugs may be placed in Tier Two for clinical reasons.
- **Tier Three** - All other prescription drugs. This includes FDA-approved drugs that are pending placement by Univera Healthcare's Pharmacy and Therapeutics Committee. There may be instances where generic drugs may be placed in Tier Three for clinical reasons.

The three-tier prescription benefit focuses on cost-sharing. Members using Tier Three drugs will be responsible for the highest out-of-pocket expenses.

Two-Tier Closed Formularies for Child Health Plus

The Child Health Plus prescription drug benefit is managed by Univera Healthcare. It is based on a two-tier closed formulary. The Child Health Plus formulary is available on our website (see below) or by calling the Pharmacy Help Desk to request a copy. The Child Health Plus benefit allows coverage for Medicaid-approved over-the-counter drugs.

- Provider.UniveraHealthcare.com/policies/prescriptions/formularies

5.3 Online Edits

The online drug claims processing system provides safety and accuracy checks. As a prescription is filled, the system checks it against a series of safety and quality criteria, including:

- **Quantity Limits**. Limits apply based on standard FDA-approved dosing and established, clinically-appropriate dosing parameters.
- **Drug Utilization Review (DUR) Messaging.** Messages assure member safety by providing information about possible drug interactions, duplications and dosing errors.

5.4 Prior Authorization

Some drugs require prior authorization before Univera Healthcare will pay for the medication. Univera Healthcare has developed a list of medications requiring Prior Authorization or Step Therapy. The list is subject to change. The most current version is available on our website at, Provider.UniveraHealthcare.com/authorizations/prescriptions.

Prescription Drugs Requiring Prior Authorization

Univera Healthcare has a general exception prior authorization fax form in addition to select drug-specific prior authorization form for many drugs or drug categories. For those drugs requiring prior authorization, prescribing practitioners can complete and submit the appropriate prior authorization form Drugs that require prior authorization are indicated on the formulary.

The most current version of each form is available from the page on our website at Provider.UniveraHealthcare.com/authorizations/medical/prescriptions. Practitioners may also call the Pharmacy Help Desk to request the appropriate form. We will fax or mail the form directly to the requestor. Telephone numbers and addresses are listed on the *Contact List* in this manual. Providers may also request prior authorization review electronically through their electronic medical record (EMR) software, if it has electronic prior authorization capability, or through the CoverMyMeds® electronic prior authorization portal, www.covermymeds.com.

Prescribing practitioners must complete all required fields on the prior authorization forms, including the member's Rx ID number, located on the front of the member card. We will return incomplete forms for correction before a review determination can be made. All prior authorization forms must be signed by the requesting provider before a review can take place.

Practitioners should fax prior authorization requests and step therapy exceptions to Univera Healthcare (the fax number is included on each form). Responses to faxed requests will be faxed to the practitioner's office if a secure fax line is identified/available. Otherwise, responses will be mailed. CoverMyMeds responses will appear in the CoverMyMeds portal, in addition to being faxed or mailed.

Offices without access to a fax machine may call the Pharmacy Help Desk to request prior authorization review. To expedite the process, providers should have all required information available prior to placing the call. In addition, provider offices may use their EMR (if it has electronic prior authorization capability) or the CoverMyMeds portal.

Step Therapy Program

The Step Therapy program promotes the use of clinically sound generics and cost-effective therapeutic alternatives in select therapeutic classes. The program provides recommendations for prescribing first-line medications. The program applies to members with prescription drug benefits that include prior authorization requirements.

As part of the program, we require step therapy for certain drugs within select categories. The Step Therapy program can apply to new starts or existing users of the targeted medication. For example, a patient who

is prescribed Edarbi® for the first time and has had a trial of a generic ARB such as irbesartan, losartan or valsartan would meet for coverage.

For the most current list of step therapy prescribing recommendations, refer to our website, Provider.UniveraHealthcare.com/authorizations/prescriptions, or contact the Pharmacy Help Desk. Step therapy requests may also be submitted using the electronic prior authorization process through the provider's EMR or through CoverMyMeds.

Exception Process

To request an exception to the formulary, prior authorization, step therapy and other use management programs, the prescribing physician must either complete a request form and fax it to the Pharmacy Help Desk at the number listed at the bottom of the form, or complete and submit the coverage determination request electronically via our secure eForm, which is available on our website or through their EMR or CoverMyMeds. The *General Exception Request Form* can be accessed on our website (see below). See the sections above regarding prescription drugs requiring prior authorization for instructions to access the necessary form(s).

- Provider.UniveraHealthcare.com/authorizations/medical/prescriptions

5.5 Specialty Medication Pharmacy Network

Specialty medications such as those for the treatment of diseases, such as multiple sclerosis, hepatitis C and rheumatoid arthritis that are covered under the prescription drug benefit (self-administered medications) can be ordered from our specialty pharmacy network. Participating national vendor, Accredo Health Specialty Pharmacy, will supply and ship all self-injected medications covered under the pharmacy benefit directly to the patient.

Certain prescription drug benefits require that select specialty medications must be purchased from our participating network specialty pharmacies to receive coverage under the prescription drug benefit. Information about national and local vendors and the medications affected is available on our website, Provider.UniveraHealthcare.com/resources/prescriptions/specialty-pharmacy. Scroll down to *Network Specialty Pharmacies*. The website also provides a list of specialty medications as well as links to the national specialty pharmacy vendors.

The telephone number for Accredo Health Specialty Pharmacy is included on the *Contact List* in this manual. There are also several local pharmacies that participate in the specialty network. Providers (or members) may call the Pharmacy Help Desk to learn whether there are any in a specific area.

- Visit Provider.UniveraHealthcare.com/resources/prescriptions/split-fill-program for information on our Specialty Drug Split Fill program. The program allows doctors and patients to try expensive medications that have serious side effects for a shorter time so that they can confirm effectiveness and tolerance prior to paying for a full 30-day supply. This minimizes unnecessary expenses and medication waste.

5.6 Medical and Medical Specialty Drugs

Medical drugs are defined as those drugs that are administered by a health care provider in the office, at an infusion center, at an outpatient facility or by nurses in home care. Medical drugs are covered under a member's medical benefit *(prescription drugs are defined as those drugs that can be self-administered and are covered under a member's prescription drug benefit).*

Some medical drugs may also fall into the category of medical specialty drugs due to limited distribution or other unique characteristics. These may require prior authorization.

Please refer to Univera Healthcare's website for additional information, including a list of provider-administered drugs that require preauthorization, preauthorization forms, information about contracted specialty pharmacies, and specific medical drug policies.

> **Note:** Claims will deny or suspend for review across all lines of business for provider-administered medications that require medical necessity review, unless preauthorization has been obtained.

To access the Medical Specialty Drug preauthorization list and information how to submit a request, go to Provider.UniveraHealthcare.com/authorizations/request-authorization. Select Medical Specialty Drugs. . Our drug policies are available at Provider.UniveraHealthcare.com/policies/drug-policies.

Preauthorization is handled through the **Medical Specialty Drug Review Program**, a centralized team that performs medical necessity reviews for medications covered under the medical benefit that require prior authorization. The Medical Specialty Drug team includes pharmacy technicians, clinical pharmacists, and physicians. Providers may obtain medical drug preauthorization forms from the Univera Healthcare website.

Medical Drug Preferred Site of Care: Physician Office or Home Infusion

Univera Healthcare is committed to offering cost-effective alternate sites of care for provider-administered medications covered under the medical benefit. The site of care program provides members an alternative to outpatient hospital-based infusions, to ensure that members receive the most appropriate, cost-effective level of care. The preferred site of care is in a physician's office or home infusion setting when medically appropriate. The site of care team provides outreach to members, offering the switch to a more cost-effective site of care. Visit our website to locate participating infusion centers (physician office based) and home infusion agencies. Providers can contact their Provider Relations representative for more information regarding the program.

Specialty Pharmacy is an Option for Obtaining Medical Drugs

Univera Healthcare offers providers the option of using specialty pharmacies to obtain drugs that they prefer not to stock in the office. Univera Healthcare's contracted specialty pharmacies will ship the drug to the provider's office and bill Univera Healthcare directly.

Most medical drugs and medical specialty drugs may be obtained either through a contracted specialty pharmacy or purchased directly by a physician and billed to Univera Healthcare. Please note that you do not bill Univera Healthcare for the drug when using a specialty pharmacy. To view a list of our Participating Medical Specialty Pharmacies under the Medical Benefit, go to our website (see below) and scroll down to Medical Benefit.

- Provider.UniveraHealthcare.com/resources/prescriptions/specialty-pharmacy

Obtaining Medical Drugs from Specialty Pharmacies – What is the process?

1. **The drug the provider wishes to prescribe requires preauthorization.**
   - Submit for Prior Authorization to our Medical Specialty Drug Unit:
     - Fax the completed preauthorization form with office notes and any other required information to the medical specialty unit listed on the form OR submit via the CareAdvance Provider portal.
     - Indicate which specialty pharmacy you will be using on the PA form or in the CareAdvance Provider Portal request.
   - Submit the order to the Medical Specialty Pharmacy:
     - Electronically send or fax the prescription to the Medical Specialty Pharmacy.
       - Also include member-specific insurance and demographic information.
     - Fax numbers for specialty pharmacies are listed at the top of the preauthorization form.

2. **The drug the provider wishes to prescribe does NOT require preauthorization.**
   - Submit the order to the Medical Specialty Pharmacy:
     - See link above for Participating Medical Specialty Pharmacies.
     - Electronically send or fax the prescription to the Medical Specialty Pharmacy.
       - Also include member-specific insurance and demographic information.

5.7 Generic Advantage Program*

*****Applies only to select Univera Healthcare members.

Univera Healthcare's prescription drug benefit is designed to encourage value when selecting prescription drugs. The Generic Advantage Program for maximum allowable cost is part of that drug benefit. This program applies to a list of brand-name drugs that have Food and Drug Administration (FDA) approved generic equivalent. Child Health Plus, and Medicare members are **not** eligible to participate in this program.

With the Generic Advantage Program, if a member purchases a brand-name medication when there is a generic equivalent available, they may pay:

- the generic copayment/coinsurance amount; and
- the difference between Univera Healthcare's network discount price for the more costly brand-name medication and Univera Healthcare's price for the less expensive generic.

5.8 Mandatory Mail-Order for Maintenance Drugs

Some prescription drug benefits require select medications be purchased through the mail-service pharmacy for coverage. This does not apply to Medicare members. The most current list of medications that must be purchased through mail-service is available our website (see below). Scroll down to *Enjoy Home Delivery Service – Save up to 33%*, then click *List of Medications Required to be Purchased through a Mail Order Service Pharmacy.* Providers who do not access the Internet from the office may request a copy from the Pharmacy Help Desk.

- UniveraHealthcare.com/find-a-doctor/pharmacy

5.9 Other Web-Based Pharmacy Services

Both members and providers can access the following pharmacy services through the Univera Healthcare website, UniveraHealthcare.com.

Formulary Guides

The Univera Healthcare website provides:

- Links to all of our formularies
- Notices of recent formulary changes

Pharmacy Locator

Univera Healthcare's website also provides:

- Search capability for more than 68,000 pharmacies that participate in the pharmacy network. Information about the mail service pharmacy network available to members who have prescription drug coverage. https://www.univerahealthcare.com/find-a-doctor/pharmacy
- Information about Univera Healthcare's Specialty Rx Care Program that helps manage the high costs of biotech medications by using specialty pharmacies that focus on monitoring and distributing these new, high-cost medicines. https://provider.univerahealthcare.com/resources/prescriptions/specialty-pharmacy

Ask the Pharmacist - Drug Information Via Email

The clinical pharmacists of Univera Healthcare Pharmacy Management are available to answer questions on a broad range of topics, including new clinical data, adverse drug reactions, optimal drug selection, therapeutic uses, drug interactions and monitoring parameters and a generic drug options chart.

Visit Provider.UniveraHealthcare.com/resources/prescriptions/ask to send an email message. We make every effort to answer questions as soon as possible. However, please allow three business days for a response.

5.10 Medicare Part D Prescription Drug Benefit

Univera Healthcare offers the Medicare Part D prescription drug benefit for many of its Medicare Advantage (MA) products. Univera Healthcare also offers a regional Medicare prescription drug plan (PDP), Simply Prescriptions$^{\Diamond}$. The PDP provides drug coverage for Medicare-eligible individuals who are enrolled in traditional Medicare, who have Medigap coverage or who have health coverage through an employer group that does not offer Medicare HMO or PPO plans.

The Medicare Part D Prescription Drug benefit was designed for the unique medication needs of Medicare beneficiaries.

Medicare Part D Formulary

A formulary is a list of drugs covered by the plan. The Medicare Part D formularies focus on clinically and cost-effective choices for our Medicare and D-SNP eligible populations. The drugs listed on our Medicare approved formularies have been selected with the help of a Pharmacy and Therapeutics Committee, composed of a team of practicing community providers and clinical pharmacists. The most current Medicare Part D formularies, as well as other program information, are available on the Univera Healthcare website at Provider.UniveraHealthCare.com/policies/prescriptions/formularies.

Univera Healthcare will generally cover the drugs listed on the Medicare Part D formularies if the drug is prescribed for a medically accepted indication, applicable drug utilization management criteria are met, and the prescription is filled at a participating pharmacy. During the plan year, in accordance with Medicare rules, the plan may make changes to the formularies. Some of these changes include adding newly available drugs, replacing brand-name drugs with new generics, removing drugs due to safety concerns or manufacturer withdrawal, and adding/removing restrictions to currently listed formulary drugs. You may preview upcoming changes to the formulary on the Univera Healthcare website at Provider.UniveraHealthCare.com/policies/prescriptions/formularies.

Medicare Drug Utilization Criteria

Some formulary drugs require drug utilization criteria be met, such as, prior authorization or step therapy before Univera Healthcare will pay for the medication. This helps ensure patients have access to safe, effective drug therapy and helps protect against inappropriate use and waste. A current list of formulary drugs requiring prior authorization or step therapy can be found on the Univera Healthcare website at Provider.UniveraHealthcare.com/authorizations/prescriptions. The lists are updated monthly and subject to change.

Medicare Part B vs Part D

Some medications require prior authorization to determine if coverage should be provided under the Medicare Part B (Medical) benefit or Medicare Part D (Pharmacy) benefit. In accordance with the Centers

for Medicare and Medicaid Services (CMS) rules and regulations, Univera Healthcare is prohibited from covering a Part B eligible medication under the Medicare Part D benefit. This includes but is not limited to:

- Drugs that usually aren't self-administered by the patient and are injected or infused by a physician, hospital outpatient, or ambulatory surgical center
- Drugs which require durable medical equipment (such as nebulizers) that were authorized by the plan
- Immunosuppressive drugs for patients with a Medicare covered organ transplant

Medication Safety

In addition to specific drug utilization criteria, the plan provides other safety and accuracy checks. When a prescription is filled, the online drug claims processing system checks against a series of safety criteria including:

- **Quantity Limits**. Limits apply based on standard FDA-approved dosing and established, clinically appropriate dosing parameters.
- **Drug Utilization Review (DUR) Messaging**. Assures patients' safety by providing information about possible drug interactions, duplications and dosing errors.
- **Opioid Safety Edits.** Point-of-sale (POS) safety edits to prevent the overuse of short and long-acting opioids based on the prescribed morphine milligram equivalent (MME) dosage. The Plan's Medicare Part D Formulary Level Cumulative Opioid Point of Sale Edits Policy is available on the Univera Healthcare website at Medicare Part D Formulary-Level Cumulative Opioid POS Edit.docx

  To request an exception to our formulary, prior authorization, step therapy and other use management programs, the prescribing physician must submit a request and fax it to the Pharmacy Help Desk, submit a coverage determination request electronically via our secure Eform | Providers | Univera Healthcare available on our website, or through the provider's EMR or CoverMyMeds. The most current forms are available at: Prior Authorization Forms | Medicare Patients | Univera Healthcare.

Transition

Univera Healthcare provides a temporary or "transition" supply of at least a month's supply (unless the patient presents with a prescription written for less) of a Part D drug that isn't on our formulary, or that has coverage restrictions or limits. We provide this temporary supply in the following situations:

- **New Patient or Current Patient** - We will cover a temporary supply of the drug during the first 90 days the patient is with the plan if they are a new patient OR during the first 90 days of the calendar year if the patient was in the plan last year. The patient is given one 30-day supply of their medication during the first 90 days. If the prescription is written for fewer days, the Plan will allow multiple fills up to a maximum of a 30-day supply of medication.
- **Current patient and a resident of a LTC Facility** - For those patients who have been in the Plan for more than 90 days, reside in a long-term care (LTC) facility and need a supply right away, the

Plan will cover one 31-day supply of a particular drug, or less if the prescription is written for fewer days.

- **Current patient with a level of care change** - For patients who are being admitted to or discharged from a LTC facility, the Plan will not utilize early refill edits which will allow appropriate and necessary access to the patient's Part D benefit. Patients will be allowed to access a refill upon admission or discharge.

We will provide the patients and you with a written notice after we cover the temporary or transition supply. The notice will explain the next steps, such as requesting a formulary exception for the drug or having the patient talk to the provider about switching to an appropriate drug on our formulary.

Pharmacy Network

Patients are covered locally and nationally with our extensive pharmacy network. Most patients can save money with lower copays for medications on Tiers 1-4 when they use one of our preferred pharmacies. Higher copays may apply for medications on Tiers 1-4 if a standard pharmacy is utilized. Prescriptions filled at non-network pharmacies are covered only in certain situations. The network has a robust selection of free-standing pharmacies, grocery store chains, and local independent pharmacies.

Univera Healthcare also offers patients the option to fill their prescriptions via home delivery with Wegmans Home Delivery or Express Scripts. Prescriptions can be sent by providers to these facilities and the medications will be mailed to the patient's home within 8-10 business days of the pharmacy receiving the prescription.

Univera Healthcare has a Pharmacy Locator tool available on our website at Find a Pharmacy | Medicare Patients | Univera Healthcare. The tool allows the user to search for participating pharmacies nationwide.

In addition to our retail and mail order pharmacies, our participating specialty pharmacy, Accredo Health will supply and ship all self-injected specialty medications covered under the pharmacy benefit directly to the patient. Specialty medications, such as those for the treatment of diseases like multiple sclerosis, hepatitis C and rheumatoid arthritis that are covered under the prescription drug benefit (self-administered medications) can be ordered from Accredo.

The Phases of the Part D Benefit

2024

The Medicare Part D prescription drug program consists of four stages: deductible, initial coverage, coverage gap and catastrophic coverage. The cost for a drug depends on which stage the patient is in at the time the patient gets their prescription filled or refilled. For 2024, the patient will pay the following in each phase of the benefit:

- **Deductible** – if the patient's plan has a deductible, they will pay 100% of the costs until the deductible has been met.
- **Initial Coverage Phase** – the patient will pay their copay or coinsurance for their prescription drug. The patient will stay in this phase until the patient and the plan have paid $5030 in total drug costs.

- **Coverage Gap –** this phase starts when the total drug costs reach $5030. The patient is responsible for 25% of the total cost for generic and brand medications covered under the plan during this phase. Once the patient has paid $8000 during the year, which includes out-of-pocket costs (deductible, copayments and coinsurances), the patient enters the catastrophic phase.
- **Catastrophic –** the patient pays a $0 copay for all medications in this phase for the remainder of the calendar year.

2025

The Part D prescription drug program will change significantly in 2025. The coverage gap phase will be eliminated and the patient's pharmacy maximum out of pocket cost **for prescription drugs** will be $2000. This pharmacy maximum out of pocket is separate from the medical out of pocket maximum. The patient will pay the following in these Part D phases in 2025:

- **Deductible** – if the patient's plan has a deductible, the patient will pay 100% of the costs until the deductible has been met.
- **Initial Coverage Phase** – the patient will pay their copay or coinsurance for their prescription drug. The patient, the manufacturer and the plan, contribute to the cost sharing for the drugs during this phase. When the **patient** has paid $2000 in pharmacy out-of-pocket costs for prescription drugs, the patient will move into the catastrophic phase.
- **Catastrophic –** the patient pays a $0 copay for all medications in this phase for the remainder of the calendar year.

The phases reset every year on January 1st.

Insulin

In accordance with the Inflation Reduction Act, patients can fill prescriptions for covered insulin under their Medicare Part D plan and will not pay more than $35 for a month's supply of each insulin that is dispensed at a participating pharmacy. Part D deductibles will not apply to the covered insulin product.

Patients with Medicare Part B who take insulin through a traditional insulin pump will not pay more than $35 for a month's supply of insulin and the deductible will not apply to the insulin. Insulin used in an insulin pump can be obtained at a participating pharmacy or a durable medical equipment provider.

TransactRx Vaccines

TransactRx is an independent company that offers a real time online tool for providers to bill Medicare Part D vaccines administered in the office. Univera Healthcare requires the use of the Transact Rx billing tool when submitting Medicare Part D vaccine claims. To learn more, enroll, or to register for a TransactRx demonstration, go to www.transactrx.com/physician-vaccine-billing.

TransactRx allows providers to determine:

- If a patient has Medicare Part D coverage and the plan in which the patient is enrolled
- The patient's cost sharing for the specific vaccine. Most Part D vaccines are covered at $0
- How much the provider will be reimbursed for the vaccine.

It also offers administrative advantages, such as:

- Upfront costs prior to vaccine administration
- The administration fee is included in the Part D vaccine reimbursement, eliminating the need to bill separately
- Copayments can be collected at the time of service, eliminating the need to bill the patient the full cost of the vaccine.

Medicare Part D vaccine claims submitted outside the TransactRx billing tool will be denied and the provider will be held liable. Patients may not be billed for preventative Medicare Part D vaccines which were not submitted using TransactRx. These include but are not limited to:

- Diphtheria/Tetanus (Tenivac®)
- Tetanus, diphtheria toxoid and acellular pertussis (Adacel®, Boostrix®)
- Zoster vaccine recombinant, adjuvanted (Shingrix®).
- M-M-R II

TransactRx should NOT be used for vaccines only covered under Medicare Part B (medical) or vaccines that could potentially be covered under a patient's Medicare Part B benefit. These vaccines include but are not limited to:

- Influenza vaccine (Flu)
- Pneumococcal vaccine (Pneumovax 23, Prevnar 13)
- COVID-19
- Hepatitis B vaccine for patients at moderate to high risk (Recombivax HB, Engerix-B)
- Tetanus vaccine (for treatment of an injury)
- Rabies virus vaccine (RabAvert, Imovax Rabies)

Providers should continue to bill these vaccines to the patient's medical benefit with the appropriate diagnosis code. For helpful patient information on how to navigate Medicare vaccine coverage visit the Univera Healthcare website at Understanding Your Vaccines.

Safe Disposal of Medications

Once the expiration date for a medication has passed, there is no guarantee that the medicine will be safe and effective. Proper disposal of expired or needless medicines is essential.

The preferred method for medication disposal is year-round drop off sites. These include local pharmacies, hospitals, and police stations. The DEA (Drug Enforcement Agency) Controlled Substance Public Disposal Locations - Search Utility (usdoj.gov) provides a ZIP code search tool to find the closest drop off site

located near you. The US Department of Health and Human Services provides additional information about the safe disposal of prescription drugs. How to Safely Dispose of Drugs | HHS.gov

Extra Help from Medicare for Prescription Drugs

Patients may be eligible to receive financial assistance for their prescriptions and premiums through Medicare's Extra Help program. The program helps lower the copays for prescriptions and the monthly plan premium will be lower if they qualify for Extra Help.

Patients can do the following to determine if they qualify for Extra Help by calling:

- 1-800-Medicare of TTY users call 1-877-486-2048 (24 hours a day / 7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday t through Friday. TTY users should call 1-800-325-0778.

NYS EPIC

Elderly Pharmaceutical Insurance Coverage (EPIC) is a New York State program* for seniors that helps with out-of-pocket Medicare Part D drug plan costs. It works together with Medicare Advantage plans, and over 320,000 New Yorkers have joined EPIC to save on their prescription drug coverage. EPIC helps pay Medicare Part D drug plan premiums or provides assistance by lowering the EPIC deductible. There are two plans based on income:

- The Fee Plan is for patients with incomes up to $20,000 if single or $26,000 if married.
- The Deductible Plan is for patients with incomes ranging from $20,001 to $75,000 if single or $26,001 to $100,000 if married.

The patient can apply at any time of the year for NYS EPIC. The patient will need to complete the application EPIC Application and Contact Information (ny.gov) and mail or fax it to EPIC. EPIC verifies information with the Social Security Administration and the New York State Department of Taxation and Finance.

* The patient must be a New York State resident 65 years of age or older and be enrolled or eligible to be enrolled in a Medicare Part D drug plan to receive EPIC benefits and maintain coverage. EPIC provides secondary coverage for Medicare Part D- and EPIC-covered drugs after any Part D deductible is met. EPIC also covers approved Part D-excluded drugs such prescription vitamins as well as prescription cough and cold preparations once a patient is enrolled in a Part D drug plan. Learn more at the New York State Department of Health website.Elderly Pharmaceutical Insurance Coverage (EPIC) Program (ny.gov)

Medication Therapy Management (MTM)

Patients with a Medicare Prescription Drug Plan who have complex health needs may be able to participate in a Medication Therapy Management (MTM) program. MTM is a service offered by our Health Plan at no

additional cost. This program ensures the patient and the provider that the patient's medications are appropriate. The MTM program is required by the Centers for Medicare and Medicaid Services (CMS).

To take part in this program, the patient must meet certain criteria set forth in part by CMS. These criteria are used to identify people who have multiple chronic diseases and are at risk for medication-related problems. If the patient meets these criteria, Univera Healthcare will send the patient a letter inviting them to participate in the program and information about the program, including how to access the program. Enrollment in MTM is voluntary and does not affect coverage for drugs covered under Medicare.

Univera Healthcare
Participating Provider Manual

Section 6: Behavioral Health

Revised September 2024

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6.1 Program Administration

Behavioral Health Services

The Behavioral Health (BH) clinical staff maintains, monitors, and evaluates BH care and services for clinical effectiveness and efficiencies, aligning with the corporate mission and goals. Services are assessed for appropriate, medically necessary, effective levels of care, supportive resources and progressive interventions for improvement to ensure high quality care and member safety. Treatment services are reviewed in accordance with nationally recognized criteria, such as Change Healthcare's Behavioral Health InterQual® Level of Care Criteria, corporate medical policies and New York state policies for mental health to determine medical necessity.

Effective May 8, 2023, for inpatient mental health, mental health residential,mental health partial hospital, mental health intensive outpatient (IOP), or assisted outpatient treatment (AOT) Safety Net only), the New York State Office of Mental Health is requiring the use of InterQual Criteria. In addition, if the concurrent review information does not meet InterQual criteria, the Utilization reviewers are then required to review via our secondary corporate medical policy called, "Level of Care Criteria for Inpatient, Residential, Partial Hospital, and Intensive Outpatient Mental Health Services for Adults and Children." If it still doesn't meet the criteria, it will be sent to our Medical Director for review.

For substance use services (OASAS) delivered to our Commercial, Child Health Plus, Essential Plan (EP), Health and Recovery Plan (HARP) and Medicaid Managed Care (MMC) members, Univera Healthcare uses the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) tool developed by the NYS Office of Addiction Services and Supports (OASAS), and American Society of Addiction Medicine (ASAM) standards to determine medical necessity.

Effective July 1, 2022, all requested inpatient mental health and substance use services for Medicare members will be reviewed for medical necessity based on Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).

Information regarding NCD and LCD criteria effective July 1, 2022 is available at Provider.UniveraHealthcare.com/policies/view.

Behavioral Health Integration

The BH clinical staff reviews proposals and collaborates with ad hoc workgroups for input into BH clinical services programs and activities, case management program enhancements, service quality, continuity and coordination of care program activities and practitioner utilization trends. The workgroups provide feedback for development and implementation of quality and utilization management initiatives, measurements, interventions and guidelines for improvement.

The workgroups include leadership and staff from Utilization Management, Case Management, Health Care Improvement, Government Programs and Compliance along with our Behavioral Health Medical Directors. Committees may also engage specialty consultants to provide additional feedback for program changes, clinical practice guidelines and coordination with medical management and disease management interventions.

Behavioral Health Services for Enrollees in Medicaid Managed Care (MMC) or Dual Special Needs Plan (D-SNP)

The following BH services are available for enrollees in a MMC or D-SNP plan. Some services may require medical necessity review and/or preauthorization:

- Assertive Community Treatment (ACT)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Continuing Day Treatment Program (CDTP)
- Inpatient Psychiatric Services
- Outpatient Mental Health Clinic Services
- Partial Hospitalization Program (PHP)
- Personalized Recovery Oriented Services (PROS)
- Crisis Intervention
- Health Home Care Coordination and Management
- Home and Community Based Services (HCBS) -HARP member benefit only
- Community Oriented Recovery Empowerment Services (CORE)- HARP member benefit only

Crisis Services/Detoxification (OASAS)
- Medically Managed Withdrawal and Stabilization Services
- Medically Supervised Inpatient Withdrawal and Stabilization Services
- Medically Supervised Outpatient Withdrawal and Stabilization Services

Inpatient Rehabilitation Services (OASAS)
Residential Addiction Treatment Services (OASAS)
- Stabilization
- Rehabilitation
- Reintegration

Outpatient Addiction Treatment Services (OASAS)
- Outpatient Clinic
- Intensive Outpatient Treatment
- Ancillary Withdrawal Services
- Medication Assisted Treatment
- Outpatient Rehabilitation Services
- Opioid Treatment Programs (OTP)

Annual Review of Behavioral Health Programs

Each year, Univera Healthcare evaluates the performance data from the BH utilization management, quality management and compliance programs to measure the effectiveness in servicing members seeking BH services. The BH services standards are reviewed on an annual basis to ensure there is inclusion of recent changes and updates from Univera Healthcare's accreditation and regulatory entities.

6.2 Substance Use Treatment Consent Regulation

Patient Consent Required

A claim for services rendered by a Part 2 Program, as that term is defined under 42 CFR s. 2 ("Part 2 Regulation"), shall not be submitted to Univera Healthcare, unless the Part 2 Program has obtained a signed Part 2 Regulation-compliant patient consent form: a) authorizing the Part 2 Program to disclose Patient Identifying Information to Univera Healthcare for payment and healthcare operations, and b) authorizing Univera Healthcare to re-disclose Patient Identifying Information to the Part 2 Program for purposes of the Part 2 Program's payment activities, including but not limited to, eligibility inquiries and remittance advice. The provider's participation agreement with us requires the provider to obtain patient authorizations or consents from our members directly. Offices obtain these authorizations as part of routine administrative business practice. If this is not a routine part of the practice, it will be necessary to obtain such authorizations or consents for release of patient records if not already done so. Univera Healthcare shall rely on the fact that a claim for Part 2 services was submitted, as confirmation that the Part 2 Program has complied with the requirements set forth here.

6.3 Outpatient Treatment

Outpatient Mental Health Treatment

Univera Healthcare provides outpatient coverage for mental health treatment. BH practitioners should determine if any service for any member requires authorization before providing the service. Providers may use the web-based referral system called CareAdvance Provider (CAP) for some health benefit programs that require preauthorization.

Refer to our preauthorization guidelines at Provider.UniveraHealthcare.com/authorizations/medical.

Note: A Facets Provider ID is required to use CareAdvance Provider® (CAP) Please visit our website, Provider.UniveraHealthcare.com, to view policies related to the delivery, management and oversight of outpatient BH services. These policies can also be requested by calling Customer Care.

Recommended Procedures for Practitioners/Facilities

A member contacts a participating BH provider to make an appointment to receive care. The provider/member may or may not be required to obtain prior authorization (refer to the preauthorization guidelines on our website, Provider.UniveraHealthcare.com/authorizations/medical).

Prior to meeting with the member, the provider should determine the member's eligibility and benefits via any of the inquiry methods described in the *Administrative Information* section of this manual.

During the member's initial visit, the provider performs an assessment. Providers must request written consent from a member to share information with the member's PCP and other BH practitioners currently providing treatment. Providers must also secure information from practitioners that recently provided treatment and document the member's response to previous treatment in the record.

Providers must coordinate care with the PCP and other practitioners (as necessary) to ensure that the member receives a seamless transition to the appropriate level of care, and that there is an exchange of information for continuity between medical and BH care. The PCP, BH practitioner, or member may initiate the first request for outpatient mental health treatment for member contracts requiring preauthorization.

Referral, preauthorization, notification guidelines

Step 1: Check the member's benefits and coverage on our website, Provider.UniveraHealthcare.com, for plan-specific preauthorization requirements.

Step 2: Submit the Request via the CareAdvance Provider online tool, or by calling 1-800-363-4658. There may be services which require preauthorization or notification that do not require clinical review. Final determination of coverage is subject to the member's benefits and eligibility on the date of service. For questions about preauthorization, please call 1-800-363-4658.

Step 3: If the service requires clinical review; utilization management (UM) staff will review the submitted request or contact the provider requesting the preauthorization for clinical information to review for medical necessity. The request will be reviewed with the appropriate criteria based on the service requested (e.g., InterQual, LOCADTR, NYS Guidelines, ASAM, corporate medical policies).

Step 4: Once the medical necessity review is completed the provider and member will receive verbal and written notification based on utilization management time frames.

In the event the BH staff and practitioner do not concur on the plan of care, the case is referred to a BH medical director, all of whom are board-certified psychiatrists. The BH medical director may conduct a phone review and/or request additional information.

Outpatient Substance Use Treatment

Univera Healthcare covers outpatient substance use treatment in accordance with the terms of the member's contract. Most member contracts include a substance use benefit for treatment, but there could be exceptions.

Members do not need referrals or preauthorization to obtain covered outpatient substance use services under most member contracts (see section 10.1 Restricted Recipient Program).

A participating substance use disorder provider may bill Univera Healthcare to obtain payment for treating the family of a member who may or may not be in substance use treatment. The member does not have to be in treatment in order for the family member to access this benefit.

Participating providers should **always** check the member's eligibility for covered benefits before providing services. Check the members benefits and coverage on wnyhealthenet.com.

Due to HIPAA and privacy laws, provider log-in is required to access member benefit and coverage information.

6.4 Inpatient Treatment

> **Note**: For information about emergency room admissions, see the *Benefits Management* section of this manual.

Policy Overview

Urgent substance use treatment admissions (i.e., inpatient detoxification) may or may not utilize the BH benefit, depending on the type of facility to which the member is admitted.

Some inpatient mental health services request the provider to obtain preauthorization. Substance use treatment admissions do not require preauthorization. Therefore, it is important for requesting providers to verify benefits and eligibility prior to a member's admission.

Univera Healthcare routinely conducts concurrent review in assessing inpatient admissions subject to the terms described below.

Procedures

Substance Use Treatment

The Insurance Law requires that level of need and appropriate level of care must be determined utilizing LOCATDR, the only tool designated/approved or approved, by OASAS, and policies applying ASAM, with modifications for consistency with LOCADTR for substance use partial hospitalization reviews.

Insurance Law provisions prohibit Plans from requiring preauthorization for inpatient SUD treatment with respect to participating facilities in New York that are certified by OASAS. Preauthorization is required for treatment received at all non-participating facilities and at participating facilities outside of New York. The requirement that a facility be certified by OASAS is consistent with coverage requirements in the Department of Financial Services (DFS) model subscriber contract language.

Further, concurrent review is not permitted during the first 28 days of the stay if the facility notifies the Plan of the admission, and the initial treatment plan is provided to the Plan within two business days of admission. If both notice and a treatment plan are not provided within this time period, Plans are permitted to conduct concurrent review immediately upon learning of the admission.

Facilities are required to provide daily oversight of the member's clinical condition. Upon discharge, the facility is required to give the member and the Plan a written discharge plan including arrangements for additional services needed following discharge.

Mental Health Treatment

It is recommended that facilities provide written or verbal notification of admission to mental health treatment facilities within two business days in order to verify eligibility, benefits, and to report that the member is receiving inpatient treatment. The facility may be required to include clinical information to the Plan to support the admission. See the *Contact List* in Section 2 of this manual for telephone numbers.

The UM reviewers will perform the initial review with the inpatient facility to determine if triggers are met and what approximate length of stay will initially be approved. UM reviewers assess services in accordance with nationally recognized criteria and corporate medical policies and do not automatically approve fixed lengths of stay at facilities.

Effective May 8, 2023, for inpatient mental health, mental health residential,mental health partial hospital, mental health intensive outpatient (IOP), or Assisted Outpatient Treatment (AOT) Safety Net only), the office of Mental Health is requiring the use InterQual Criteria. In addition, if the concurrent review information does not meet InterQual criteria, the Utilization reviewers are then required to review via our secondary corporate medical policy called, “Level of Care Criteria for Inpatient, Residential, Partial Hospital, and Intensive Outpatient Mental Health Services for Adults and Children“. If it still doesn’t meet the criteria, it will be sent to our Medical Director for review.

During the patient’s stay, a UM reviewer will concurrently review the member’s clinical presentation as often as deemed necessary. Following each review, Univera Healthcare will send a notice to the facility and the member indicating denial or approval of coverage of services, and the length of service approved.

If the UM reviewer concludes that the inpatient admission or hospital stay does not meet BH criteria, the reviewer will discuss the case with the Health Plan's BH medical director. The BH medical director will either make a determination based on the clinical information provided or arrange for a clinical discussion with the member's attending physician before a decision is made.

For members under age 18, coverage for the first 14 days of inpatient mental health will not be subject to concurrent review so long as the facility provides notice to the Plan of the admission *AND* the initial treatment plan is provided within two business days of admission.

Payment is based on the terms of the member's contract and the provider's participation agreement.

Inpatient Mental Health and Substance Use Residential Care

Mental Health Residential Treatment Facility: The facility must meet either (a) a "residential treatment facility for children and youth" as defined in Mental Hygiene Law 1.03(33), or (b) a facility that is part of a comprehensive care center for eating disorders identified in accordance with Public Health Law Article 27-J; and for out-of-state facilities, the facility must be licensed or certified in that state to provide the same level of treatment.

Substance Use Disorder Residential Treatment Facility: The facility must be OASAS-certified to provide services and for out-of-state facilities, the facility must be licensed by a similar state agency or Joint Commission accredited as an alcohol or substance use treatment program to provide the same level of treatment.

These facilities must:

a. Be a licensed or certified mental health or substance use facility with a seven day per week, 24-hour highly-structured therapeutic setting.

b. Be certified by the Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), The Joint Commission Accreditation, Health Care and Certification (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF) or equivalent licensing agency out of state.

c. Be congruent with New York State Department of Financial Services model language as the intensive level of residential care.

d. Provide documentation of the differences in programming/staffing and use the appropriate billing code for the level of care provided for facilities providing multiple levels of care.

e. Document a process showing appropriate medical clearance, safety planning for the arrival of the member, as well as robust engagement with the out-of-state family network, when these facilities encourage members to transfer treatment out of New York State.

f. All residential programs (including specialty residential programs) must demonstrate evidence-based therapeutic interventions for the primary diagnosis being treated.

g. Transitional, structured therapeutic environment that allows individuals to successfully reintegrate back home and into a lower level of care and is not considered a long-term substitute for lack of available living environment.

h. Follow InterQual® and the secondary corporate medical policy "Level of Care Criteria for Inpatient, Residential, Partial Hospital, and Intensive Outpatient Mental Health Services for Adults and Children" for mental health, and LOCADTR for substance use, to determine medical necessity and length of stay in residential programs (excluding Medicare). To be transparent, these following pathways will be adhered to. Providers may view the full clinical criteria of these pathways, which are posted on our website, Provider.UniveraHealthcare.com/policies/view.

Note: The following residential levels of care are not covered: group homes, residential reintegration, supportive housing, wilderness programs and school programs.

6.5 Utilization Clinical Review Management

The BH Utilization Clinical Reviewers are a clinical care team of behavioral health professionals that collaborates with the provider from the time of admission through the member's transition into outpatient care. Each level of care is based on given clinical information, nationally recognized criteria, such as Change Healthcare's Behavioral Health InterQual® Level of Care Criteria or corporate medical policies, as well as best practices for mental health to determine medical necessity.

Effective July 1, 2022, all requested inpatient mental health and substance use services for Medicare members will be reviewed for medical necessity based on Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).

Information regarding NCD and LCD criteria effective July 1, 2022 is available at Provider.UniveraHealthcare.com/policies/view.

For substance use services delivered to our Commercial, Child Health Plus Essential Plan (EP), Health and Recovery Plan (HARP) and Medicaid Managed Care members, Univera Healthcare uses its Corporate Medical Policies and the New York State LOCADTR tool or ASAM to determine medical necessity. This process results in establishing partnerships with the providers to promote continuity and coordination of care to maximize the effectiveness of the patient centered care.

In accordance with the Univera Healthcare Medical Advisory Committee, the utilization clinical reviewer provides pre-service, concurrent, and post-service review for mental health and substance use diagnoses in accordance with New York State Insurance Law and the Univera Healthcare policies. This process facilitates access to high quality, medically necessary, cost-effective BH services; ensuring members receive the highest standard of care in a timely and seamless manner, while assisting to fulfill the overall treatment needs for each individual member.

Univera Healthcare plans of care are the primary source for the utilization management process and the Health Plan complies with New York State Medicaid guidance, including managed care policy documents, relevant performance improvement specification documents or manuals and policies governing

preauthorization, concurrent or retrospective review. Specifically, Univera Healthcare incorporates the following resources into its utilization management process:

- OMH Clinic Standards of Care https://omh.ny.gov/omhweb/clinic_restructuring/default.html
- OASAS Clinical Guidance https://oasas.ny.gov/providers/clinical-support
- OCFS Working Together: Health Services for Children/Youth in Foster Care Manual https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf
- OHIP Principles for Medically Fragile Children (Attachment G) https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf

Retrospective Review Process

For services requiring preauthorization please visit our website:

- Provider.UniveraHealthcare.com/authorizations.

Step 1: Check the member's benefits & coverage for plan-specific preauthorization requirements.

Step 2: When a claim is submitted for a service that requires preauthorization and there is no preauthorization on file, clinical information will be requested to review for medical necessity for service.

Step 3: Clinical information requested for retrospective reviews are requested through the Medical Records Unit. A letter is sent to the provider requesting clinical information needed to complete the medical necessity review for services rendered. A letter is also sent to the member indicating clinical information requested from the provider billing services. Verbal notification is also made to the member.

Step 4: Once clinical is received the Behavioral Health utilization management staff will review the clinical information for medical necessity. Based on the service requested; the request will be reviewed with appropriate criteria (e.g., InterQual, LOCADTR, ASAM, NYS Guidelines, NCD, LCD, corporate medical policies).

Step 5: Once the medical necessity review is completed, the provider and member will receive written notification of determination based on utilization management time frames.

The Case Management Program

Our Integrated Case Management program is designed to holistically support members throughout their journey to health and deliver quality care at the lowest cost. The care continuum approach includes integrated clinical case management licensed physical health and behavioral health clinicians, non-clinical administrative support, and enterprise functions that influence the member experience. The objective is to positively influence each member's health literacy, address social determinants of health, barriers to care, and support our members to be autonomous on their health care journey. We identify member's needs (physical, behavioral/emotional/mental, social determinants of health, financial, occupational), stratify according to risk, outreach to engage members, educate and assist members', self-management of health condition(s). Services promote healthy behaviors and adherence to medications and treatment plans impacting health condition(s) including, but not limited to, Diabetes, Heart Failure, Chronic Obstructive

Pulmonary Disease, Asthma, Depression/Anxiety, Substance Use, Pregnancy, and others as warranted. The multifaceted approach aims to keep members healthy with preventative outreach along with identifying those with emerging risk, multiple chronic conditions, and complex/catastrophic illnesses.

Univera Healthcare utilizes telephonic, written communication, and a digital health management Mobile App to communicate with our members. At initial contact, a comprehensive assessment is completed telephonically for all members who agree to participate in the case management program. The care plan is developed in conjunction with the member/caregiver/authorized representative or guardian, authorized family members, and other members of the care team such as Health Homes. The case manager assures all parties agree with the care plan, including member self-management plans, to ensure successful implementation. Once a member agrees to participate in the program, the member receives support based on his/her/their individual needs and preferred communication methods.

The Mobile App is available to our members, a HIPAA compliant platform which allows for two-way asynchronized texting between members and their care team, accessible via smart devices. The member is provided an interactive and personalized care program with the ability to engage in daily health checklists, review educational content, and record health status. Case Managers can create personalized health improvement plans, send daily tips and reminders to provide customized support for a member's personal health journey, and provide real-time support when needed most.

There are a variety of educational programs members can participate in to assist with their specific condition(s).

For more information call our Case Management Team at 1-877-222-1240 between 8 a.m. and 5 p.m. EST or email case.management@univerahealthcare.com.

Emergency Behavioral Health Calls

When a Univera Healthcare member calls Customer Care with an emergency Behavioral Health issue, the member will be connected to a qualified clinician by a Customer Care advocate. When the Customer Care advocate receives a call identified as potential crisis, or that could escalate into a crisis, the caller will be warm transferred to a qualified clinician, who will assess the nature of the member's needs and will either call 911 or available mobile crisis unit, refer the member for services, refer the member to their health care provider, or resolve the crisis over the telephone as appropriate. These calls are being managed by a third-party vendor and will be referred back to Univera Healthcare's clinical case managers who will coordinate any appropriate follow-up with the member.

The Behavioral Health Advocate

A Behavioral Health Advocate is available to assist members/member advocates or providers, that have received a denial of services. The advocate can assist with understanding clinical criteria, obtaining the clinical criteria, filing an appeal or grievance for the denied service, and/or locating a participating provider. To talk to the Behavioral Health Advocate, please call 1-844-809-7518 (for all Commercial and Medicare products, and the Federal Employee Program) and 1-844-635-2662 (for Child Health Plus, Essential Plan (EP), Health and Recovery Plan (HARP) and Medicaid Managed Care products).

6.6 Quality Standards and Measures

Clinical Practice Guidelines

The Health Care Quality Programs Oversight Committee (HC QPOC) is responsible for the adoption and revision of clinical practice guidelines. All guidelines are reviewed and approved by the Quality Program Oversight Committee. Univera Healthcare researches the adoption of clinical practice guidelines for the provision of BH services as relevant to the populations served based on volume and the member's experience. Guidelines include information for the identification and referral of members with behavioral health conditions to ensure that members receive care in settings where they are most likely to present.

The Health Care Quality Program Oversight Committee (HC QPOC) is responsible for the adoption and revision of clinical practice guidelines. All guidelines are reviewed and approved by the Quality Program Oversight Committee upon significant new scientific evidence, change in national standards or at a minimum, every two years.

Univera Healthcare disseminates approved clinical practice guidelines to the practitioner network and enrollees in a timely manner through a variety of channels, which may include, however is not limited to, mail, email, fax, provider manual, provider newsletter, Univera Healthcare website and upon individual request. Upon revision of an established guideline, Univera Healthcare ensures appropriate communication of updates through the same distribution channels.

Univera Healthcare ensures that the adoption and revision process is consistent with and supports the utilization management authorization and approval process for all medical necessity services.

Clinical practice guidelines may include, but are not limited to:

- ADHD
- Depression
- Schizophrenia
- Bipolar disorder
- Substance use disorder
- Anxiety
- Trauma informed care
- Assertive community treatment
- Illness management and recovery
- Integrated dual disorder treatment for co-occurring disorders
- Supported employment
- Family psychoeducation
- Tobacco cessation
- Office of Mental Health first episode psychosis practice guidelines
- Seeking safety
- Motivational enhancement therapy
- Twelve-step facilitation
- Cognitive behavioral therapy for substance use disorder
- Screening, brief intervention, and referral to treatment
- Medication-assisted treatment for substance use disorder

Behavioral Health Appointment Availability Standards

The following tables present access standards for services provided by all BH practitioners and providers participating with Univera Healthcare. These standards are used by Univera Healthcare for quality and regulatory purposes as required by applicable governing entities (e.g., the New York State Department of Health and the National Committee for Quality Assurance).

BH Appointment Availability Standards: Commercial, Medicare, Child Health Plus, Essential Plan (EP), Health and Recovery Plan (HARP) and Managed Medicaid Care

Access Measure	Standards	Managed Care Organization Measurement Tool
Timeliness of initial routine BH care appointments	Should be available within 10 business days.	BH Member Experience Survey including Consumer Assessment of Healthcare Providers and Systems, and complaint analysis
Timeliness of BH urgent care appointments	Should be available within 24 hours.	BH Member Experience Survey including Consumer Assessment of Healthcare Providers and Systems, and complaint analysis
Timeliness of BH emergency care	In *life-threatening* emergencies, a BH specialist should be accessible immediately by telephone, 24 hours a day, 7 days a week. In *non-life-threatening* emergencies, a BH specialist should be accessible within 6 hours.	Random sample of BH private, participating, practitioners After-hours Secret Shopper Audit, and BH Member Experience Survey, and Complaint analysis
Timeliness of behavioral health follow-up routine care	Should be available within 7 calendar days or 5 business days following a MH or substance use disorder inpatient discharge.	BH Member Experience Survey including Consumer Assessment of Healthcare Providers and Systems, Random Sample of BH facilities Secret Shopper Audit, and complaint analysis

Additional BH Appointment Availability Standards: Medicaid Managed Care and HARP

Service	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
Mental Health Outpatient Clinic		Within 24 hours of request	Within one week		Within five days of request	Within five days of request
ACT (18 and older)		Within 24 hours of request			Within five days of request	

Service	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
PROS (18 and older)		Within 24 hours of request	Within one week	Within two weeks	Within five days of request	Within five days of request
Continuing Day Treatment (18 and older)			Two to four weeks	Two to four weeks	Within five days of request	Within five days of request
Intensive Psychiatric Rehabilitation Treatment (IPRT)			Two to four weeks		Within 24 hours	
Partial Hospitalization					Within five days of request	
Inpatient Psychiatric Services	Upon presentation				Within five days of request	Within five days of request
CPEP	Upon presentation					
Behavioral Health Services- Substance Use/Addiction Crisis Services						
Inpatient Addiction Treatment Services (hospital or community based)	Upon Presentation	Within 24 hours			Within five days of request	Within five days of request
Medically Managed Withdrawal Management	Upon presentation					
Medically supervised withdrawal (Inpatient/Outpatient)	Upon presentation					
Residential Addiction Services Stabilization in Residential Setting		Within 24 hours of request	Within one week	Two to four weeks	Within five days of request	Within five days of request
Residential Addiction Services Rehabilitation in Residential Setting		Within 24 hours of request	Within one week	Two to four weeks	Within five days of request	Within five days of request
Outpatient Addiction Treatment Services/ Intensive Outpatient Treatment (IOP)		Within 24 hours of request	Within two to four weeks		Within five days of request	Within five days of request
Outpatient Rehabilitation Services		Within 24 hours of request	Within one week		Within five days of request	Within five days of request

Service	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
Outpatient Withdrawal Management		Within 24 hours of request	Within one week		Within five days of request	Within five days of request
Medication Assisted Treatment (MAT)		Within 24 hours of request	Within one week		Within five days of request	Within five days of request
Opioid Treatment Program (OTP)		Within 24 hours of request	Within one week		Within five days of request	Within five days of request
Behavioral Health Services						
Accessibility Modifications (Children)		Within 24 hours	Within two weeks		Within 24 hours	Within 24 hours
Adaptive and Assistive Equipment (Children)		Within 24 hours	Within two weeks		Within 24 hours	Within 24 hours
Caregiver/Family Supports and Services (Children)			Within five business days		Within five business days	Within five business days
Community Mental Health Services (599 clinic services offered in the community- adult)		Within 24 hours of request	Within one week		Within five days of request	Within five days of request
Community Self-Advocacy Training and Support (Children)			Within five business days			Within five business days
CPST, Habilitation, Family Support and Training, and Psychosocial Rehabilitation (adult)			Within 2 weeks		Within five days of request	Within five days of request
CPST (Children)		Within 24 hours (for intensive in-home and crisis response services under definition)	Within one week		Within 72 hours of discharge	Within 72 hours
Crisis Intervention (Children)	Within one hour				Within 24 hours of Mobile Crisis Intervention response	

Service	Emergency	Urgent	Non-urgent MH/SUD	BH Specialist	Follow-up to Emergency or Hospital Discharge	Follow-up to Jail/Prison Discharge
Crisis Intervention (Adult)	Upon presentation	Within 24 hours for short-term respite			Immediate	
Crisis Respite (Children)	Within 24 hours	Within 24 hours			Within 24 hours	
Educational and Employment Support Services (Adult)			Within two weeks			
Family Peer Support Services (Children)		Within 24 hours	Within one week		Within 72 hours	Within 72 hours
Habilitation (Children)			Within two weeks			
OLP-Other Licensed Practitioner – provides individual, group, and family therapy in the home or in the community		Within 24 hours	Within one week		Within 72 hours	Within 72 hours
Palliative Care (Children)			Within two weeks		Within 24 hours	
Peer Supports		Within 24 hours	Within one week		Within five days	
Planned Respite (Children)			Within one week		Within one week	
Prevocational Services (Children)			Within two weeks			Within two weeks
PSR (Children)		Within 72 hours	Within five days		Within 72 hours	Within 72 hours
Short Term and Intensive Crisis Respite (Adults)	Immediate	Within 24 hours			Immediate	
Youth Peer Support and Training (Children)			Within one week		Within 72 hours	Within 72 hours

After-hours Coverage

BH providers are required to provide necessary telephonic services to members 24-hour-per-day, seven-day-per-week basis in case of telephone calls from established patients or patients' family members concerning clinical mental health life-threatening emergencies. This is critical for coordinating care when a member has presented to the emergency room with an urgent/emergent or life-threatening crisis. Providers must also arrange for complete backup coverage with other participating clinician(s) that can provide the same level of care in the event the practitioner is unable to provide covered services to established patients.

Univera Healthcare members must be able to:

- Reach the practitioner or a person with the ability to patch the call through to the practitioner (i.e., answering service, pager); or
- Reach an answering machine or voice mail with instructions on how to contact the practitioner or their backup (i.e., message with number for home, cell phone or pager) in case of a clinical urgent/emergent situation. Call forwarding may also be used, but the message must state that the call is being forwarded to the practitioner's contact number.

The practitioner's answering machine message is automatically forwarded to a phone (i.e., practitioner's cell phone, pager) where the practitioner retrieves and responds to those messages for life-threatening emergencies, after-hours, as soon as possible.

Unacceptable answering for members when contacting their provider's office after-hours includes:

1. Reaching an answering machine that instructs the active member to go to the nearest emergency room, crisis center hotline, lifeline and/or call 911, for all services including non-life-threatening.
2. Reaching an answering machine with no instructions.
3. Reaching an answering machine recommending the member call during business hours.
4. No answer.
5. A busy signal three times, within 30 minutes.

To promote quality service to our membership, in conjunction with the delivery systems, Univera Healthcare monitors for compliance with this access standard. This standard is relevant to all lines of business.

Failure to comply with the accessibility guidelines constitutes a material breach of the provider's participating provider agreement and may be cause for termination from the provider panel. Additionally, the New York Education Department Office of Professions and Code of Ethics for each discipline must support the after-hours accessibility guidelines for active members with a life-threatening emergency.

Continuity and Coordination of Care

Univera Healthcare collaborates with behavioral health care practitioners to monitor and improve coordination between medical care and behavioral healthcare. Continuity of care is concerned with quality of care over time. The intent is twofold:

- Member-centric, seamless access to continuous integration of health care services and their person perspective.
- Provider perspective related to models of health care delivery and improve patient outcomes.

Key to both medical and behavioral health transitions of care is linkages and partnership for an integrated approach to health care. In addition, Univera Healthcare collaborates with behavioral health care practitioners, primary care providers, pharmacies, health care facilities and ancillary providers at its disposal to coordinate and promote continuity of healthcare.

The organization annually collects data about opportunities for collaboration between medical care and behavioral health care in the following areas:

1. Exchange of information
2. Appropriate diagnosis, treatment, and referral
3. Psychopharmacological medication
4. Access and follow up of coexisting medical and BH disorders
5. Primary or secondary preventive behavioral healthcare program implementation
6. Special needs of members with severe and persistent mental illness

Univera Healthcare measures three critical components annually for continuity and coordination of care. (These HEDIS measures apply to Univera Healthcare members enrolled: Commercial, Essential Plan, Marketplace/Exchange, Medicare, Medicaid Managed Care and HARP.

They align with the previously listed six areas for collaboration between medical and BH care and are HEDIS measures, including:

A. **Follow-Up After Hospitalization for Mental Illness (FUH)** is the first critical component of continuity and coordination of care for Univera Healthcare members. Upon discharge from an inpatient psychiatric admission, Univera Healthcare requires the member to have an outpatient mental health appointment within seven days and within thirty days of discharge, according to the New York State Department of Health (NYSDOH), and the Health Effectiveness Data and Information Set (HEDIS). Failure to adhere to this time frame may lead to readmission or emergency room visit(s). The HEDIS measures are supported by the NYSDOH, establishing the following guidelines and recommendations.

Note the following:

- A tour or orientation, in lieu of an initial mental health outpatient appointment, after a mental health hospitalization is not considered acceptable as a follow-up appointment, according to NYSDOH and national quality standards.
- When billing for a member who begins a partial hospitalization program (PHP) the same day as a mental health hospitalization discharge, it should be billed as an outpatient PHP visit.

Inpatient mental health provider responsibilities:

- Begin discharge planning upon admission.
- Validate that the member has an initial mental health follow-up appointment within seven calendar days or five business days from the date of discharge of their mental health hospitalization.
- Fax the discharge plan to the member's primary care physician and outpatient mental health practitioner/clinic.
- Ensure that the member has a copy of the discharge plan, agrees with and understands the plan.
- Confirm, prior to discharge, that the member has the necessary resources to get to their initial follow-up appointment.
- Connect the member to a Univera Healthcare BH care manager as needed.
- Certify that the member's initial follow-up appointment is for mental health therapy and/or mental health medication management with a mental health practitioner (i.e., LCSW, psychologist or psychiatrist).
- Do not bill for a hospital day if the member is discharged that same day to PHP.

Outpatient mental health clinics, facilities, or private practitioner's responsibilities:

- Ensure that the progress notes include the date, time, patient's name, date of birth, medical record number and clinician's name and credentials.
- Expect a Univera Healthcare BH staff member to call to confirm whether the member has attended their initial follow-up appointment.
- HIPAA permits use or disclosure of PHI between payers and providers without authorization for mental health information.
- Encourage the member to reschedule any cancelled initial follow-up appointments to be within seven calendar days or five business days from discharge.
- It is important to emphasize that care should be coordinated between all medical and mental health practitioners.

Follow-Up After Hospitalization for Substance Use (FUI) Upon discharge from an inpatient substance use rehabilitation facility or residential treatment, this HEDIS measure requires the member to have an outpatient substance use appointment within seven days of discharge, according to the New York State Department of Health (NYSDOH), and the Health Effectiveness Data and Information Set (HEDIS). Failure to adhere to this time frame may lead to readmission or emergency room visit(s).

B. **Antidepressant Medication Management (AMM)** is the second critical component. This measure looks at those members 18 years of age and older with a diagnosis of major depression that were newly treated with an antidepressant medication, and who remained on medication treatment for the following phases on the HEDIS reports:

   i. Effective Acute Phase Treatment – Those members newly diagnosed and treated, who remained on an antidepressant medication for at least 84 days (12 weeks).

   ii. Effective Continuation Phase Treatment – Those members newly diagnosed and treated, who remained on an antidepressant medication for at least 180 days (six months).

C. **The four Schizophrenia and/or Bipolar HEDIS measures** are the third critical components. According to HEDIS, which is supported and maintained by the National Committee for Quality Assurance (NCQA), patients dispensed an antipsychotic are significantly more likely to have a higher incidence of the illnesses listed below, as compared to those people not taking an antipsychotic:

- Diabetes
- Cardiovascular concerns
- Higher level of blood cholesterol

HEDIS measures targeting individuals with schizophrenia and/or bipolar include:

- **Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD).** Members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- **Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).** Members 18-64 years of age with schizophrenia and diabetes, who had both an LDL-C test and an HbA1c test during the measurement year.
- **Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC).** Members 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
- **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*.** Members 18 years of age and older during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

The HEDIS measures listed below provide an opportunity for medical and behavioral health providers to collaborate on improving care coordination for members.

Follow-Up Care for Children Prescribed ADHD Medication (ADD) Participating providers with children of newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication are recommended to have at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

i. Initiation Phase: Members who are 6-12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, which had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

ii. Continuation and Maintenance (C & M) Phase. Members who are 6-12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days after the Initiation Phase.

Initiation and Engagement of Substance Use Disorder (IET). The measure is for clients who have a new episode of substance use disorder (SUD) who received the following:

i. Initiation of SUD Treatment: The percentage of members who initiate treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth visit within 14 days.

ii. Engagement of SUD Treatment: The percentage of SUD episodes that have evidence of treatment within 34 days of initiation.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) This measure is for children and adolescents between 1 – 17 years of age, who had been on two or more antipsychotic prescriptions and had metabolic testing.

HEDIS Measures reflecting transition of behavioral health care:

Follow-Up After Emergency Department Visit for Mental Illness (FUM)- This measure is for members who are six (6) years of age and older who had an emergency room visit, with a principal diagnosis of mental health. The following two rates reported:

i. The percent of ED visits for which the member received follow-up within 30 days of the ED visit,

ii. The percentage of ED visits for which the member received follow-up within five (5) days of the ED visit.

Follow-Up After Emergency Department Visit for Substance Use (FUA). This measure is for members who are 13 years of age and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose who had a follow up visit. The following two rates are reported:

i. The percent of ED visits for which the member received follow-up within 30 days of the ED visit,

ii. The percentage of ED visits for which the member received follow-up within five (5) days of the ED visit.

Resources

Recommendations: Collaboration and communication between a BH practitioner, PCP and other appropriate treatment providers best practice guidelines include:

- Formulation of initial assessment with behavioral health diagnosis.
- Treatment plan including pharmacological management and other behavioral health modalities.
- Documentation should also be contained within the member's chart with notation of method and content of collaboration with other treatment providers, including medical and behavioral health providers.
- Patient consent for release to other treatment providers, agencies, and Regional Health Information Organizations per New York State Department of Health regulations. Specific diagnoses under the NYS DOH protected diagnosis law requires written consent outlying release of protected diagnosis, timeframe for allowed release and all parties involved in such content.
- Inter-agency release pertaining to Health Homes and Substance Use require a specific type of consent form for NYS DOH protected diagnosis.

HEDIS Measure

- Information regarding HEDIS measures, please go to www.NCQA.org.
- Please contact our Provider Relations team at UniveraPR@univerahealthcare.com for specific questions targeting:
    - Behavioral health quality standards
    - Continuity and coordination of behavioral health and medical services
    - Quality measurements from the above section

Integrated Case Management including behavioral health

- To connect the Univera Healthcare member to a Univera Healthcare BH Case Manager:
  - 1-844-694-6411 (for Commercial, Child Health Plus, Essential Plan (EP), Health and Recovery Plan (HARP) and Medicaid Managed Care products)
  - Monday through Friday from 8 a.m. to 5 p.m.

Evidence-Based Assessment Resources and Tools

Behavioral Health (Mental Health & Substance Use)

The following tools and resources are available on the website at:
Provider.UniveraHealthcare.com/resources/behavioral-health/tools-resources

Alcohol Assessments

- CAGE Questionnaire
- CRAFFT Questionnaire

Substance Use Disorders

- Addiction and Misuse
- Addiction and Misuse - Opioid Risk Tool
- National Alcoholism and Substance use Information Center
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health approach for early intervention
- Clinical Opiate Withdrawal Scale (COWS)

Depression Screening Tool

- PHQ-9 Spanish
- PHQ-9 English
- PHQ-9 Scoring Tool

Eating Disorders

- Eating Disorders Screening Tool
- BMI Chart - Girls - age 2 to 20 (National Center for Health Statistics)
- BMI Chart - Boys - age 2 to 20 (National Center for Health Statistics)

Mental Health

- Substance use and Mental Health Services Administration
  - Substance use and Mental Health Services Administration (SAMHSA) Suicide Assessment Five-step Evaluation and Triage (SAFE-T) app and pocket care for clinicians.
- ADHD Guideline
  - Adopted from the American Academy of Pediatrics December 2015.
- Depression Guideline Adults in Primary Care
  - Adopted the Institute for Clinical Systems Improvement, Inc. (ICSI) Health Care Guideline "Adult Depression in Primary Care Sixteenth Edition September 2013" Guideline reviewed April 2016.

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Section 7: Billing and Remittance

This section describes billing and reimbursement policies and procedures that apply to benefit packages offered by Univera Healthcare. It includes instructions for submitting claims to Univera Healthcare, either electronically or on paper.

Revised September 2024

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7.1 Electronic Submission of Claims Required

In 1994, New York State enacted Public Health Law Section 2807-e(4) requiring hospitals, outpatient clinics and physicians to submit health care claims to third-party payors electronically, using electronic formats designated by the New York State Department of Health. These formats have since been replaced by federally required formats (see below). However, the requirement to submit electronically still exists. Physicians who annually submit fewer than 1,200 claims to third party payors for direct payment were exempted from this requirement, but only upon obtaining a waiver from the Department of Health.

The federal Health Insurance Portability and Accountability Act (HIPAA) also includes provisions affecting claims submissions. While HIPAA does not require providers to submit claims electronically, it requires all providers who submit claims electronically to do so using national HIPAA claims formats and standards.

All hospitals, outpatient clinics and physicians in New York *who have not obtained a waiver* from the Department of Health must submit claims to payors electronically, using HIPAA claims formats and standards. In addition, any other provider who submits claims electronically must do so using HIPAA-compliant electronic formats. See paragraphs under heading *How to Submit Electronic Claims* for more information about submitting claims electronically.

7.2 General Requirements for Claims Submissions

- Claims must be completed accurately and in full, in accordance with the instructions presented in this manual (see subsequent paragraphs). Univera Healthcare cannot pay claims that are inaccurate or incomplete.
- Procedures must be identified by Current Procedural Terminology (CPT-4)[1], HCPCS or ICD-PCS codes. Diagnoses must be identified by ICDCM[2] diagnosis codes.

[1]The AMA is the owner of all copyright, trademark and other rights to CPT and its updates. AMA reserves all rights.

[2]ICD-CM refers to the clinical modification (CM) of the most recent revision of the *International Classification of Diseases,* a book that lists diagnosis codes according to a system assigned by the World Health Organization of the United Nations. The ICD is distributed by the U.S. Printing Office in Washington, DC, and by commercial publishers.

Note: CPT, ICD-CM, ICD-PCS, and HCPCS codes are revised at various times of the year by the organizations responsible for them, the Centers for Medicare & Medicaid Services (CMS) and/or the American Medical Association (AMA). Univera Healthcare accepts these codes as implementation dates are designated by these organizations.

- Place of service (POS) must be identified using the codes established by CMS. These codes apply to paper submittals of professional claims. Valid place of service codes for electronic submittals are included in providers' implementation guides for HIPAA-compliant electronic transactions. Visit the CMS website at:

  www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
- Procedures and diagnoses should be coded to the highest degree of specificity: for example, include 4th through 7th digits on ICD-CM codes when applicable.

- Claims with referral or prior authorization requirements must include the authorization number.
- Facility billers must include a revenue code to identify services rendered.
- All required supporting material must be made available to Univera Healthcare upon request.
- **Claims submitted to all payors, including Medicare, must include an NPI to identify each provider for which data is reported on the claim.** Univera Healthcare cannot accept any claims that do not include an NPI.
- Taxonomy codes are required on all claim submissions. Claims submitted without taxonomy codes will be returned. Providers may have multiple taxonomy codes and should only include the taxonomy code that applies to the services performed and reported on the claim submission.
- Patient consent is required for behavioral health providers. See Section 6 for additional details.
- For Dual Special Needs Plan (D-SNP) members, claims for drugs must include the National Drug Code (NDC) assigned by the U.S. Food and Drug Administration. Drug claims that do not contain the NDC will be rejected.

Timely and Accurate Filing

Univera Healthcare requires that participating providers submit claims in a timely manner.

- Participating providers should submit all claims as soon as possible after rendering service (or after the processed date of a primary payor's explanation of benefits, or EOB). Most participating provider agreements contain a time limit within which claims will be accepted. Claims submitted after that time limit may be denied for late filing. ***Providers should review their participating provider agreements for these time limits.*** In the event of a declared pandemic, Univera Healthcare may extend the time limit.
- Univera Healthcare will reject claims with incorrect or incomplete entries in required fields outlined in later paragraphs regarding submittal of electronic claims and paper claims. For example, Univera Healthcare will reject all claims submitted without member ID numbers.

Accurate and Complete ICD-CM Diagnosis & ICD-PCS Procedure Coding

So that claims may process appropriately, it is important that submitters enter accurate and complete ICD-CM diagnosis and ICD-PCS procedure codes on all claims. Univera Healthcare encourages participating providers to follow the *Tips for Accurate and Complete Diagnosis Coding guidelines* available on our website, Provider.UniveraHealthcare.com/claims-payments.

Using Modifiers

Univera Healthcare requires providers to use appropriate modifiers applicable to CPT codes and HCPCS codes when submitting claims. Using the right modifier may affect how the claim is paid.

There are certain instances where use of modifiers 25 or 59 is not appropriate. Univera Healthcare has established guidelines for these circumstances. The guidelines are available on the website (see below) or from Customer Care.

- Provider.UniveraHealthcare.com/claims/submissions/procedure-code-modifiers

Complete information about CPT codes and their modifiers is found in the most current issue of the American Medical Association (AMA) manual on current procedural terminology (CPT). Complete information about HCPCS (Health Care Procedure Coding System) codes and their modifiers is available through the website, cms.gov/MedHCPCSGenInfo/, or from various publications about the codes.

Additional References to Support Accurate Claims Submission

In addition to this manual, providers should refer to the following materials for information regarding claims submission.

- ***Participating Provider Agreement.*** The Participating Provider Agreement describes the provider's rights and obligations with respect to claims submission to Univera Healthcare. This manual is intended to clarify provisions of the Agreement. *In the event of a conflict between the provisions of this manual and a Participating Provider Agreement, the Agreement supersedes this manual.*
- ***Current Procedural Terminology (CPT).*** CPT code books list descriptive terms and identifying CPT codes for reporting medical services and procedures performed by providers. Univera Healthcare requires the use of these codes on claims. CPT codes and all CPT materials are under copyright by the American Medical Association.
- ***International Classification of Diseases, Procedure Coding System (current version).*** ICD-PCS is a classification system that arranges procedures into groups according to established criteria. ICD-PCS codes are required for reporting procedures to all CMS programs. Univera Healthcare also requires the use of these codes.
- ***International Classification of Diseases, Clinical Modifications (current version).*** ICD-CM is a classification system that arranges diseases and injuries into groups according to established criteria. ICD-CM codes are required for reporting diagnoses and diseases to all CMS programs. Univera Healthcare also requires the use of these codes.
- ***HCPCS Level II National Codes.*** HCPCS is the acronym for the HCFA (CMS) Common Procedure Coding System. This system is a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies. Univera Healthcare requires use of HCPCS codes and associated modifiers for certain kinds of claims.
- ***InterQual® Criteria.*** InterQual Criteria are guidelines for screening the appropriateness of medical and behavioral health interventions and levels of care. The criteria are the property of Change

Healthcare. Change Healthcare owns the copyright. Univera Healthcare uses InterQual guidelines in evaluating inpatient appropriateness of care and for some outpatient services.

- ***CMS Website.*** The CMS website is an extensive resource for forms, information and training materials associated with claims submission. The Web address is https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html.

Claims for Sterilization or Hysterectomy – Government Programs

When submitting a claim for sterilization or hysterectomy procedure performed on a member in Medicaid Managed Care, the performing provider must retain a copy of the completed *Sterilization Consent Form* or *Acknowledgement of Receipt of Hysterectomy Information* form. **New York State requires the retention of this record type for 10 years after the date of service pursuant to Section 19.4(a) of the MMC Model Contract**. As a participating provider with Univera Healthcare, it must be maintained on our behalf. **Univera Healthcare will conduct post payment audits against** any filed claims for sterilization or hysterectomy services. Providers will be expected to produce a copy of the form at that time. Failure to produce the form will result in a retraction of payment **per New York State requirements.** See specific information regarding the procedures, where to get forms, and the time frames for submittal in the *Government Programs* section of this manual.

Vaccines for Children Claims

All providers administering vaccines to children under age 19 covered by Univera Healthcare MyHealth℠ or Child Health Plus must participate in the New York Vaccines for Children (NYVFC) program. NYVFC provides the vaccines to the physician free of charge. For more information about VFC and how to get vaccines, providers should call VFC directly. The eligible vaccines are listed on the CDC website. (The telephone number for NYVFC and the website for the CDC VFC program are included on the *Contact List* in this manual).

While Univera Healthcare will reimburse for administration of the vaccines for Univera Healthcare MyHealth℠ or Child Health Plus, claim history is needed for quality measures and compliance reporting to the Department of Health. Therefore, in addition to billing for vaccine administration, providers should also submit vaccine codes for quality reporting indicators for childhood immunization. Only vaccines that are listed on the state's immunization schedule are included in the VFC program.

VFC applies only to children with Univera Healthcare MyHealth℠ or Child Health Plus coverage.

7.3 How to Submit Electronic Claims

Univera Healthcare accepts electronic claims through a clearinghouse. For information about how to submit electronic claims, including information about HIPAA claims formats and standards, email EDI.Solutions@univerahealthcare.com.

Filing Tips

- To support accurate and prompt claims processing, providers must use the correct Payor Identification Number (Payor ID) when submitting claims electronically.
- All required fields must be populated. If any required field has no entry, the clearinghouse will reject the claim.
- Use valid codes in fields such as those defining relationship, sex and place of service. If the code entered does not match the type of service being billed, the claim may pend and require manual intervention to be processed.
- Claims submitted to all payors, including Medicare, must include an NPI to identify each provider for which data is reported on the claim.

Response Reports

Following submission of electronic claims, the provider will receive three reports:

- **Clearinghouse Acknowledgment Report.** This report indicates whether the transmission was successful.
- **Clearinghouse Response Report.** This report validates claims and lists both accepted and rejected claims.
- **Payor Response Reports.** These reports will be available within 24 to 48 hours after submission. The reports will show both accepted and rejected claims.

Providers must review these reports, identify those claims that were rejected and correct the errors and resubmit the claims, *if appropriate.*

A provider should not consider that the clearinghouse has accepted an electronic claim until they have received all three reports, and the Payor Response Report shows that the claim was not rejected. Providers are encouraged to keep copies of these reports to help verify claims submission.

Secondary Claims

The clearinghouse can accept secondary claims that are submitted electronically, including those where Medicare is primary. See the paragraphs *Payment and Other Party Liability (OPL)* under the heading *Coordination of Benefits* for a list of what must be included in the claim in order for Univera Healthcare to process a claim for which it is secondary payor.

Use Correct Payor ID Number

To support accurate and prompt claims processing, providers must use the correct Payor Identification Number (Payor ID) when submitting claims electronically. The Payor ID to be used on all Univera Healthcare claims is '**UNINW**'.

7.4 How to Submit Paper Claims

There are two types of paper claim formats:

- CMS-1500 for most professional services
- UB-04 (CMS-1450) for hospital and other facility services

As stated earlier, all hospitals, outpatient clinics and physicians in New York *who have not obtained a waiver* must submit claims to payors electronically, using HIPAA claims formats and standards. See preceding information about electronic claims submission. In addition, the requirements related to the national provider identifier (NPI) apply to paper claims as well.

Providers that submit on paper must do so according to the general requirements listed below under the heading *General Paper Claim Requirements.*

As stated in those requirements, claims submitted to all payors, including Medicare, must include an NPI to identify each provider for which data is reported on the claim.

Paper Claim Requirements

Univera Healthcare uses Optical Character Recognition (OCR) technology to read most paper claims. The following are important points to observe so that a paper claim may be processed using OCR rather than manually. Following these guidelines, helps ensure timely processing.

- Use original forms that are printed in red. Do not use photocopies.
- Do not use red ink to fill in data field or attachment information. OCR equipment does not recognize red ink.
- Entries should be typed and dark enough to be legible. Change the printer toner cartridge regularly.
- So that information prints in the appropriate field, forms should be properly aligned prior to printing.

- When submitting multi-page claims, submitters must ensure that the Tax ID, NPI, Patient ID and patient account number are reproduced and consistent on all pages.
- Use these guidelines when including attachments, such as medical records or primary payor information.
- Submit paper claims to the claims address specified on the *Contact List* in this manual.

For more information about accurate submission of paper claims, contact Customer Care.

Professional Services

The CMS-1500 form entitled *Health Insurance Claim Form*, was designed for use by non-institutional providers and suppliers.

Univera Healthcare follows New York State Insurance Department claim submission guidelines in determining what constitutes a complete, or "clean," claim, unless stated otherwise in a provider's participating provider agreement. See *Clean Claim Guidelines* below.

New York State Clean Claim Submission Guidelines for CMS-1500

In addition to the NPI requirements, the New York State Insurance Department has issued *claim submission guidelines* (Regulation No. 178, 11 NYCRR 230.1) to interpret the prompt pay law. The guidelines specify that:

- A health insurer cannot reject a claim submitted on a CMS-1500 claim form as incomplete if the claim contains accurate responses in specified fields, unless otherwise specified.
- In situations where one or more of the required fields is not appropriate to a specific claim, the submitter may leave the field blank.

Additionally, the guidelines state that Univera Healthcare may request additional information other than that on the claim form if it needs this information to determine liability or make payment. In other words, depending on the service being billed, **there may be other fields that Univera Healthcare requires for processing**. Further, Univera Healthcare is not prohibited from determining that a claim is not payable for other reasons.

Hospital and Other Facility Services

CMS-1450, the UB-04 uniform billing form, is most commonly used by hospitals, skilled nursing facilities, home health agencies and other selected providers to submit health care claims on paper.

Providers that submit on paper using the UB-04 must do so according to the general requirements listed above under the heading *Paper Claim Requirements*.

Univera Healthcare's requirements for the completion and submission of the UB-04 claim form are, for the most part, consistent with Medicare, Medicaid, and other major payors.

To support accurate completion of UB-04 forms, providers should refer to the following:

- The contractual arrangements between Univera Healthcare and the provider as described in the participating provider agreement.
- CMS requirements as specified in the instructions for form CMS 1450 can be found on the CMS website, https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html.
- The chart, *UB-04 Field Descriptions*, at the end of this section of the manual.

  Effective January 1, 2021, Univera Healthcare requires CPT/HCPCS codes to be included with most revenue codes billed on a Form UB-04 type of bill 013X. The full list of revenue codes is available on our website (see below). This requirement aligns with all national billing coding guidelines. A blank CPT/HCPCS code field submitted with one of these revenue codes will result in a claim rejection.

  - Provider.UniveraHealthcare.com/claims/submissions/revenue-codes

Submitting Claims for Mid-Level Practitioners

When submitting claims to Univera Healthcare, mid-level practitioners — i.e., Nurse Practitioners (NPs), Physician Assistants (PAs) Certified Registered Nurse Anesthetists (CRNAs) — should follow the billing guidelines below:

- **Billing as "Rendering Provider" (not incident to):** When billing mid-level practitioner services as rendering provider, the rendering provider information should be indicated in field 24 on the CMS Form 1500 paper claim. The supervising (or billing) provider's NPI should be indicated in field 33a on the CMS Form 1500 paper claim.

  For the ANSI 837 electronic claim, supervising provider information should be indicated in loop 2310D and the supervising provider's NPI would be indicated in loop 2310D, segment NM1.09. The billing provider information should be the same as the supervising provider/group information.
- **Billing "Incident to:"** Univera Healthcare follows Medicare guidelines for billing mid-level practitioner services performed incident to physician services. In such cases, the mid-level practitioner's incident to services are to be billed using only the collaborating/supervising physician's provider ID number indicated in field 24J on the CMS Form 1500 paper claim.

  For the ANSI 837 electronic claim, supervising provider information should be indicated in loop 2310D and the supervising provider's NPI would be indicated in loop 2310D, segment NM1.09. The mid-level practitioner should not submit another claim for him/herself.
- **Taxonomy Code:** When billing for services rendered, mid-level practitioners must include the taxonomy code used to register their NPI number through the CMS website. Claims submitted without taxonomy codes will be returned.
- **Billing Modifiers:** Univera Healthcare requires providers to use appropriate modifiers applicable to CPT codes and HCPCS codes when submitting claims. Using the correct modifier may affect how a claim is reimbursed.

7.5 Claims Processing

Prompt Payment Law

Note: Agreements with specific groups may include more rigorous prompt pay requirements. In the absence of such an agreement, NYS law governs prompt pay requirements.

Under New York State prompt payment law, applicable to claims received on or after January 22, 1998, Univera Healthcare is required to decide, within 30 calendar days after receipt of a claim, whether to pay, deny, or require additional information.

- Univera Healthcare requires providers to submit a "clean" claim (see above).
- Effective with claims received on or after January 1, 2010, if adjudication leads to the decision to pay the claim, Univera Healthcare will pay an electronically submitted claim within 30 calendar days after receipt and will pay a paper claim submission within 45 calendar days. Providers should not resubmit before the applicable time period is up unless the claim has been denied or returned unprocessed due to being incomplete.
- If Univera Healthcare pays a claim more than 30 calendar days (electronic submission) or more than 45 calendar days (paper submission) after receiving it, Univera Healthcare *in most cases* will apply interest at the annual rate set by the Commissioner of Taxation or 12 percent, whichever is greater. Univera Healthcare will make adjustments and/or pay interest when a claim was incorrectly paid due to Univera Healthcare error, but only if the original claim was "clean."
- If the decision to pay is not reasonably clear, Univera Healthcare will notify the claimant within 30 calendar days of receipt of the claim whether the claim has been denied or partially approved, and which claim or medical payment it is not obligated to pay, stating the specific reasons why it is not liable.
- If adjudication requires more information regarding the claim, Univera Healthcare will submit to the claimant a detailed request for such information within 30 calendar days following receipt of the claim.
- Univera Healthcare periodically performs prompt pay audits, and as a result of those audits, a reconciliation of prompt pay interest paid to the provider may be required. If necessary, Univera Healthcare will contact the provider regarding these audits.
- If an upward adjudication is required after receipt of additional information, Univera Healthcare will pay an electronically submitted claim within 30 calendar days after receipt and will pay a paper claim submission within 45 calendar days but no more than 15 days from the date of decision to adjust the claims based on the additional information. If Univera Healthcare pays a claim more than 30 calendar days (electronic submission) or more than 45 calendar days (paper submission) or more than 15 calendar days from the date of decision after receiving it, Univera Healthcare in most cases will apply interest at the annual rate set by the Commissioner of Taxation or 12 percent, whichever is greater.

Fee Schedules

Univera Healthcare pays a participating provider for covered services provided to Univera Healthcare members on the basis of a fee schedule pursuant to the terms and conditions of the provider's participation agreement. For more information about fee schedules, see the *General Provider Information* section of this manual.

Univera Healthcare deducts copayments, coinsurance, and deductibles from the amount to be reimbursed, as applicable. These amounts are determined from the member's benefit package, the product lines in which the provider participates, and the terms established in the provider's participation agreement with Univera Healthcare.

Fee schedules appropriate to a specific participating provider are available upon request from Customer Care. (For contact information, see the *Contact List* in this manual.) In addition, physicians may access commercial fee schedule information via our website:

- Provider.UniveraHealthcare.com/claims-payments

Clinical Editing

As part of the claims adjudication process, Univera Healthcare's claims systems will review the claim to determine that it fulfills corporate medical policies, referral requirements, preauthorization requirements (including those for medical necessity) and other benefit management specifications.

Univera Healthcare uses clinical editing criteria based on code edits recommended by multiple sources for the purpose of coding accuracy. The two principal sources are the American Medical Association's Current Procedural Terminology (CPT) publications and the Centers for Medicare & Medicaid Services national Correct Coding Initiative (CCI).

Univera Healthcare may also use standards derived from evidence-based guidelines for medicine and clinical appropriateness that are developed by its medical staff and other medical professionals. These medical policies outline Univera Healthcare determination of the appropriate use of medical services. Medical policies are available on our website (see below) or upon request from Customer Care. (For contact information, see the *Contact List* in this manual.)

- Provider.UniveraHealthcare.com/policies/medical

Univera Healthcare has incorporated clinical editing software into its claims systems. This software is used to determine the accuracy of procedural and diagnostic coding. The systems detect irregularities such as:

- **Unbundled procedures.** Providers should not bill using several procedure codes when there is a single inclusive procedure code that describes the same services.
- **Incidental procedures.** Providers should not bill separately certain procedures that are commonly performed in conjunction with other procedures as a component of the overall service provided. An *incidental* procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.
- **Mutually exclusive procedures.** Providers should not bill combinations of procedures that differ in technique or approach but lead to the same outcome. In some instances, the combination of procedures may be anatomically impossible. Procedures that represent overlapping services or

accomplish the same result are considered mutually exclusive. Generally, an open procedure and a closed procedure performed in the same anatomic site are not both recommended for reimbursement. Mutually exclusive edits are developed between procedures based on, but not limited to, the following CPT descriptions: limited/complete, partial/total, single/multiple, unilateral/bilateral, initial/subsequent, simple/complex, superficial/deep, with/without.

- **Procedures inappropriate for gender, age, etc.** Certain clinical edits will cause the system to generate a letter requesting additional information. Other clinical edits may result in a denial, which will appear on the provider's remittance advice. Providers can also initiate a provider inquiry related to the edit determination by completing the *Clinical Editing Review Request Form*, described below.

Clinical Editing Reviews

Providers who disagree with a clinical editing determination for a procedure code combination may request a clinical editing review. The *Clinical Editing Review Request Form* is available on the website or from Customer Care. To access the form, visit Provider.UniveraHealthcare.com/resources/forms. Submit the form to the address listed on the form. In addition, disputes can be submitted online at Provider.UniveraHealthcare.com/claims-payments (website login is required).

It is important to include any clinical documentation that will support the request. Univera Healthcare will make a determination on the review and notify the provider in writing within 45 days of receipt of all necessary information.

Unless otherwise stated in the provider's participation agreement, Univera Healthcare allows 365 days from the date that the provider received the original claim determination to request a review.

Submission of Medical Records

Univera Healthcare may request submission of relevant medical records to facilitate reviews for:

- Services or procedures requiring preauthorization.
- Services or procedures where a corporate medical policy indicates criteria for medical appropriateness or for services considered cosmetic, experimental or investigational.
- Quality of care and quality improvement.
- Medical necessity.
- Pre-existing conditions.
- Determination of appropriate level of care.
- Case management or care coordination.

In addition, medical records may be needed for processing claims with:

- Modifier 22 (unusual procedural services) appended
- Modifier 52 (reduced services) appended
- Modifier 53 (discontinued procedure) appended

- Modifier 62 (co-surgeon) appended

For services billed with unlisted, not otherwise specified, miscellaneous or unclassified codes, a description of service is required. Additional records may be requested for these services, depending on the description provided.

In addition to the above, Univera Healthcare may request medical records relevant to:

- Credentialing and Coordination of Benefits.
- Claims subject to retrospective audit.
- Investigation of fraud and abuse or potential inappropriate billing practices in circumstances where there is a reasonable belief that such a need exists.

There may be additional individual circumstances when Univera Healthcare needs to request medical records to support claim processing.

Effective January 1, 2010, a provider may be required to include medical records with the initial claim submission if the service requires review to determine medical necessity, including possible experimental/investigative services, under one of Univera Healthcare's medical policies. A listing of the codes that require up-front submission of records and the clinical information needed to perform the review is located on our website. If the provider does not submit the records as required, claims may be denied, and the provider may be required to resubmit a new claim with the necessary information. A provider will not be required to submit records for services if: preauthorization was obtained from Univera Healthcare or the services rendered were for behavioral health or substance use. Univera Healthcare will continue to request other records as needed for codes not on the list, or for other circumstances as described elsewhere in this manual.

Guidelines for up-front submission of medical records, including details on specific procedure codes and the records required for review, are on our website.

Retrospective Medical Claim Review

The purpose of medical claim review is to analyze whether a claim reflects services rendered, and to verify that the services rendered are appropriate to the clinical variables of each case, based on the standards of medical care, subscriber contract benefits and terms of participating provider agreements. This review includes:

- Reviewing supporting documentation to determine medical necessity post-service.
- Reviewing coding/pricing as appropriate.
- Adhering to quality-of-care standards of care.
- Assisting with special studies such as the Healthcare Effectiveness Data and Information Set (HEDIS®), as designed or recommended by the Quality Management department; and
- Referring cases to Quality Management as needed.

Coordination of Benefits - Univera Healthcare as Secondary Payor

Univera Healthcare subscriber contracts allow coordination of payments with other payors when a member is covered by more than one health benefit program. This is to prevent duplicate payment for health care services. **The member's contract defines how Univera Healthcare implements coordination of benefits (COB) for that contract.**

Univera Healthcare follows COB rules set forth by the New York State Insurance Department's regulations, as well as COB guidelines established by the National Association of Insurance Commissioners (NAIC). Medicare secondary payor rules take precedence.

Participating providers agree to accept Univera Healthcare's secondary payment for covered services and not balance-bill the member/subscriber in excess of deductibles, copays and/or coinsurance.

Note: If a member has coverage under two (or more) plans that both require referrals, the member must have obtained a valid referral and/or authorization from each plan to which a claim will be submitted.

Univera Healthcare follows the procedures below in order to prevent duplication of payment, prevent overpayment for services provided when a member has health benefits coverage under more than one plan, and to clarify the order of primacy for Other Party Liability (OPL), Worker's Compensation, Motor Vehicle Accident and Medicare claims.

General Adjudication Policies

Brief summaries of special, statutory-based claims adjudication policies are provided below. They are furnished only to provide information to providers in the context of this manual and are not to be relied upon as definitive legal statements of the coverage requirements relating to these programs.

Benefits will be coordinated as follows when members are covered under Univera Healthcare and another health care benefit package.

- *When Univera Healthcare is considered primary coverage*, Univera Healthcare will reimburse the full extent of covered services, which is the provider's billed charge or the fee schedule maximum (less any applicable copayment, coinsurance or deductible), whichever is less.
- *When Univera Healthcare is secondary*, Univera Healthcare will reimburse the provider for Univera Healthcare covered services in conjunction with the primary plan so that the two plans pay no more than 100 percent of charges or the Univera Healthcare fee schedule maximum, whichever is less.
- If a member does not have a legal obligation to pay all or a portion of the provider's billed charges, then Univera Healthcare shall have no obligation to pay any portion of the provider's billed charges.
- *When Medicare is primary and denies the entire claim,* and the claim is for covered services, Univera Healthcare will reprocess the claim as primary. All services provided will be subject to copayments, preauthorization, and all other Univera Healthcare policies regarding claims.
- When Univera Healthcare is primary and there is a balance after Univera Healthcare has reimbursed the fee maximum for covered services, the provider may balance-bill the secondary carrier (unless the secondary carrier is also Univera Healthcare). However, the provider **may not** balance-bill the patient.

- When Univera Healthcare is secondary, the primary is not Medicare, and there is a balance after the primary plan has made payment and Univera Healthcare or the other plan has reimbursed the fee maximum for covered services, the provider may not balance-bill the patient even if Univera Healthcare makes no payment.
- As a secondary payor, Univera Healthcare will never pay more than it would have if Univera Healthcare had been the primary plan.

Workers' Compensation and Other Employer Liability Laws

A Univera Healthcare certificate of coverage excludes coverage for services obtained by a member as a result of injury or illness that occurs on the job. These expenses are covered under the state's Workers' Compensation Laws.

Univera Healthcare will closely review claims for such injuries or illnesses to determine if they are work-related. If necessary, Univera Healthcare will send the member a questionnaire. Univera Healthcare will deny any claim determined to be work-related and will notify the provider that they must file the claim through the applicable Workers' Compensation carrier or through the member's employer.

If Univera Healthcare mistakenly pays a claim on a work-related injury or illness, and it is later discovered that the injury or illness was work-related, Univera Healthcare will take legally permissible steps to obtain appropriate recoveries from all parties who have received claims payments.

Medicare

A Univera Healthcare member continuing to work and remaining actively employed after age 65 will have as primary coverage either Medicare or the Univera Healthcare program provided by their employer or group. This also applies to the dependent over-65 spouse of an active employee who is a member of Univera Healthcare.

Once a Univera Healthcare member is no longer an active employee or spouse of an active employee of a Univera Healthcare group, Medicare coverage automatically becomes primary.

When Medicare is primary and Univera Healthcare is secondary, Univera Healthcare will pay up to its fee schedule.

Motor Vehicle Accident Claims

Univera Healthcare health benefit programs exclude coverage for services obtained by a member as a

result of injury related to an automobile accident for members who reside in a mandatory no-fault state. These expenses are covered under the member's mandatory no-fault benefits.

Univera Healthcare will closely review claims for injuries to determine if they are related to an automobile accident. If necessary, Univera Healthcare will send the member a questionnaire. Univera Healthcare will deny any claim determined to be related to the motor vehicle accident and will notify the provider that they must file the claim through the no-fault insurance carrier.

If Univera Healthcare mistakenly pays a claim on a motor vehicle related injury, and later discovers that the injury was related to the motor vehicle accident, Univera Healthcare will take necessary steps to obtain appropriate recoveries from all parties who have received claims payments.

Please note: Univera Healthcare will consider claims if the no-fault insurance carrier's rejection was based on the carrier's independent medical examination. However, Univera Healthcare will deny claims that were

not submitted within the no-fault timely filing limit or if a required authorization was not obtained for services provided. Univera Healthcare will send a letter of inquiry to the member to determine the status of their injuries and follow up with the member.

Payment and Other Party Liability (OPL)

Univera Healthcare reviews claims to determine the primary and/or secondary payor. Univera Healthcare may generate a COB questionnaire to help determine the coordination of benefits payment order.

Claims that are denied because the Explanation of Payment (or Explanation of Medicare Benefits) was not attached must be resubmitted with the Explanation of Payment attached.

If it is determined that Univera Healthcare is the primary carrier, Univera Healthcare will process the claim and make payment for the covered services provided in accordance with the fee schedule.

If Univera Healthcare is determined to be the secondary carrier, it will deny the claim. Providers should resubmit these denied claims to the primary carrier. After the primary carrier has made payment, resubmit the claim to Univera Healthcare to be considered for payment of a portion of services.

Inquiring about the Status of a Claim

Providers may use one of the inquiry systems described in *Administrative Information* section of this manual to inquire about the status of a Univera Healthcare claim. Providers may also fax or mail a completed *Claims Status Request* form (available on the website or from Customer Care), or they may call Customer Care.

Upon receipt of a *Claim Status Request* form, a Customer Care representative will research the claim to determine if it has been, or shortly will be, processed. If the claim is still outstanding, the representative will complete the bottom section of the form and promptly return it to the submitter.

7.6 Remittance

A participating physician who submits claims for Univera Healthcare benefits plans receives a remittance advice that summarizes all claims processed since the last payment was made to the submitter.

Note: Remittances may come in multiple envelopes. This occurs when a remittance exceeds the number of pages that Univera Healthcare's remittance processing system is able to mail in a single envelope.

When Additional Information is Required

For some claims, Univera Healthcare may need additional information before it can make a determination to cover or deny the service. These claims will be so marked on the remittance with a message asking the submitter to provide additional information. A provider has 45 days from the date printed on the remittance to submit supporting documentation related to the service in question.

Understanding the Remittance

The remittance includes details about each claim as well as:

- **Explanation Codes.** Providing the reasons why a specific claim has not been paid. Reasons for non-payment include denials and the need for more information. Explanation codes associated with a specific claim are on the claim line; descriptions of what the codes mean are presented at the end of the remittance.
- **Adjustments.** All adjustments made to previously submitted claims are listed at the end of the remittance.
- **Recoupments.** All recoupments related to a remittance check will appear in the adjustment section, and the total dollars recovered will be shown.
- **OPL.** OPL payment amounts are indicated.
- **Procedure, Revenue, and DRG codes.** All codes will appear in the field, Service**.** If both a procedure and revenue code was submitted for a claim, the Service field will display the procedure code first, followed by the revenue code.
- **Patient Responsibility.** As applicable, is displayed in four fields: Co-Pay, Co-Ins, Ded, and Other.

Electronic Remittance Advice and Electronic Funds Transfer

We are pleased to offer InstaMed® for Electronic Payments (EFT), Remittance Advice (ERA) and more, as a free service to our participating providers. There are two options for registering to receive EFT/ERA delivery: Complete and submit the InstaMed Network Funding Agreement or visit instamed.com/eraeft and complete the online registration process.

Benefits of InstaMed:

- **Possible reduction in accounting expenses** - By importing electronic remittance advice from the Web directly into practice management or patient accounting systems, the need for manual re-keying is reduced or eliminated.
- **Improvement in cash flow** - Electronic payments can mean faster payments, resulting in improved cash flow. Paper checks will be discontinued upon enrollment.
- **Control of bank accounts** - Maintain total control of the destination of claim payment funds; multiple practices and accounts are supported.
- **Prompt match of payments to remittance advice** - Immediately associate electronic payments with electronic remittance advice. View remittance advice online and print when convenient.
- **Increase in reporting functionality** - Ability to create functional reports that support the internal needs of the practice.
- **Easier management of multiple payors**- Reuse enrollment information to connect with multiple payors. Assign different payors to different bank accounts as desired.

- **Reduction of paper usage** - Paper checks will be discontinued by the next pay cycle after enrollment. Paper remittances will be discontinued four weeks after enrollment with electronic funds transfer.

7.7 Requesting a Change in Claims Payment

There are various circumstances after a claim has been processed that may require Univera Healthcare to take another look. These include incorrect payments or denials, or services billed incorrectly or in error.

Adjustments

Univera Healthcare has a claims adjustment process that providers can initiate *after the claim has been processed*.

Please note that claims returned to the submitter because they were inaccurate or incomplete have not been processed and consequently cannot be adjusted. This includes electronically submitted claims that don't pass edits at the clearinghouse or payor system. In addition, Univera Healthcare cannot adjust a claim when the dollar amounts change due to the provider's corrections (such as adding a service line or a modifier). A corrected claim must be submitted.

Policies

- Univera Healthcare will make adjustments when a claim is paid incorrectly due to Univera Healthcare error, but only if the original claim was "clean."
- If Univera Healthcare mistakenly underpays a provider for a claim, Univera Healthcare will make an adjustment on a subsequent remittance.
- Univera Healthcare calculates interest on adjustments in accordance with specifications of New York State prompt payment law.
- If Univera Healthcare mistakenly overpays a claim to a participating provider, Univera Healthcare will make an adjustment and deduct that amount from future payments.

  Note: Providers may also return overpayments to Univera Healthcare. See the paragraph headed *Overpayments*.
- Review of a claim does not guarantee a change in payment disposition.

Procedure

Adjustments may be requested via:

- **Website**. Participating physicians who are registered users of the Univera Healthcare website may request an adjustment electronically via an interactive form available on the website. Physicians may also submit related additional information, such as medical records, electronically. To access, go to our website (see below) and click *Claim Adjustment Request Online*.

  - Provider.UniveraHealthcare.com/claims/request-adjustment

- **Paper *Request for Research/Claim Adjustment* form**. This form is available on the website (see below) or from Customer Care.
  - Provider.UniveraHealthcare.com/claims/request-adjustment (click *Claim Adjustment Request Mail)*

Attach a copy of the remittance advice that included the claim, a copy of the original claim form, and other relevant supporting documentation.

If a claim was denied for no authorization, but there **was** an authorization, the provider can use the *Request for Research/Claim Adjustment* form and attach a copy of the authorization.

Inpatient claims denied for no preauthorization, medical necessity or combined admissions, or claims paid at a different DRG than billed cannot be corrected through claims adjustment. Instead, they must be processed through Inpatient Appeals.

The *Request for Research/Claim Adjustment* form is also not appropriate for questioning edits made by our electronic claim review system. See paragraph below that addresses this issue.

- **Customer Care**. Representatives may be able to take information over the phone, in limited amounts, to initiate an adjustment. If documentation is required, provider may be advised to use the *Request for Research/Claim Adjustment* form.

Clinical Editing Review Requests

For certain claims, Univera Healthcare's claim systems may have determined that a procedure was mutually exclusive (or incidental) to a primary procedure. **The *Request for Adjustment* form is not appropriate for questioning the results of electronic claim review**. Instead, providers should use the *Clinical Editing Review Request* process described earlier in this section of the manual.

Overpayments

Univera Healthcare has a mandatory process for receiving returned overpayments in lieu of an adjustment on a subsequent claim. In order to credit the returned payment properly, Univera Healthcare requires the claim number, member or subscriber ID, and the date of service. Providers may supply this information separately or by including a copy of the applicable remittance.

Providers are required to report, return and explain overpayments to Univera Healthcare within 60 days of identifying the overpayment.

Overpayments must be mailed directly to the address included on the Overpayment Return Form (see the link below). You may also obtain the mailing information by contacting Customer Care.

- Provider.UniveraHealthcare.com/Resources/Forms (select the *Overpayment Return Form* in the Billing and Remittance section).

As a reminder, if Univera Healthcare mistakenly overpays a claim to a participating provider, it will make an adjustment and deduct that amount from future payments. If the provider disagrees with Univera Healthcare's decision regarding the adjustment, the provider should contact Customer Care.

DRG Review Request

If a hospital needs Univera Healthcare to review the DRG reimbursement it received on a specific claim (or claims), it should use the *DRG Review Request Form*, available on our website (see below) in the *Billing and Remittance* section, or by contacting Customer Care. ***Please use this form only for paid claims that require review of the DRG paid versus the DRG submitted, or if questioning our DRG payment calculations.*** As stated on the form, the provider must also include a DRG calculation sheet and copy of the claim submittal (UB-04 or paper copy of electronic equivalent) with the form.

- Provider.UniveraHealthcare.com/resources/forms

APC & APG Review Request

APC Review Request

If a hospital needs Univera Healthcare to review the ambulatory payment classification (APC) reimbursement received on a specific claim(s), the hospital should complete and submit the *APC Pricing Dispute Form*, available on our website (see below) in the *Billing and Remittance* section, or by contacting Customer Care.

- Provider.UniveraHealthcare.com/resources/forms

Please use this form only if questioning our APC payment calculations or APC denial. As stated on the form, the provider must also include an APC calculation sheet and copy of the claim submittal (UB-04 or paper copy of electronic equivalent) with the form.

APG Review Request

If a hospital needs Univera Healthcare to review the ambulatory payment classification (APG) reimbursement received on a specific claim(s), the hospital should complete and submit the *APG Pricing Dispute Form*, available on our website (see below) in the *Billing and Remittance* section, or by contacting Customer Care.

- Provider.UniveraHealthcare.com/resources/forms

Please use this form only if questioning our APG payment calculations or APG denial. As stated on the form, the provider must also include an APG calculation sheet and copy of the claim submittal (UB-04 or paper copy of electronic equivalent) with the form.

False Claims Act Reminder

Univera Healthcare expects participating providers to understand the state and federal requirements regarding false claims recovery. Providers participating with Medicare and Medicaid are obligated to report and return overpayments to the plan within 60 days of the time when the overpayments are identified. Information about our policies on false claims and overpayment procedures is available on our website.

7.8 Claim Form Completion

Claim Form Completion Tools

Univera Healthcare offers tools to help with completion of the CMS-1500 and UB-04 CMS-1450 form. A tip book for completing the CMS-1500 form that can be accessed via our website (see below) In addition, the field descriptions for the UB-04 CMS-1450 are provided on the following pages.

- Provider.UniveraHealthcare.com/resources/management/tip-sheets

UB-04 CMS-1450 Field Descriptions

See notes at the end of this chart.

Field	Name	Entry
1	Unlabeled	4 lines for Provider Name, Address, Telephone, Fax, Country Code (only if address/phone outside the U.S.)
2	Unlabeled	4 lines for Pay-to Name, Address, etc.
3a	PAT CTL #	Patient Control Number assigned to patient by provider
3b	MED REC #	Medical record number assigned to patient's medical record by provider
4	TYPE OF BILL	4-digit code that identifies type of facility, bill classification (variations for hospital, clinic or special facilities), and frequency (indicates sequence of bill in particular episode of care).
5	FED. TAX NO.	Tax identification number (TIN) or employer identification number (EIN)
6	STATEMENT COVERS PERIOD (From/Through)	Enter beginning and ending dates of the period included on the claim
7	Unlabeled (2 lines)	2 lines – not used
8a	PATIENT NAME – ID	Patient ID number (depending on primary, secondary, tertiary in field 60)
8b	PATIENT NAME	Enter name of patient
9	PATIENT ADDRESS	Lines a through e for street and number or box number, city, state, zip code and country code (if address outside the U.S.)
10	BIRTHDATE	Enter patient's date of birth

UB-04 CMS-1450 Field Descriptions

See notes at the end of this chart.

Field	Name	Entry
11	SEX	Enter F or M
12	ADMISSION DATE	Date of admission or commencement of services
13	ADMISSION HOUR	Time of day of admission or commencement of services
14	ADMISSION TYPE	Appropriate code for emergency, urgent, elective, newborn, etc.
15	ADMISSION SRC	Source of admission code
16	DHR	Discharge hour
17	STAT	Patient discharge status code
18-28	CONDITION CODES	Relate to type or lack of coverage
29	ACDT STATE	Accident state
30	Unlabeled (2 lines)	Not used – 2 lines
31-34	OCCURRENCE CODE and DATE	Enter applicable occurrence code(s) and associated date in lines a and b
35-36	OCCURRENCE CODE and SPAN (FROM/ THROUGH)	Enter applicable occurrence code(s) and associated date span in lines a and b
37	Unlabeled	Unused – lines a and b
38	Unlabeled	5 lines for responsible party/subscriber name and address
39-41	VALUE CODES and AMOUNTS (lines a through d)	Lines a through d. Value codes and amounts, including those for covered days (80), non-covered days (81), coinsurance days (82) or lifetime reserve days (83) should be placed here.
42	REV CODE	Revenue code for each service billed – 22 lines
43	DESCRIPTION	Revenue code description for each service billed – 22 lines
44	HCPCS / RATE / HIPPS CODE	HCPCS or HIPPS code corresponding to each service billed – 22 lines
45a	SERV. DATE	Service date of each service billed – 22 lines
45b	CREATION DATE	Date claim form is completed
46	SERV. UNITS	Service units corresponding to each service billed – 22 lines
47	TOTAL CHARGES	Total charges for each service billed – 22 lines

UB-04 CMS-1450 Field Descriptions

See notes at the end of this chart.

Field	Name	Entry
48	NON-COVERED CHARGES	Non-covered charges for each service billed – 22 lines
49	Unlabeled	22 lines – not used
47-48	TOTALS	Total amount of charges and total amount of non-covered charges
50	PAYOR NAME	3 lines, one each for primary, secondary and tertiary payors.
51	HEALTH PLAN ID	This spot reserved for the national health plan identifier when one is established. 3 lines, one each for primary, secondary and tertiary payors.
52	REL INFO	Release of information certification indicator (Y or I). 3 lines, one each for primary, secondary and tertiary payors.
53	ASG BEN	Assignment of benefits certification indicator. 3 lines, one each for primary, secondary and tertiary payors.
54	PRIOR PAYMENTS	Payments from other payors or patient. 3 lines, one each for primary, secondary and tertiary payors.
55	EST. AMOUNT DUE	Estimated amount due from patient. 3 lines, one each for primary, secondary and tertiary payors.
56	NPI	NPI for billing provider.
57	OTHER PRV ID	Other provider identifier (non-NPI assigned by Univera Healthcare). 3 lines, one each for primary, secondary and tertiary payors. DO NOT USE after May 22, 2008.
58	INSURED'S NAME	Name of holder of the insurance contract. 3 lines, one each for primary, secondary and tertiary payors.
59	P REL	Patient's relationship to insured. 3 lines, one each for primary, secondary and tertiary payors.
60	INSURED'S UNIQUE ID	Insured's insurance identification number. 3 lines, one each for primary, secondary and tertiary payors.
61	GROUP NAME	Insured's group name. 3 lines, one each for primary, secondary and tertiary payors.
62	INSURANCE GROUP NO.	Insured's group number(s), if available. 3 lines, one each for primary, secondary and tertiary payors.

UB-04 CMS-1450 Field Descriptions

See notes at the end of this chart.

Field	Name	Entry
63	TREATMENT AUTHORIZATION CODES	Univera Healthcare authorization number. 3 lines, one each for primary, secondary and tertiary payors.
64	DOCUMENT CONTROL NUMBER	Area for Univera Healthcare to assign claim number
65	EMPLOYER NAME	Insured's employer name. 3 lines, one each for primary, secondary and tertiary payors.
66	DX	Qualifier code reflecting ICD revision. Enter the number "0" to indicate ICD-10 or "9" to indicate ICD-9.
67	Label is 67	Enter principal diagnosis code. Include all digits (4-5) where applicable
67	A through Q	Other diagnosis codes. Include all digits (4-5) where applicable.
68	Unlabeled	2 lines – not used
69	ADMIT DX	Admitting diagnosis code (if inpatient claim)
70	PATIENT REASON DX	Patient's reason for visit (diagnosis) code(s) (3 blocks)
71	PPS CODE	Prospective Payment System code
72	ECI	External cause of injury code(s) (3 blocks)
73	Unlabeled	Input DRG code here.
74	PRINCIPAL PROCEDURE CODE and DATE	Enter principal procedure code and date of procedure
74a-e	OTHER PROCEDURE CODE and DATE	As applicable, enter other procedure codes and dates
75	Unlabeled	4 lines - not used
76	ATTENDING – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of attending provider and last and first names of attending provider
77	OPERATING – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of operating provider and last and first names of operating provider
78	OTHER – NPI, QUAL, LAST, FIRST	5 boxes. Enter NPI of other provider and last and first names of other provider
79	OTHER – NPI, QUAL, LAST, FIRST	Same as above
80	REMARKS	4 lines for notation that doesn't go elsewhere

UB-04 CMS-1450 Field Descriptions See notes at the end of this chart.		
Field	Name	Entry
81	CC	Code-Code (lines a through d, 3 boxes each)
81a	Taxonomy code qualifier and taxonomy code(s)	In first box, enter qualifier code B3 for field 56 billing provider taxonomy code. In second (and third, if applicable) boxes, enter taxonomy code(s) for the field 56 billing provider.
81b	Other code qualifier and other code	As needed
81c	Other code qualifier and other code	As needed
81d	Other code qualifier and other code	As needed

KEY

Bolded and shaded fields indicate that claim cannot be processed if information in these fields is missing, illegible or invalid. The claim will reject at the front end.

Note: ***Univera Healthcare requires information in certain other fields before it can adjudicate the claim. These fields may vary with the type of service being billed. Completion of all fields does not guarantee payment.***

Univera Healthcare
Participating Provider Manual

Section 8: Quality Improvement

Providers who agree to participate with Univera Healthcare have also agreed to cooperate in and comply with the standards and requirements of Univera Healthcare's quality improvement (and other) initiatives. As part of the quality improvement process, Univera Healthcare complies with the NCQA Population Health Management (PHM) standards. Clinical quality improvement projects also include programs and ad hoc activities from the Center for Medicaid and Medicare Services and New York State Department of Health Quality Improvement, Office of Mental Health and Office of Addiction Services and Supports. Univera Healthcare's goal is to address our members' health across all points on the continuum of care, including the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.

Revised September 2024

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8.1 Quality Improvement Program

Note: To request a copy of the complete *Quality Improvement Program* Description, contact Customer Care. For Univera Healthcare address and contact phone numbers, see the *Contact List* in Section 2 of this manual or access it through the website at:

- Provider.UniveraHealthcare.com/resources/clinical/quality-improvement

Purpose

The Quality Improvement (QI) Program provides a formal process to monitor, improve, and evaluate the quality, efficiency, affordability, safety and effectiveness of care and service utilizing a cross-functional, collaborative approach objectively and systematically. The QI program description is reviewed and approved at least annually by the Health Care Quality Program Oversight Committee (HC-QPOC), as well as the Health Plan Committee (HPC) of Lifetime Healthcare, Inc. Boards of Directors (Board).

Scope

The QI Program strives to align with the Center for Medicare and Medicaid Services (CMS), New York State Department of Health (NYSDOH), National Committee for Quality Assurance (NCQA), and the National Quality Strategy visions as well as other regulatory requirements including the Dual Special Needs Plan Model of Care. The QI Program framework provides the Plan with a formal decision-making structure where data-driven goals and objectives are identified, improvement team performance is reviewed, and progress is measured, monitored and reported. The organization has integrated behavioral health into its program to align behavioral and physical health care to maximize the coordination and care members receive, improve access and increase member satisfaction. These programs provide a flexible framework to allow for monitoring, ongoing analysis, and adjustment to assure continued progress toward defined outcomes, supporting efforts to adapt to the complex, rapidly changing environment.

The QI Program is applicable to all lines of business accredited by Univera Healthcare, including all products under the following product lines: Commercial; Medicaid Managed Care, including , Medicare; Essential Plan and Marketplace (except those carved out by self-insured no-touch; Medicare supplemental; vison/dental stand alone or Indemnity). This program also serves as the QI Program for Excellus Health Plan Community Care, LLC (EHPCC), servicing our Dual Eligible Special Needs Plan (D-SNP). Activities and components of the program that only pertain to particular products are called out specifically in the document.

Strategic Goals and Objectives

The QI Program is in alignment with Univera Healthcare's mission "to help people in our communities live healthier and more secure lives through access to high quality, affordable health care." The QI Program's goal is to lead a dynamic and cross-divisional quality program that demonstrates and drives excellence in Quality and Customer Experience.

The QI program goal extends process improvement, project management, across all lines of business and all divisions to drive optimal performance by using the following strategic objectives:

- Drive organizational readiness
- Enhance the customer experience culture
- Identify high-value opportunities
- Lead collaborative strategic development
- Support cross-divisional strategy execution
- Ensure program deliverables
- Advance health equity, including the provision of culturally and linguistically appropriate services (CLAS))
- Advance quality measurement capabilities

The action plan contains, but not limited to, interventions, measurable goals, and timeframes.

Quality Improvement Program Action Plan

The annual QI Program Action Plan is prepared and reviewed in collaboration with cross-functional leaders across the organization. This Action Plan supports the QI Program as the overall organization works collaboratively to achieve excellence in all quality ratings programs, including quality of clinical care and service, safety of clinical care and member experience. Using HEDIS and other measurement, the QI program also strives to determine whether health care disparities exist and implement actions to address them. HC-QPOC supports the launch of various improvement project teams and interventions based on data analysis and/or defined improvement opportunities and receives regular reports on the progress of improvement teams and interventions relative to their activities and measures of success. The HC-QPOC also approves revisions to the Action Plan as appropriate.

Regulatory and Accreditation

Univera Healthcare maintains systematic processes to assure sufficient evidence of compliance for accrediting bodies, regulatory agencies, members, providers and purchasers. Additionally, Univera Healthcare has a strategy to meet changing requirements of purchasers, accreditation and regulatory agencies. Univera Healthcare currently holds NCQA Health Plan Accreditation for the commercial, Medicare, Medicaid and Marketplace lines of business.

Quality Improvement Program Activities

The QI Program supports an ongoing comprehensive program of continuous quality improvement throughout the organization, monitoring the performance of our internal functional areas as well as the quality of care for our members. The QI Program is defined by NCQA, CMS, NYSDOH and the D-SNP Model of Care. The quality improvement activities are based on qualitative and quantitative data analysis and/or measurements to determine where opportunities exist. Interventions and re-measurements are conducted within designated timeframes.

Quality improvement activities include, but are not limited to, Medicare Quality Improvement Programs (QIP), Medicare and D-SNP Chronic Care Improvement Programs (CCIP), Continuity of Care Programs, Health Outcome Surveys (HOS), Performance Improvement Projects (PIPs), Health care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health care Providers and Systems (CAHPS) for Health Plan; Qualified Health Plan Quality Rating System Enrollee Satisfaction Survey, Quality Assurance Reporting Requirements (QARR) and Accountable Cost and Quality Arrangement (ACQA) improvement activities.

Cultural Competency Plan (CCP)/Culturally and Linguistically Appropriate Services (CLAS)

Univera Healthcare strives to provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of the individual members and protects and preserves the dignity of everyone. Univera Healthcare ensures culturally competent, equitable care and services by placing our members at the center of everything we do. By understanding our members cultural, language, diversity and inclusion needs and preferences, we can improve the equitability of care and reduce or eliminate potential discrimination or bias. The incorporation of a culturally and linguistically sensitive approach into all aspects of our organization, including our Quality Program, recruiting, and hiring practices, staff development, service provision and vendor procurement, enables Univera Healthcare to meet these needs. The approach is inclusive of all members, contractors, subcontractors, and Health Plan staff.

In accordance with 42 CFR 438.206 (c) (2), New York State regulatory requirements, NCQA and the national standards for CLAS, Univera Healthcare has developed a framework for goals, expectations and activities to ensure that services are provided in a culturally and linguistically competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disability status, age, gender identity, educational level or socioeconomic status.

Univera Healthcare will ensure that the Plan is monitored, and activities/initiatives are executed. Univera Healthcare will perform internal cultural competence activities such as organization wide cultural competence self-assessments, annual updates and training as needed, community needs assessments to identify threshold populations in service areas, and quality improvement projects to improve cultural competence and reduce disparities, as needed.

The CCP/CLAS/Quality Program incorporates a multifaceted approach to assess and respond to existing and emergent needs of the communities we serve, including, but not limited to:

• A robust inclusion, diversity, equity, and access (I.D.E.A) program, managed by our Human Resources department, through our Office of Diversity, that encompasses our workforce, members, providers, suppliers, and communities.

• Regular training and development opportunities for internal staff, inclusive of committee and Board members as well as the providers.

• Sharing provider language spoken in the provider directory and providing language services to providers.

• Solicit feedback from our members, the community and our providers regarding our activities and the health plan.

To implement and monitor these activities, the organization incorporates all CLAS/Health Equity and activities into the organization's goals, objectives, activities, monitoring plans, and evaluations, covering all lines of business, described in the Quality Program, Quality Action Plan, and annual Quality Program Evaluation.

Credentialing and Recredentialing

Credentialing helps ensure the provision of accessible, cost-effective quality care to members via review of all practitioners and providers who apply to participate with Univera Healthcare's managed care, Medicare Advantage or PPO products. Credentialing occurs prior to participation (initial application) and at regular intervals thereafter (recredentialing/reappointment). The process is an objective evaluation of a person's current licensure, training or experience, competence, and ability to provide particular services to our members in their credentialed specialty. Practitioners are afforded an appeal process in accordance with established policies and procedures if the Credentialing Committee reduces, suspends, or terminates a practitioner's participation for reasons related to quality of care, competence or professional conduct.

Univera Healthcare delegates the oversight of the credentialing process to the Credentialing Committee. Please see Section 3 of this manual for more information about Univera Healthcare's credentialing and recredentialing process.

Behavioral Health (BH)

The Medical Director for Behavioral Health (BH) holds the responsibility to provide oversight, direction and is engaged in the integration of behavioral health services within Univera Healthcare's medical model and quality improvement structure, inclusive of participation in quality and utilization committees and work groups.

BH care improvement actions have a two-fold direction; addressing key gaps in care with specific HEDIS measures, and contributing towards medical measurements in which behavioral health impacts gaps in care. The integrated psychosocial medical model approach is utilized for other actions to improve quality of care measures and employs Univera Healthcare staff across several divisions and disciplines to view our members holistically, as well as addressing gaps in care with both physical and behavioral health interventions. Examples include:

- The maternal case management program using depression screening to identify risk, provide support and refer to behavioral health services while linking back with primary care.
- Chronic care case management program ensuring that patients with diabetes, hypertension and cardiac health have direct access to behavioral health staff and educational materials, as these medical conditions are often severely impacted by the Health Plan's member level of coping and mental health well-being. Improving both the medical and behavioral health coping of our members impacts the quality of their lives and health.

The Quality Program uses a multifaceted approach to care, taking into account the member's physical health, behavioral health and social needs to put together a care plan that allows members to achieve the best level of health available to them. Some of Univera Healthcare's efforts to monitor and improve the behavioral health aspects of the quality program include:

- Primary prevention, which focuses on the recognition of risks/threats to one's mental health through member education via newsletters, websites and social media.
- Secondary prevention, which includes depression screening for all ages, all lines of business, resources to address depression/anxiety symptoms, primary first psychotic episodes education and case management services to mitigate significant exacerbation.
- Tertiary programs, which include resources focused on opioid dependence, access to medically assisted treatment in the community, targeted case management following discharge from inpatient mental health and substance use rehabilitation, residential services and emergency rooms. Special populations, such as children in the foster care program, members with long term medical and mental health needs and incarcerated and/or homeless members also have access to services which provide monitoring and assistance.

Additionally, there is a focus on early identification of high risk chronically ill individuals with schizophrenia to engage them in intensive case management and appropriate anti-psychotropic medications to avoid admissions and re-admissions.

Univera Healthcare uses various improvement models to identify gaps in behavioral health continuity and coordination of care. This provides Univera Healthcare the opportunity to measure specific areas that demonstrate the need for behavioral health care continuity and coordination across the health care continuum. Data measurement, analysis, identification of opportunities for improvement and active interventions address various aspects of behavioral health continuity and coordination of care areas such as:

- The exchange of information with a bi-directional approach between behavioral health providers and medical providers.
- Monitoring appropriate use of psychotropic medications.
- Access to behavioral health care services and follow up care.
- Primary or secondary behavioral health care prevention programs.
- Addressing the care needs of individuals with serious and persistent mental illness.

Wellness and Prevention

Univera Healthcare maintains a broad-based Preventive Health Program for members, designed to educate and promote healthy lifestyle choices. Preventive health is also integrated into other member touch programs throughout the organization. Univera Healthcare has implemented a number of preventive health tools and programs for members across the care continuum.

Population Health Management (PHM)

Purpose:

Univera Healthcare's PHM strategy focuses on keeping members healthy, managing members with emerging risk, patient safety, outcomes across settings, managing multiple chronic illnesses and member experience. PHM program effectiveness is evaluated regularly to guide the work of Univera Healthcare's improvement efforts both clinically and operationally in partnership with members, providers, health care delivery systems, employer groups and community groups.

Scope of PHM Activities:

Univera Healthcare programs/services supporting PHM include, but are not limited to:

- Value based payment arrangements
- Physician and hospital quality programs
- Disease condition and complex case management programs
- Telemedicine
- Utilization management
- Patient safety and risk management initiatives
- Behavioral health management and services
- Pharmacy management and medication safety programs
- Continuity and coordination of care
- Preventive Care gap closures
- Member HRA, self-management tools and wellness programs
- Member and Community Health Initiatives (MACHI)
- Delegation monitoring and oversight

Case Management

Univera Healthcare's Case Management program adheres to the Case Management Society of America's (CMSA) definition of case management: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes."

Goals and Objectives

- Improve clinical outcomes for our members in maximizing health, overall functioning, and quality of life through management of their disease or condition.
- Promote prevention and wellness to support healthy living by collaborating with members, family/caregivers/providers, and community resources.
- Improve member access to care and maximize member satisfaction.
- Determine available benefits and resources to meet member needs through oversight assistance with effective navigation of the health system through cost-effective management.

Program Segments or Population Subsets

- Univera Healthcare conducts a population assessment each year to assess the characteristics and needs including social determinants of health of our total member needs and population subsets that would benefit from PHM services. Univera Healthcare leverages this data to evaluate its current case management program in order to adequately identify whether case management interventions require improvement to meet member needs.
- The care program utilizes a proprietary Risk Stratification tool, which identifies the most actionable members for case and disease management. The tool incorporates many indicators into member identification including but not limited to condition, cost and utilization of services, gaps in care, risk cohort and predictive analytics.
- The population-based disease management programs and services span the continuum of care from early-stage conditions through acute events, severe chronic disease and end of life care.
- Individuals with multiple or complex conditions obtain coordination of services to help them access needed care, services or resources through the Complex Case Management program.

Community Focus

The Corporate Quality Improvement Program supports Univera Healthcare's mission to improve the health of the community.

Focus on Physical Activity and Nutrition

The Worksite Wellness and preventive health programs support the Member and Community Health Improvement (MACHI) council in its efforts to increase awareness of the importance of physical activity and nutrition.

Focus on Chronic Conditions

Member and provider programs focus on chronic conditions from a community, population, employer and member perspective. Care management systems are utilized to help identify members who may need education and/or care coordination. Evidence-based clinical practice guidelines assist practitioners in the management of chronic conditions. Provider and hospital incentive programs are often structured to assist in the medical management of members with chronic conditions. Univera Healthcare Pharmacy Management focuses on improving pharmaceutical management of chronic conditions.

Focus on Access to Care for the Underserved Population

Univera Healthcare's Government Programs target the underserved population with multipronged interventions to improve the health outcomes for Medicare and Medicaid Managed Care members.

Focus on Patient Safety

Univera Healthcare's member and provider programs support patient safety, as do the accreditation and regulatory processes. Univera Healthcare Pharmacy Management has created several important, pharmacy management programs, to maintain patient safety in the area of pharmaceutical utilization.

Provider Quality and Performance Improvement

Built upon the core principles of the quadruple aim - improve health care quality, lower costs and enhance the patient and provider experience – Provider Performance Improvement (PPI) Programs support the creation of a high-performance network to improve the overall quality of care provided to our members and the communities we serve. Univera Healthcare uses practitioner and provider performance data for quality improvement purposes.

As Univera Healthcare continues to support our provider partners in all sectors of health care, we strive to provide programs and venues that help decrease fragmentation, improve care coordination and allow for collaboration in comprehensive patient-centered care with higher quality and lower costs.

Physicians and hospitals are directly supported by our PPI consultant team of licensed RNs, MBAs, Certified Professional Coders, experts in population health management, quality improvement specialists, Patient Centered Medical Home (PCMH) Certified Consultants, health care administrators, Certified Case Managers, Lean Six Sigma professionals and experienced data analysts, all who have multi-specialty expertise and experience that makes them uniquely qualified to support our provider partners through comprehensive clinical quality improvement.

Consulting Services are designed to drive improvement in population health, including preventive health, acute and chronic disease care and patient safety through application of system level processes and delivery of patient-centered care. Hierarchical in nature, based on ability and/or tolerance for financial risk, the programs are built using a consistent framework for determining quality performance using established and tested measures that align with national measure sets with level of risk being the primary variable. These programs support providers in their efforts to improve patient safety outcomes while improving fiscal performance through means other than increases in payment rates.

PPI consultants provide additional ad hoc support to hospital quality teams and physician practices through targeted and focused interventions as opportunities are identified through accreditation and regulatory program activities.

Value-Based Payment Programs

Accountable Cost and Quality Arrangement (ACQA)

An Accountable Cost and Quality Arrangement (ACQA) is an innovative payment program designed to drive improvements in patient experience, cost trends, and quality of care. Like an Accountable Care Organization (ACO), the programs establish a new relationship between Univera Healthcare and partner-integrated health care systems or large primary care physician groups based on health care quality and financial gain share. ACQA, administered with the integrated healthcare systems, is a full innovative payment program with both upside and downside risk. Savings generated by exceeding the budget target is shared with the system based on overall quality performance. Should financial performance result in a loss, the proportion of the loss passed to the system is moderated by the overall quality performance score.

ACQA encourages providers to balance need of care with cost of care, emphasizes chronic illness management, patient safety and preventive care, and helps control cost of medical trend while at the same time driving improvement in quality health outcomes. ACQA promotes a more collaborative, higher quality, local health care system where care is better coordinated, helping eliminate unnecessary expenditures. Primary care physicians are encouraged to take a more active role in population health and are afforded better understanding of patient needs via advanced, predictive modeling technology provided by Univera Healthcare. The ACQA program provides a measurable way to track quality and savings performance by incorporating measures that are developed from accredited institutions, including the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA).

Clinical measure performance rates for ACQA are calculated using data reports generated from Univera Healthcare's selected performance measurement vendor, Arcadia Healthcare Solutions. Practices are expected to utilize the vendor performance reports to monitor practice aggregate and physician level measure performance and implement improvement interventions.

Rewarding Physician Excellence (RPE)

The RPE Program is a performance improvement incentive program for primary care physicians. This program is designed to introduce practices to both quality and cost improvements through a focus on both high quality and efficiency performance. The program also serves as a foundational step in a hierarchal portfolio of innovative payment programs and is set up as a foundation for seamless transition into more robust ACQA arrangements.

Physicians who achieve established performance goals for quality, efficiency, and operational measures can earn a Quality-Efficiency Bonus paid through a fee schedule enhancement. Efficiency measures

included in the RPE program include Avoidable ED visits (a subset of the APC measure of ED utilization) and Generic Fill Rate.

Clinical measure performance rates for RPE are calculated using data reports generated from Univera Healthcare's selected performance measurement vendor, Arcadia Healthcare Solutions. Practices are expected to utilize the vendor performance reports to monitor practice aggregate and physician level measure performance and implement improvement interventions.

Hospital Performance Incentive Program (HPIP)/Small Hospital Incentive Program (SHIP)

This pay for performance program is rolled out as hospital contracts open for negotiation. The menu-driven incentive program utilizes all payer data, rather than only Plan membership, for measurement and applies it to all lines of business contracted with the hospital. The program exists best as a component of multi-year agreements and models a prospective payment methodology. Annual performance targets using nationally recognized measures are established to define expectations for improved performance, and if the hospital achieves the target outcomes, the extra payment for quality applies the following year.

Partnering to Achieve Quality (PAQ): Provider Quality Improvement Programs

Provider quality improvement programs are designed to support our corporate mission to provide access to affordable health care and improve the health of the members and communities we serve. These programs help us do this by improving patient safety outcomes, helping providers improve fiscal performance through means other than increases in payment rates, providing assistive funding for participation in Health Plan-sponsored, focused quality programs, and supporting collaboration with providers, moving from individual inpatient and outpatient focus to regional Collaboratives that generate network-wide data driven results.

PPI Collaboratives

Univera Healthcare's Provider Quality Improvement programs are unique and innovative, as no other health plan in upstate NY has invested in programs of this type. These programs can be used by regional leadership to support collaborative activities and build significant relationships. Joint planning occurs to determine which program offering best fits with a hospital's strategy to improve overall quality and cost. Univera Healthcare provides supportive funding to providers when they join a collaborative; amount varies by program. The programs are viewed as employer/Health Plan investments that seek to align and integrate performance improvement programs with the goals of generating return on investment, impacting affordability, and improving quality of care for the communities served. Availability of these programs has become generally known in the provider community and important linkages have also resulted with the HPIP/SHIP program, further supporting these initiatives by focusing improvement efforts on the reduction of hospital-acquired infections, surgical complications, and other adverse patient safety events.

Current Provider Quality Improvement Collaboratives include:

- **Upstate NY Surgical Quality Initiative (UNYSQI): National Surgical Quality Improvement Program (NSQIP) Collaborative** - The American College of Surgeons' (ACS) National Surgical Quality Improvement Project (NSQIP) is a nationally, validated, risk-adjusted, outcomes-based program that measures and improves the quality of surgical care, with the goal of improving surgical outcomes and reduce the costs associated with them. There are approximately 17 hospitals across upstate New York are currently participating.

Monitoring and Surveillance

Ongoing Monitoring of Practitioner Performance

Univera Healthcare is committed to providing members with access to quality services. Ongoing monitoring includes participation in numerous clinical quality strategies and reporting, e.g., the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data Information Set (HEDIS®), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), the Quality Assurance Reporting Requirements (QARR), Center for Medicare and Medicaid Services (CMS), and Quality Rating System (QRS) including the D-SNP Model of Care.

As part of our efforts to improve quality, we conduct performance reporting, which includes medical/treatment record (*see 8.2 Medical Records*) and clinical quality reviews; and analysis of complaints and grievances, satisfaction data and appointment accessibility (*see 8.3 Appointment Availability Standards*). Practitioners are compared against an appropriate group of practitioners serving a comparable patient population. The criteria used for these reviews may be found within this manual and/or on our website (see below). The results of these activities are shared with the Healthcare Quality Program OversightCommittee as they become available. Univera Healthcare has a process in place to identify and, when appropriate, refer results from these activities to Univera Healthcare's medical director. This includes, but is not limited to, cases requiring action related to quality and safety issues. Practitioners are provided feedback from performance reporting and upon request from the practitioner.

- Provider.UniveraHealthcare.com/resources/clinical/quality-improvement

If any monitoring data that leads to identification of trends, a Univera Healthcare medical director will contact the provider to discuss the specific practitioner monitoring report findings and assist with identifying opportunities for improvement and plans to improve performance. The practitioner will be given the opportunity to discuss the unique nature of the practitioner's patient population, which may have a bearing on the outcome of these reports. In some cases, the recommendations are forwarded to the Credentialing Committee for consideration. Information also is reviewed at the time of recredentialing.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across the health care delivery system. At least annually, Univera Healthcare identifies areas for improvement across medical settings or transitions in care. Targeted activities are implemented to address the identified opportunity. Data collection, analysis and re-measurement are completed for each improvement opportunity.

Clinical Quality

Univera Healthcare participates in various clinical quality projects and reporting. The National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data Information Set (HEDIS®), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) are used by more than 90 percent of U.S. health plans to measure performance across the most pressing clinical areas, as well as dimensions of patient satisfaction and experience.

The Quality Rating System (QRS) is a measure set that consists of measures that address areas of clinical quality management, enrollee experience, plan efficiency, affordability, and management. The measure set includes a subset of NCQA's HEDIS measures. The survey measures in the QRS measure set will be collected as part of the Qualified Health Plan (QHP) Enrollee Survey, which is largely based on items from the CAHPS surveys. QRS is for Marketplace product lines only.

HEDIS, CAHPS, NCQA and QARR data collection are completed annually and provide a mechanism for Univera Healthcare to identify areas of opportunity for improvement in our member and community health.

Facility Monitoring

Univera Healthcare monitors hospitals through a number of initiatives, including the HPIP and SHIP programs and the Hospital Performance Report mentioned in the *Provider Quality and Performance Improvement* section.

Member Complaints, Grievances and Appeals

Univera Healthcare maintains a process to address member complaints (informal expression of concern), grievances (formal complaint) and appeals. The Healthcare Quality Monitoring Committee reviews complaint and grievance/appeal reports on a regular basis to identify trends of dissatisfaction. These reports may be used as the basis for service improvement activities and, if appropriate, for evaluating the effectiveness of interventions. Member complaints regarding providers are included in the Provider Monitoring Report when trending is identified.

Access and Availability

Univera Healthcare maintains appointment availability standards and monitors according to the standards to ensure members have access to care. Provider/member ratio standards and geographic access standards also are maintained and monitored regularly.

Member Cultural Needs and Preferences

Univera Healthcare assesses member needs annually by reviewing Univera Healthcare demographic data and provider availability for members who have preferred needs, such as availability of Spanish-speaking physicians for Hispanic members or needs based on requests for language interpreters. The Healthcare Quality Monitoring Committee reviews this information annually and develops action plans as needed.

Patient Safety

Patient safety is addressed through multi-pronged interventions, activities, collaborative efforts and oversight. Univera Healthcare monitors the safety of care provided to members in inpatient and outpatient settings and implements interventions or programs as deemed appropriate. In addition, Univera Healthcare promotes safe medication use and consultation programs that are designed to promote safe, effective and appropriate drug therapy.

Hospital Comparison Tool

Univera Healthcare provides a web-based hospital comparison tool allowing providers and members to compare hospital performance across numerous procedures and medical conditions. This tool can be found at Provider.UniveraHealthcare.com/find-a-doctor/compare-hospital-quality.Never Events Monitoring

In 2010, Univera Healthcare implemented a Never Events/Serious Adverse Events (SAE) policy. An SAE includes (i.) an extremely rare medical error that occurs in a hospital (inpatient or outpatient), outpatient setting, ambulatory surgery center or provider office, and should never happen to a patient, and (ii.) other events that should never happen to a patient (“never events”). The policy requests that the hospital voluntarily report SAEs to Univera Healthcare, including their root cause analysis and action plan related

to the SAE. The Provider Performance Improvement Department monitors data to identify any patterns in SAE occurrences.

Clinical Quality of Care Concerns

A clinical quality concern is one that may adversely affect the health and/or well-being of the member. Examples of this may include perceptions of/or actual inadequate or inappropriate treatment or failure to diagnose accurately. All Univera Healthcare members have the right to express concerns and complaints about care and services provided by physicians and other providers. Univera Healthcare must investigate and respond to these concerns and complaints within the designated timeframes. Quality of care complaints are complaints made against any provider (participating or non-participating, local provider or HOST provider), including pharmacies or an individual pharmacist within a particular pharmacy.

A clinical care review process is maintained to ensure that concerns regarding the quality of clinical care received by an enrollee are evaluated. Potential concerns regarding individual cases are identified by multiple sources and receive clinical review by a medical director team. All cases reviewed are monitored for trends over time and may receive immediate action as required by the results of review. Each review will be scored using a severity level scale of 0-5.

- **Level 0**: Absence of variation from the expected practice or no quality issue identified.
- **Level 1**: A variation from expected practice, which is considered minor in nature with no resulting complication or injury caused by the omission or commission involved.
- **Level 2**: A variation from expected practice, which is considered minor in nature with minor injury or complication with no disability caused by the omission or commission, involved.
- **Level 3**: A variation from expected practice, which is considered major in nature with disability caused by the omission or commission, involved. (Illegible medical records are considered a Level 3).
- **Level 4**: A variation from expected practice, which is considered major in nature with permanent injury or complication caused by the omission or commission involved.
- **Level 5**: A variation from expected practice, which is considered major in nature with disability or permanent injury, or death caused by gross negligence or incompetence.

Office Site Visits/Complaint Investigation

Univera Healthcare will investigate complaints from any source regarding deficiencies in the physical site of the practice for all credentialed practitioners. The threshold for conducting a site visit is two (2) formal or informal complaints from members within 12 months.

Point of Sale Pharmacy Edits

Drug Use Management programs are implemented to ensure members receive clinically appropriate and medically necessary prescription drugs. The programs are developed to ensure prescription drugs are filled safely according to the drugs' FDA-approved indications at the point of sale (POS). Edits and messages to pharmacists at POS alerting them of Drug Utilization Review (DUR) issues have been built into the claims management system.

High-Risk Medication (HRM) use in the Elderly Program

The Centers for Medicare & Medicaid Services (CMS) reviews Health Plan, provider level and member level use of high-risk medication (HRM) by the elderly. The medications included in this review are taken

from the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Univera Healthcare data is reviewed through monthly Acumen reports. Medication categories are selected for intervention based on analysis and significance. Letters may be sent to providers with a list of members on a particular medication along with the reason for the notification. Providers are encouraged to review the information and to make changes as clinically appropriate. Member notification may occur as well. In addition, Univera Healthcare also implements utilization management edits (prior authorization, quantity limits or non-formulary placement) to ensure appropriate prescribing.

FDA Drug Recall and Alert Notification

Ensuring that members are not taking medications that have been identified as having harmful interactions is critical to patient safety. To ensure that members are made aware of these risks, Univera Healthcare notifies members and/or prescribing practitioners upon receipt of a significant FDA drug recall or alert. When the members are informed of the alerts, they are encouraged to work with their practitioner to choose a safer medication. In the case of drug recalls, Univera Healthcare explains the safety issue and suggests alternatives to both the member and practitioner.

Collaborative efforts within the community also are undertaken to build health systems that reduce medical errors and enhance patient safety.

8.2 Medical Records

Applies to Univera Healthcare Participating Practitioners

Univera Healthcare requires that medical records in practitioner sites be kept in a manner that is confidential, current, comprehensive, organized and retrievable by the treating practitioner and comply with all state and federal laws and regulations. A separate medical record must be maintained for each patient. The treating provider must retain medical records for at least six years after the date of service. For treatment of a minor, medical records must be maintained for three years after the age of majority or six years after the date of the date of service, whichever is later. For Medicare Advantage, the treating provider must retain medical records for at least ten years after the end of the contract.

Medical Record Review

Univera Healthcare participating provider agreements require that providers allow for medical record access/retrieval for clinical encounter data collection programs which are part of ‘health care operations’ and without cost to Univera Healthcare. This can be done by electronic medical record (EMR) access, on-site office visits, uploading records to a portal, faxing to a secure line or mailing records. The Health Insurance Portability and Accountability Act (HIPAA) provides regulations that describes circumstances in which Univera Healthcare is permitted to use and disclose Personal Health Information (PHI) for certain activities without first obtaining individuals consent for authorization: including for treatment, payment and for health care operations such as the following:

- Conducting quality assessment and improvement activities such as the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®).

- Centers for Medicare & Medicaid Services (CMS) reporting requirements.
- Quality Rating System (QRS) reporting requirements.
- Ad hoc requests such as data research to support a focused initiative (e.g., gaps in care).
- Request of a clinical quality concern.
- Request of the Credentialing department.

Univera Healthcare Quality Measurement staff or other departmental staff collects data annually to support these activities and reports its rates to the respective oversight agencies as required. For additional information about HIPAA, see section 2 of this manual.

Univera Healthcare reserves the right to review medical records for Medical Record Documentation standards at the discretion of the Health Plan.

Medicaid Perinatal Care Medical Record Review

Univera Healthcare is required by the New York State Department of Health (NYSDOH) to perform a Medicaid Perinatal Medical Record review annually. The review supports and assesses practitioners' compliance with the NYSDOH Medicaid Perinatal Care Standards. These standards ensure that the model of perinatal care provides all pregnant women who qualify for Medicaid, comprehensive, high-quality, prenatal and postpartum care.

The process is as follows:

1. Healthcare Quality staff, Medical Director(s) and participating provider(s) develop medical record standards. Standards are based on current medical practice guidelines and reflect requirements put forth by regulatory and accrediting bodies.
2. Data Source: High-risk perinatal cases identified via in-house medical director approved OB clinical risk factors.
3. Identify members with two (2) or more high-risk diagnoses as identified by our claims data.
4. Send out notification to Health Information Management (HIM) or participating providers advising they have been selected to participate in the record review.
5. Perform review based on identified key elements of care utilizing a medical record documentation tool.
6. Records are reviewed by the Healthcare Quality Coordinator(s).
7. An analysis of the aggregate data from medical record outcomes is reported to the Healthcare Quality Committees annually.
8. Post review letters mailed to providers(s) sharing the outcome noting improvement opportunities, if indicated.

Advance Care Planning

Univera Healthcare encourages providers to discuss advance care planning and end-of-life care, including MOLST or eMOLST as appropriate, with members. All members aged 18 and older are appropriate for advance directives including completing a health care proxy to designate a health care agent to assume the responsibility of making health care decisions when the member is unable to do so. Members who are seriously ill or near the end of life are appropriate for MOLST or eMOLST.

Univera Healthcare's medical records documentation standards state that medical charts must include documentation indicating that adults aged 18 years and older, emancipated minors, minors who are married, and minors with children were given information regarding advance directives, including the Health Care Proxy.

A copy of the member's health care proxy and/or living will should also be included in the medical record, as available. For members who are appropriate for end-of-life discussions, a MOLST or eMOLST discussion should be offered and a copy of the MOLST (Medical Orders for Life-Sustaining Treatment), reference to eMOLST, or other DNR order should also be included in the medical record if they were completed.

Providers can learn more about MOLST at the website below and gain access to eMOLST at NYSeMOLSTregistry.com.

- https://www.health.ny.gov/professionals/patients/patient_rights/molst/

Univera Healthcare makes advance care planning information and forms available to providers and members through:

- Univera Healthcare's website: UniveraHealthcare.com/health-wellness/advance-care.
- Customer Care. Practitioners may request free copies of an advance care planning booklet by calling Customer Care. (For Univera Healthcare phone numbers, see the *Contact List* in this manual).

  Note: Treatment decisions cannot be conditional on the execution of advance directives.

8.3 Appointment Availability Standards

Univera Healthcare has established appointment availability standards to provide reasonable patient access to care.

These standards are available on the Univera Healthcare website (see below). Practitioners are advised that New York State standards allow visits with nurse practitioners and physicians assistants to be counted toward appointment availability compliance.

- Provider.UniveraHealthcare.com/resources/clinical/quality-improvement (in the *Quality Standards* section).

Coverage Arrangements

Physicians who participate in Univera Healthcare's managed care programs are required to advise Univera Healthcare in writing of covering participating physician arrangements or changes to those arrangements, including situations in which physicians in the same office are covering for each other. To notify Univera Healthcare of a change in coverage, physicians should update their *Practitioner Demographic Changes* form (described in the *Administrative Information* of this manual) and submit it to Univera Healthcare. Physicians should also communicate coverage arrangements to their patients.

After-Hours Care

PCPs and Specialists

When acting as a primary care physician or specialist physician, the physician must make all necessary arrangements with other network physicians to assure the availability of covered services to members of managed care benefit packages 24 hours a day, 7 days a week, including periods after normal business hours, on weekends, or when the physician is otherwise unavailable. It is understood that the physician will refer managed care members only to other network physicians, except in cases of an emergency or when no network physician is reasonably available. In the latter case, prior authorization from Univera Healthcare's medical director is required.

Acceptable Methods of After-Hours Coverage

Univera Healthcare has made a determination of what constitutes acceptable versus unacceptable methods of after-hours coverage.

Univera Healthcare members with medical problems must be able to:

- Reach the practitioner or a person with the ability to patch the call through to the practitioner (e.g., answering service); or
- Reach an answering machine with instructions that result in the ability to contact the practitioner or their backup (i.e., message with number for home, cell phone or beeper); or

- Leave a message that is automatically forwarded to the physician's beeper or cell phone. **This option is compliant only if the recording explains to the patient how the message will be handled.**

After-Hours/Urgent-Care Centers

With after-hours or urgent-care centers, patients who have minor injuries or illnesses can get the care they need and avoid time-consuming and expensive visits to the emergency room. The centers specialize in treating minor illnesses or injuries after primary care physician offices have closed for the day. Examples of minor injuries or illnesses include cuts, sprains, simple fractures, flu-like symptoms, earaches, fever and minor burns. A member who thinks they may need urgent care should first call their primary care physician to be sure the after-hours or urgent-care centers are the right place to go for treatment of their condition. Providers may view a complete list of after-hours/urgent-care centers on Univera Healthcare's website.

8.4 NYSDOH Requirements for HIV Counseling and Testing, and Care of HIV Positive Individuals

Early identification of Human Immunodeficiency virus (HIV) infection and entry into care can help HIV-infected persons live longer, healthier lives. In addition, identifying infection leads to education, which can help prevent spread of the disease.

The New York state Department of Health (NYSDOH) has HIV counseling, testing and reporting requirements, along with guidelines to help increase HIV testing, ensure entry into care, and increase laboratory reporting.

An HIV test is the only way to determine whether a person has HIV, and the decision to have an HIV test is voluntary.

All practitioners and providers must comply with the HIV confidentiality provisions of Section 2782 of the New York Public Health Law to assure the confidentiality of HIV-related information. Compliance requires:

- Initial and annual in-service education of staff and contractors.
- Identification of staff allowed access to HIV-related information and the limits of access.
- Procedure to limit access to trained staff, including contractors.
- Protocol for secure storage, including electronic storage.
- Procedures for handling requests for HIV-related information; and
- Protocols to protect from discrimination persons with or suspected of having HIV infection.

Routine HIV Testing in Medical Settings

In 2014, identifying individuals with undiagnosed HIV infection was made one of the three pillars of the New York State End the Epidemic initiative. Accessible and routine testing is intended to expand the number of patients who know their HIV status and to facilitate entry into the continuum of care or prevention once HIV testing is completed.

Health care providers in New York state are required to offer HIV testing at least once to all patients aged 13 and older. The offering must be made to members who are in inpatient settings, persons seeking services in emergency departments, persons receiving primary care as an outpatient at a clinic or from a physician, physician assistant, nurse practitioner or midwife. Testing should be offered annually or more frequently to patients with ongoing risk of infection.

Informed Consent Notification for HIV Counseling and Testing

To reduce barriers to HIV testing, the NYSDOH has published the "Expect the Test" brochure, which is available on the NYSDOH website, https://www.health.ny.gov/publications/9822.pdf.

Expressed consent is no longer a requirement for HIV testing. However, notification must be provided to the individual being tested or, if the individual lacks capacity to consent, to the person lawfully authorized to consent to health care for such individual. Minors may also consent to HIV treatment and prevention. HIV testing providers must inform patients prior to conducting an HIV-related test and must document every offer of an HIV test in the patient medical record. Patients have the right to decline the test. A patient refusal should be documented in the record, although it is not mandatory.

Universal Recommendation for Testing of Pregnant Women

HIV counseling and recommendation of testing is indicated for all women in prenatal care without regard to risk, including women presenting in labor if their status is not documented. The NYSDOH recommends that HIV counseling and testing be provided early in pregnancy, preferably at the first prenatal visit, to ensure that women who test positive receive appropriate health care, as well as therapy to reduce the risk of mother-to-child HIV transmission. It is recommended that testing and administration of prophylaxis extends to infant in cases where mother is confirmed to have a positive HIV status. Additional information regarding HIV testing during pregnancy and at delivery can be found at hivguidelines.org.

Repeat Testing in the Third Trimester of Pregnancy

Third trimester HIV testing is indicated before 36 weeks' gestation, preferably between 28 and 32, for all women who test negative for HIV early in pregnancy. This third-trimester repeat testing is strongly recommended for women who have continued risk behaviors during pregnancy or STIs. Recent studies have shown that infection during pregnancy, after an initial negative test early in pregnancy, is a leading cause of residual mother-to-child HIV transmission. The *Informed Consent* form includes language to allow pregnant women to consent once for two tests during pregnancy.

Rapid Test Technology

Rapid HIV antibody tests that can provide a preliminary* result during a single appointment are an important means for providing access to HIV testing, especially in community-based settings. Individuals may be more likely to be tested for HIV if they know that the appointment, inclusive of counseling, consent and testing, will be relatively brief.

*Further testing is always required to confirm a reactive (preliminary positive) screening test result.

Additional information about rapid testing is available at the DOH website at:

- http://www.health.ny.gov/diseases/aids/providers/testing/index.htm.

NYSDOH AIDS Institute Counseling and Testing Resources

The NYSDOH has created *the HIV Testing Toolkit: Resources to Support Routine HIV Testing for Adults and Teens* for providers, which is available at:

- https://www.health.ny.gov/diseases/aids/providers/testing/index.htm.

Contact numbers to call for HIV information, referrals or information on how to obtain a free HIV test without having to give the client's name and without waiting for an appointment are listed in the "Expect the Test" brochure. Upstate New York numbers are also listed below:

Albany: 1-800-962-5065 Rochester: 1-800-962-5063

Buffalo: 1-800-962-5064 Syracuse: 1-800-562-9423

Special initiatives are available to providers who wish to arrange for a program presentation or possible anonymous HIV counseling and testing at their sites. Providers should contact the regional coordinator of the Anonymous HIV Counseling and Testing Program at the appropriate toll-free number listed above.

NYSDOH AIDS Institute Resource Directory

The NYSDOH HIV Patient Resources Directory is a directory intended for use by individuals seeking services and as a referral tool for providers. This directory is arranged by region, with each organization listed under the region it services, and then by the service(s) it provides. This directory can be found at the NYSDOH website at:

- health.ny.gov/diseases/aids/general/resources/index.htm

Partner Notification (PN)

Medical providers are required to discuss options for partner notification (PN) with their HIV-infected patients. The NYSDOH Partner Services program (see below) can help HIV-infected patients and medical providers who would like help notifying partners that they may have been exposed to HIV. Providers are required to report all known sexual and needle-sharing partners of newly diagnosed HIV cases using the *Medical Provider Report* form (PRF) (DOH 4189).

In addition to positive HIV antibody results, laboratories are required to report electronically to the NYSDOH all viral load test results, all CD4 count and percentage results, and all genetic resistant profiles of HIV-positive persons. These results must include patient name, address, date of birth, sex, race/ethnicity, and

the ordering provider name and address. Since laboratory reports do not include partner/contact, risk factor and testing history information, medical providers medical providers are required to report online at https://commerce.health.state.ny.us/public/hcs_login.html.

NYS Partner Services (PS)

Partner Services (or Contact Notification Assistance Program – CNAP - in New York City) is a public health program that has many years of experience working with the partners of HIV positive clients. PS staff can assist health care providers in the following areas:

- Working collaboratively to address the partner notification needs of patients
- Providing consultation to health care providers who are coaching patients through self-notification
- Reviewing good practices for conducting a provider-assisted notification
- Clarifying questions about HIV confidentiality and partner notification
- Providing information about accessing HIV counseling and testing services
- Providing information about the specific conditions under which a physician, PA or NP may notify a partner of exposure to HIV without the patient's consent
- Screening for risk of domestic violence

Information about this program is available at the following number:

- PS (Statewide, outside NYC) 1-800-541-2437 (available 9 a.m.-5 p.m. weekdays)
- Or by visiting the NYSDOH website at: https://www.health.ny.gov/diseases/communicable/std/partner_services/info_for_providers.htm

NYSDOH Reporting Requirements

Public Health Law Article 21 (Chapter 163 of the Laws of 1998) requires the reporting of persons with HIV as well as AIDS to the NYSDOH within 21 days of diagnosis. The law also requires that reports contain the names of sexual or needle-sharing partners known to the medical providers or who the infected person wishes to have notified. A NYSDOH reporting form, the *Medical Provider Report* (PRF) (DOH-4189) must be completed for persons with the following diagnoses:

1. Initial/new HIV diagnosis – first report of HIV antibody positive test results
2. Previously diagnosed HIV infection (non-AIDS) Applies to a medical provider who is seeing the patient for the first time.
3. Initial/new diagnosis of AIDS – including <200 CD4 cells/ul or opportunistic infection (AIDS-defining illness).
4. Previously diagnosed AIDS – (applies to a medical provider who is seeing the patient for the first time).
5. Known sex or needle-sharing partners of persons with diagnosed HIV infection.

Information about the Electronic Clinical Laboratory Reporting System can be found at:

- https://www.health.ny.gov/professionals/reportable_diseases/eclrs/.

The PRF (DOH-4189) can be completed electronically using the Provider Portal on the NYSDOH Health Commerce System at:

- https://commerce.health.state.ny.us/public/hcs_login.html

Blank forms are available by calling the NYSDOH. The NYSDOH Bureau of HIV/AIDS Epidemiology and the New York City Department of Health and Mental Hygiene HIV Surveillance and Field Services Program also will work with clinicians to understand the documentation needed for reporting of HIV and AIDS diagnoses as required by Public Health Law 2130.

For more detailed information related to the NYSDOH reporting requirements, see the DOH website at health.ny.gov/diseases/aids/providers/regulations/index.htm.

Facilitation of Referrals and Access to Care and Services for Patients Infected with HIV

Advances in treatment have made it possible for persons with HIV infection to live longer, healthier lives. Early entry into care is critical, and the improved health of persons with HIV infection on antiretroviral therapy has contributed to an improved understanding of the importance of referral to care.

The clinician who receives a patient's confirmed positive HIV test result must make an appointment or schedule an appointment for follow-up HIV medical care as soon as possible after the positive test results are received. If the clinician does not provide HIV medical care, the patient's medical record should reflect the name of the medical provider/facility where the appointment was made. Providers should explain that if a person with HIV appears to have fallen out of care, he or she may be contacted by the medical provider or health department staff to address barriers to entry into care and promote engagement in care. For more information on finding HIV care providers and additional resources, go to health.ny.gov/diseases/aids.

The *HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information* allows individuals to use a single form to authorize release of general medical information, as well as HIV-related information to more than one provider and to authorize designated providers to share information between and among them. This form can be found at the DOH website at http://www.health.ny.gov/diseases/aids/providers/forms/index.htm.

Designated AIDS Centers

Providers may obtain information about HIV experienced providers and HIV specialist primary care physicians on our website, UniveraHealthcare.com, by using the "Find a Doctor" tool, or by Calling Customer Care at 1-866-265-5983

Designated AIDS Centers in the Univera Healthcare coverage area include Erie County Medical Center and John R. Oishei Children's Hospital. Contact information for these centers may be found using the "Find a Doctor" tool on our website.

Care of Individuals with Positive HIV Status

The NYSDOH AIDS Institute clinical guidelines pertaining to HIV prevention and the medical management of adults, children, and adolescents with HIV infection can be found on the DOH website at hivguidelines.org. Additional HIV information can also be found at:

- health.ny.gov/diseases/aids/providers/standards/index.htm.

8.5 Prevention and Treatment of Sexually Transmitted Infections

Participating providers are responsible for educating members about the risk and prevention of sexually transmitted infections (STIs). Providers must also screen and treat individuals for STIs and report cases of STI to the local public health agency or department of social services in accordance with New York State guidelines (Part 23 of Title 10 NYCRR). This regulation now allows providers to "render medical care related to sexually transmitted infections without consent or knowledge of the parent or guardian" (including HIV treatment and HPV vaccines).

Additional information and member education resources may be found at:

- https://www.health.ny.gov/diseases/communicable/std/.

STI Treatment Guidelines may be found on the CDC website at:

- https://www.cdc.gov/std/treatment-guidelines/.

Reporting of communicable disease requirements and forms may be found at:

- https://www.health.ny.gov/professionals/diseases/reporting/communicable/.

8.6 Clinical Practice Guidelines

Univera Healthcare researches adoption of clinical practice guidelines for the provision of medical and behavioral health services relevant to the populations served based on volume and the member's experience.

The Health Care Quality Planning & Monitoring Committee (HC QPMC) is responsible for the adoption and revision of clinical practice guidelines. All guidelines are reviewed and updated by the Health Care Quality Planning & Monitoring Committee upon significant new scientific evidence, change in national standards or at a minimum, every two years.

Univera Healthcare disseminates approved clinical practice guidelines to the practitioner network and enrollees in a timely manner through a variety of channels, which may include, but is not limited to, mail, email, fax, provider manual, provider newsletter, Health Plan website and upon individual request. Upon revision of an established guideline, Univera Healthcare ensures appropriate communication of updates through the same distribution channels and ensures that the adoption and revision process is consistent

with and supports the utilization management authorization and approval process for all medical necessity services.

Clinical practice guidelines vary; for a full list of programs please refer to our website:

- Provider.UniveraHealthcare.com/resources.

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Participating Provider Manual

Section 9: Medicare Advantage Programs

This section of the manual is intended for providers who participate in Medicare Advantage programs. The following provisions apply to all Medicare Advantage programs.

Revised September 2024

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9.1 Definition of Terms

For the purposes of this section:

Appeal means any of the procedures that apply to the review of adverse Univera Healthcare determinations on the health care services a member believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the member's health), or on any amounts the member must pay for a service. These procedures include reconsideration by Univera Healthcare and, if necessary, review by an Independent Review Entity (IRE), hearings before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council (MAC), and judicial review.

Quality Improvement Organization (QIO) means organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare health plans, and ambulatory surgical centers. QIOs also review continued stay denials for members receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) can provide informal dispute resolution between the health care provider (e.g., physician, hospital) and enrollee.

Contract means the agreement between Univera Healthcare and the Centers for Medicare & Medicaid Services (CMS) enabling Univera Healthcare to offer Medicare Advantage plans.

Covered Services means health care services covered under a member's Medicare Advantage plan offered by Univera Healthcare.

Dismissal is a decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

Effectuation means authorization or provision of a benefit that a plan has approved, payment of a claim or compliance with a complete or partial reversal of a plan's original adverse determination.

Grievance means an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of healthcare items, services or prescription drug, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an Organization Determination or Coverage Determination or an LEP Determination. A member or their representative may make the complaint or dispute, either orally or in writing, to Univera Healthcare, facility or provider. An expedited grievance may also include a complaint that Univera Healthcare refused to expedite an Organization Determination or reconsideration or invoked an extension to an Organization Determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Independent Review Entity means an independent entity contracted by CMS to review Univera Healthcare's adverse reconsiderations of Organization Determinations.

Inquiry means any oral or written request to Univera Healthcare, provider, or facility without an expression of dissatisfaction, such as a request for information or action by a member. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or Organization Determination process.

Member means a Medicare eligible individual who is enrolled in a Medicare Advantage plan offered by Univera Healthcare.

Organization Determination means any determination made by Univera Healthcare with respect to any of the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services
- Payment for any other health services furnished by a provider that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Univera Healthcare
- Univera Healthcare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by Univera Healthcare
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment, or
- Failure of Univera Healthcare to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member

Participation Agreement means the agreement between Univera Healthcare and any provider for the provision of covered services to members, either directly or through an intermediary organization.

Provider means any health care services provider with whom Univera Healthcare contracts, either directly or through an intermediary organization, for the provision of Covered Services to members.

Quality of Care Issues means issues pertaining to the quality of services or care provided to a member that may be raised through Univera Healthcare's grievance process and/or through a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by Univera Healthcare contracted providers meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration is a member's first step in the appeal process after an adverse Organization Determination; Univera Healthcare or IRE may re-evaluate an adverse Organization Determination, the findings upon which it was based, and any other evidence submitted or obtained.

Reopening is a remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

Representative is an individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of a member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member or party in obtaining an Organization Determination, in filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described in 42 CFR Part 405.

Urgently Needed Care refers to a non-emergency situation in which: (i) the member is temporarily absent from Univera Healthcare's service area; (ii) the member needs medical attention right away for an unforeseen illness, injury or condition and (iii) it is not reasonable, given the circumstances, to require the member to obtain services through Univera Healthcare's contracted providers.

Withdrawal is a voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

9.2 Program Summary

Univera Healthcare has contracted with CMS to offer Medicare Advantage plans to Medicare-eligible individuals. For a list of available plans, see the product portfolio elsewhere in this manual.

Univera Healthcare uses the Medicare regulations and guidelines to determine coverage and reimbursement.

Eligibility and Enrollment

Source: Medicare Managed Care Manual, Chapter 2, sections 20, 50, 50.1

Enrollment in, or voluntary disenrollment from, a Medicare Advantage program is a beneficiary election and is subject to federal government regulations. CMS has established periods in which a *beneficiary may make an election. For some such periods, there is a limit on the number of elections* that may be made.

A Medicare beneficiary may enroll in a Medicare Advantage program if they are entitled to Medicare Part A and enrolled in Part B, provided that they will be entitled to receive services under Medicare Part A and B as of the effective date of coverage under the plan, and meet other eligibility requirements.

Univera Healthcare may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS.

Discrimination Against Medicare Beneficiaries Prohibited

Source: Medicare Managed Care Manual, Chapter 4, Section 10.5.2

Univera Healthcare may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in one of its Medicare Advantage health benefit programs on the basis of any factor related to the member's health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence; and
- Disability
- End-stage renal disease*

*An individual with end-stage renal disease can enroll in a 2021 Medicare Advantage plan offered by Univera Healthcare.

Univera Healthcare observes the provisions of Section 1557 of the Affordable Care Act, Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Univera Healthcare has procedures in place to ensure that a member is not discriminated against in the delivery of health care services consistent with the benefits covered in the member's policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

General Coverage Information

Source: Medicare Managed Care Manual, Chapter 4

The following paragraphs detail *some* of the general benefits that, according to CMS, Medicare Advantage benefit packages must include. Members of Medicare Advantage health benefit programs may receive many other benefits in addition to those listed here. For details, see the product descriptions on Univera Healthcare's website.

> **Note:** For benefit information specific to any Medicare Advantage member, call Customer Care. Telephone numbers are included on the *Contact List* in this manual.

According to CMS, all Medicare Advantage benefit packages must offer coverage that includes:

- No waiting periods or exclusions from coverage due to pre-existing conditions.
- Ambulance services dispatched through 911 or its local equivalent where other means of transportation would endanger the member's health (42 CFR 410.40).
- Emergency and urgently needed services supplied without prior authorization, whether the services are obtained from participating or non-participating providers.
- Maintenance and post-stabilization care services: that is, covered services related to an emergency medical condition and that are provided after the member is stabilized either to maintain the member's stabilized condition or, under certain circumstances to improve or resolve the member's condition.
- Medically necessary dialysis from any qualified provider that the member selects when they are temporarily absent from Univera Healthcare's service area and cannot reasonably access Univera Healthcare's contracted dialysis providers.
- Screening mammography and influenza vaccinations that require no referral and no copayment.
- Original Medicare covered services, such as inpatient medical, surgical and psychiatric hospitalization, that are only covered for the duration of the benefit period.

Member Protections

Providers shall cooperate with Univera Healthcare to ensure that an initial assessment of each member's health care needs is completed within 90 days after the effective date of enrollment.

Providers shall provide covered services to members in a manner consistent with professionally recognized standards of health care.

Providers may not hold any member liable for payment of any fee that is the legal obligation of Univera Healthcare.

Providers shall continue to provide covered services to members for the duration of the contract period for which CMS has made payments to Univera Healthcare.

In the event that (i) Univera Healthcare's contract with CMS terminates, or (ii) Univera Healthcare becomes insolvent, participating providers must continue to provide covered services through the date of discharge to all members who are hospitalized.

Quality Assurance and Improvement

The Beneficiary and Family-Centered Care Quality Improvement Organization (QIO) is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. Providers must cooperate with the activities of a QIO approved by CMS in connection with the provision of covered services to members, including providing the QIO with pertinent patient care data such as information on health outcomes and information on Medicare member satisfaction.

Providers must participate in and cooperate with any Quality Assurance, Quality Improvement, and/or Resource Management program established or adopted by Univera Healthcare. Univera Healthcare shall consult with, and solicit input from, providers regarding Univera Healthcare's medical policy, quality assurance program, and medical management procedures. Providers must agree to cooperate with Univera Healthcare to ensure that the following standards are met:

- Practice guidelines and utilization management guidelines are based on reasonable medical evidence or a consensus of health care professionals in the particular field.
- Guidelines consider the needs of the enrolled population and are developed in consultation with contracting health care professionals.
- Guidelines are reviewed and updated periodically.
- Guidelines are communicated to providers and, as appropriate, to members.
- Decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

9.3 Provider Obligations

The obligations of each participating provider that are specifically applicable to Medicare members are detailed in the provider's agreement with Univera Healthcare, including obligations Univera Healthcare delegates to the provider and obligations Univera Healthcare permits the provider to delegate or subcontract.

The agreement also stipulates requirements and conditions for:

- Reporting and disclosure
- Access to books and records
- Retention of information
- Accountability
- Claims turnaround time
- HIPAA – release of information
- Univera Healthcare's termination of participation in a Medicare Advantage contract

Univera Healthcare shall not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an individual who is a patient and enrolled in a Medicare Advantage plan, about:

- The patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options,
- The risks, benefits and consequences of treatment or non-treatment; or
- The opportunity for the individual to refuse treatment and to express preference about future treatment decisions.

Healthcare professionals must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Health care professionals must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

9.4 Audits/Reviews of Medicare Advantage Programs

CMS has implemented a risk-adjusted payment methodology for Medicare Advantage programs. The methodology is based on diagnostic information as well as demographic information. In providing covered services to Medicare members, providers agree to comply with access and reporting requirements.

Medicare Advantage ICD-CM Diagnosis Coding Review

CMS requires Univera Healthcare to confirm that all diagnoses are collected and submitted with correct ICD-CM codes (current version). Therefore, Univera Healthcare conducts ICD-CM Coding Reviews of selected diagnosis codes submitted by physicians who participate in the network of Medicare Advantage providers. The coding review helps Univera Healthcare comply with CMS regulations and assist participating physicians in achieving maximum appropriate reimbursement. (Refer to the information on accurate and complete ICD-CM coding in the *Billing and Remittance* section of this manual.)

During this review, Univera Healthcare requires a copy of the pertinent medical record be obtained to support the requirements of CMS. A request for medical record documentation will be initiated by Univera Healthcare's Risk Adjustment staff or by a designated third party of Univera Healthcare. Should the provider be chosen to participate in a review of this type, the provider's office will be notified regarding the review time frames. Following this notification, a representative will contact the provider's office by phone to arrange a method of record retrieval that is most convenient for the provider. The provider may choose to submit the medical records by scheduling a time for a reviewer to come to the office or facility to electronically scan the records, or they may choose to return the records by mail or fax. Electronic transmittal is also available for those who have electronic medical records.

Medicare Advantage Risk Adjustment Data Validation Audit

Source: CMS Instructions for Medicare Advantage Risk Adjustment Data Validation Audit

CMS conducts data validation every year after risk adjustment data is collected and submitted, and payments are made to Univera Healthcare. The purpose of the risk adjustment data validation is to ensure

risk-adjusted payment integrity and accuracy. Risk Adjustment Data Validation (RADV) is the process of verifying that diagnosis codes submitted for payment by Univera Healthcare are supported by medical record documentation for a member (according to coding guidelines).

Overview of CMS Risk Adjustment Data Validation Audit

The Medicare Advantage Risk Adjustment Data Validation Audit (RADV Audit) is accomplished through medical record review. A Univera Healthcare Risk Adjustment staff member or a designated third party will initiate the review by sending a letter to providers selected for review; this letter will include a list (roster) of Medicare Advantage members identified for audit. In addition to the request, a letter from CMS will also be provided, asking for this information. The staff member or designated third party will contact the provider following the mailing of the notification to coordinate the medical record retrieval in a manner most convenient for the provider.

Univera Healthcare requires that a copy of the medical record be provided to substantiate the results of the audit by CMS. The medical record documentation is required to record pertinent facts, findings and observations about a member's health status, including past and present illnesses, examinations, tests, treatments and outcomes. The guiding principle for validation states the risk adjustment diagnosis must be:

- Based on clinical medical record documentation from a face-to-face encounter
- Coded according to the ICD-CM Guidelines for Coding and Reporting
- Assigned based on dates of service within the data collection period; and
- Submitted to Univera Healthcare from an appropriate:
  - Risk adjustment (RA) provider type (inpatient, outpatient and physician)
  - Physician data source (refer to RA physician specialty list)

Technical Medical Record Requirements

A medical record represents one face-to-face encounter on one date of service (for outpatient and physician records) or a date range (for inpatient records). Per CMS, medical records must meet the following requirements:

- The patient's name must be listed on every page of the medical record.
- The date of service must be listed on every page of the medical record and should also be within the data collection period.
- The medical record should list an acceptable risk adjustment provider type and physician specialty.
- All medical records must include a valid signature and credentials. If this is missing, the provider will be required to sign a CMS-generated attestation.

The primary goals of risk adjustment data validation are to:

- **Identify**
  - Continued risk adjustment discrepancies
  - Organizations requiring assistance to improve quality of risk adjustment data

- **Measure**
  - Accuracy of risk adjustment data
  - Impact of discrepancies on payment
- **Improve/Inform**
  - Quality of risk adjustment data
  - Correct coding
  - The CMS risk adjustment models

For more information about the ICD-CM Diagnosis Coding Validation Review or Medicare Advantage Risk Adjustment Data Validation Audit, call the number listed for Medicare Advantage Coding Review on the *Contact List* in this manual.

9.5 Member Grievances, Organization Determinations and Appeals

Source: Code of Federal Regulations (CFR) 42, Section 422.562

Relative to grievances, Organization Determinations and appeals, the rights of a Univera Healthcare Medicare Advantage member include, but are not limited to, the following:

Grievances

- The right to have grievances heard and resolved in accordance with Medicare guidelines.
- The right to request from Univera Healthcare quality of care grievance data.
- The right to file a quality-of-care grievance with a QIO.

Organization Determinations

- The right to a timely Organization Determination.
- The right to request an expedited Organization Determination or an extension, and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.
- The right to a written notice from Univera Healthcare of its own decision to take an extension on a request for an Organization Determination, which explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension.
- The right to receive information from Univera Healthcare regarding the member's ability to obtain a detailed written notice from Univera Healthcare regarding the member's services.
- The right to receive from Univera Healthcare a detailed written notice of Univera Healthcare's decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment, which includes the member's right to appeal.

Appeals

- The right to request and receive appeal data from Univera Healthcare.
- The right to request an expedited reconsideration.
- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE).

- The right to automatic reconsideration by an IRE when Univera Healthcare upholds its original adverse determination in whole or in part.
- The right to an Administrative Law Judge (ALJ) hearing if the IRE upholds the original adverse determination in whole or in part, and the remaining amount in controversy meets the appropriate threshold requirement.
- The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part.
- The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the member, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement.
- The right to request a QIO review of a termination of coverage of inpatient hospital care.
- The right to request a QIO review of a termination of services in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities.
- The right to request and be given timely access to the member's case file and a copy of that case, subject to federal and state laws regarding confidentiality of patient information (Univera Healthcare has the right to charge the member a reasonable amount for duplicating the case file material).
- The right to challenge local and national coverage determinations.

For more information about these and other member rights, contact Customer Care (See the *Contact List* in this manual).

9.6 Grievances

A member may file a grievance with Univera Healthcare for the following types of issues:

- Problems with the quality of the medical care or services provided, including quality of care during a hospital stay.
- Disagreement with Univera Healthcare's denial to give an expedited appeal.
- Disagreement with Univera Healthcare's decision to extend the time frame for making an initial decision or appeal, in which case the member may request an expedited grievance.
- The member believes they are being encouraged to disenroll from Univera Healthcare's Medicare Advantage plan.
- Difficulty getting through on the telephone or problems with Customer Care.
- Problems with waiting on the phone, in a provider's waiting room, or in a provider's examination room.
- Problems with getting appointments when needed, or in a timely fashion.
- Disrespectful or rude behavior by providers, receptionists or other staff.
- Cleanliness or condition of providers' offices, clinics or hospitals.
- Physician behavior and demeanor, adequacy of facilities and other similar member concerns
- Involuntary disenrollment situations (although disenrollment for cause requires prior CMS approval).
- Timeliness of services.

Procedure

Note: The grievance procedures presented in this section of the manual do not apply whenever the Medicare Reconsideration/Appeals Procedures are applicable**.**

1. Members may register grievances orally, in writing, via fax, via webpage, or in person no later than sixty (60) calendar days after the event.
2. Univera Healthcare will respond to most grievances in writing within thirty (30) calendar days from the date the request is received. However, if the member is filing the grievance because Univera Healthcare has determined not to give the member an expedited initial decision or an expedited appeal on a request for service, or if Univera Healthcare extends the time frame of an initial decision or appeal, Univera Healthcare will respond within twenty-four (24) hours from receipt of the request.

   All decision notifications will include information about the basis of Univera Healthcare's decision. Grievances involving clinical decisions will be made by qualified clinical personnel. Members have the right to have a representative file and/or pursue a Grievance on their behalf.

9.7 Organization Determinations

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 40.1

Note: The following paragraphs apply ONLY to Medicare Advantage programs. For information about Univera Healthcare's utilization review process applicable to other health benefit programs, see the *Benefits Management* section of this manual.

An *Organization Determination* is any determination (i.e., an approval or denial) made by Univera Healthcare for a member of a Medicare Advantage health benefit program regarding:

Payment for temporarily out of the area renal dialysis services, area emergency services, post-stabilization care, or urgently needed services.

- Payment for any other health care services furnished by a provider that the Medicare Advantage member believes are covered under Medicare or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Univera Healthcare.
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services that a Medicare Advantage member believes should be furnished or arranged for by Univera Healthcare.
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or
- Failure of Univera Healthcare to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay adversely affects the health of the member.

In circumstances where there is a question whether or not the plan will cover an item or service, the enrollee, enrollee's representative, or the provider on behalf of the enrollee, has the right to request a pre-service organization determination (prior authorization) from the plan. Such pre-service requests to the plan (even if to an agent or contractor of the plan, such as a network provider) are requests for an

organization determination and must comply with the applicable regulatory requirements. Whenever an enrollee contacts an MA plan to request a service, the request itself indicates that the enrollee believes the MA plan should provide or pay for the service. However, when a provider declines to furnish a service requested by an enrollee, this is not an organization determination because the provider is making a treatment decision (which may be based on the provider's judgment about whether the item or service should be part of the enrollee's treatment plan or whether the provider is willing to furnish the item or service, regardless of coverage by the plan).

If the enrollee wishes to request information about coverage of the benefit, the enrollee must contact the MA plan to make a coverage request for the service in question, or the provider may make the coverage request on the enrollee's behalf. The MA plan must educate enrollees and providers that when there is a disagreement with a provider's decision to decline to furnish a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive an organization determination from the MA plan about whether coverage of the benefit would be provided; such determination about coverage would likely address if the item or service is medically necessary. Further, enrollees have the right to seek treatment from other providers (such as from another provider in the network).

The following sections describe the procedures Univera Healthcare has established for making timely Organization Determinations regarding the benefits a member is entitled to receive under their Medicare Advantage plan.

Please note: a member, member's representative or a provider acting on a member's behalf has the right to request a pre-service Organization Determination if there is question about whether particular health care item or service is covered by Univera Healthcare. CMS considers participating providers to be agents of Univera Healthcare and they are responsible for knowing what health care items or services are covered or not covered before the health care items or services are furnished to members. If a participating provider is uncertain about whether a particular health care item or services is a covered benefit or whether the member may obtain those services from a non-participating provider, the participating provider is required to use the Organization Determination prior to furnishing the health care item or service or prior to sending the member to a non-participating provider.

Once an "Organization Determination" has been made, the appeals process may be triggered if a member believes that Univera Healthcare's decision is unfavorable. In the presence of any adverse Organization Determination — that is, when Univera Healthcare determines that it will not provide or pay for a requested service, in whole or in part, or if Univera Healthcare discontinues or reduces a service — Univera Healthcare must send the member a written denial notice that includes appeal rights.

If a member of a Medicare Advantage program disputes an Organization Determination, Univera Healthcare will follow the procedures outlined in paragraphs 9.8.

If a member complains about any other aspect of Univera Healthcare, (e.g., the manner in which care was provided), the grievance process described above will apply. Generally, Univera Healthcare will consider complaints about quality of care as grievances, but such complaints may also be received and acted upon by a Quality Improvement Organization (QIO).

Standard Organization Determinations

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 40.10 & 40.11

When a Medicare Advantage member requests a service, Univera Healthcare must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date Univera Healthcare receives the request for a standard Organization Determination. Part B Drug requests must be completed within 72 hours from when the request is received.

Univera Healthcare may extend the time frame up to an additional 14 calendar days for non-participating providers requesting services. This extension is allowed to occur if the member requests the extension or if Univera Healthcare justifies a need for additional information and documents how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change Univera Healthcare's decision to deny). When Univera Healthcare grants itself an extension to the deadline, it must notify the member, in writing, of the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with Univera Healthcare's decision to grant an extension. Univera Healthcare must notify the member, in writing, of its determination as expeditiously as the member's health condition requires, but no later than the expiration of any extension that occurs. Part B Drug timeframes cannot be extended.

If Univera Healthcare fails to provide the member with a timely notice of an adverse determination, this failure itself constitutes an adverse organizational determination and may be appealed.

Expedited (or "Fast") Organization Determinations

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 40.6, 40.8 &40.10

A Medicare Advantage member or any physician (regardless of whether the physician is affiliated with Univera Healthcare) may request that Univera Healthcare expedite an Organization Determination when the member or their physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

> **Note:** Expedited Organization Determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. However, if the case includes both a payment denial and a pre-service denial, the member has a right to request an expedited appeal for the pre-service denial.

Univera Healthcare will evaluate a request for an expedited determination and will promptly determine whether to approve the request. If the member's physician initiated the request for a fast determination, or if the member initiated the request for a fast determination with the support of their physician, Univera Healthcare automatically will expedite the determination. Part B Drug requests must be completed within 24 hours from when the request is received.

If Univera Healthcare decides to expedite the request, it must render a decision as expeditiously as the member's health condition might require, but no later than 72 hours after receiving the member's request.

Univera Healthcare may extend the time frame up to an additional 14 calendar days for non-participating providers requesting services. This extension is allowed to occur if the member requests the extension or

if Univera Healthcare justifies a need for additional information and documents how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change Univera Healthcare's decision to deny). When Univera Healthcare grants itself an extension to the deadline, it must notify the member, in writing, of the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with Univera Healthcare's decision to grant an extension. Univera Healthcare must notify the member, in writing, of its determination as expeditiously as the member's health condition requires, but no later than the expiration of any extension that occurs. Part B Drug timeframes cannot be extended.

If Univera Healthcare denies a request for a fast determination, Univera Healthcare will provide oral notice of the determination, with a written notice to follow within three (3) calendar days and will automatically transfer the request to a standard Organization Determination within a fourteen (14) calendar-day timeframe. Univera Healthcare may take an additional 14 calendar days if the member requests the extension, or if it is to the member's benefit when it is a non-participating provider requesting services. The notice will state that the request will be processed using the time frame for standard determinations, and that the member has the right to resubmit the request for an expedited determination or file with Customer Care an expedited grievance regarding this decision. The notice also will provide instructions on how to file a grievance.

Notification of Adverse Determinations

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 40.1, 40.12.1 & 40.12.2

Notification by Provider

Whenever a member contacts a Medicare health plan to request a service, the request itself indicates that the member believes that the Medicare health plan should provide or pay for the service. Thus, the request constitutes a Request for a Determination, and the Medicare health plan's response to the request constitutes an Organization Determination. However, if a provider declines to give a service that a member has requested or offers alternative services, this is not an Organization Determination (the provider is making a treatment decision). In this situation, the member must contact the Medicare health plan to request an Organization Determination for the service in question, or the provider may request the Organization Determination on the member's behalf. The Medicare health plan must educate members and practitioners that when there is a disagreement with a practitioner's decision to deny a service or a course of treatment, in whole or in part, the member has a right to request and receive an Organization Determination from the Medicare health plan regarding the services or treatment being requested.

Notification by Univera Healthcare

If Univera Healthcare decides to deny, discontinue or reduce services or payment, in whole or in part, and the member believes the services should be covered, then Univera Healthcare must give the member a written notice of its determination. This written notice will include:

- The specific reason for the denial that considers the member's presenting medical condition, disabilities, and special language requirements, if any.
- Information regarding the member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member's behalf.

- For service denials, a description of both the standard and expedited reconsideration processes and the time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeal process.
- For payment denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
- Notice of the member's right to submit additional evidence in writing or in person.
- An explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

9.8 Appeals Process

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 50

There are various levels of appeals available to members of Medicare Advantage health benefit programs following the receipt of notification of an adverse Organization Determination. These levels are to be followed sequentially only if the original denial continues to be upheld by the reviewing entity:

- Reconsideration of an adverse Organization Determination made by Univera Healthcare.
- The right to request and receive appeal data from the Health Plan.
- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE).
- The right to automatic reconsideration by an Independent Review Entity (IRE) when Univera Healthcare upholds its original adverse determination in whole or in part.
- Hearing by an Administrative Law Judge (ALJ), if the amount in controversy meets the appropriate threshold requirement as set forth in Section 70 of Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance.
- The right to request Medicare Appeals Council (MAC) review; and Federal Court Review if the amount in controversy is at least that established each year by the federal government.
- The right to challenge local and national coverage determinations. Individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs.

An initial, revised or reconsideration determination made by Univera Healthcare can be reopened:

- Within one year for any reason
- Within four years for just cause
- At any time for clerical correction or in cases of fraud; and
- At any time for a decision under the coverage (National Coverage Determination – NDC) appeals process.

IRE, ALJ and MAC may reopen reconsideration, hearing or review decisions, respectively, for good cause within 180 days from the date of decision, or at any time if the decision was procured by fraud or similar fault.

Right to Reconsideration

A member has the right to an appeal (also called a "reconsideration") if they do not agree with Univera Healthcare's decision about medical care or services (i.e., after receiving an adverse Organization Determination).

A member may appeal if they believe:

- Univera Healthcare has processed a claim with member liability.
- Univera Healthcare will not approve or give care it should cover, or a provider will not provide care or referrals the member thinks he or she needs.
- Univera Healthcare is stopping care that the member still needs.

Note: If a member is discharged from a hospital and the member feels it is too soon, the member must request an immediate QIO review. The member may remain in the hospital without becoming financially liable until the QIO makes its decision.

Who May Request Reconsideration?

Standard Pre-Service Reconsideration

- A member may act on their own behalf,
- A member's representative,
- The member's treating physician acting on behalf of the member* or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider); or
- Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.

*If the member's records indicate that he or she has not previously visited the requesting physician, the MA plan should undertake reasonable efforts to confirm that the member has received appropriate notification of the appeal.

Standard Payment Reconsideration

- A member may act on their own behalf,
- A member's representative,
- Non-contract provider (A non-contract provider, on his or her own behalf, may request a reconsideration for a denied claim only if the non-contract provider completes a Waiver of Liability (WOL) statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal).
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.

Expedited Reconsideration

- A member may act on their own behalf,
- A member's representative,
- Any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the member.

Representatives Filing on Behalf of the Member

Individuals who represent members may either be appointed or authorized (for purposes of this guidance, both are referred to as "representatives") to act on behalf of the enrollee in filing a grievance, requesting an initial determination, or in dealing with any of the levels of the appeals process.

- A member may appoint an authorized representative to act on their behalf, e.g., a doctor, a friend, or a lawyer.

- A member may appoint an authorized representative to act on their behalf. The member must submit Form CMS-1696, Appointment of Representative (AOR), or an equivalent written notice (hereinafter, collectively referred to as a representative form).

- A court-appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a healthcare consent statute, or an Executor of an estate may act as the member's representative to the extent provided under New York State law.

Support for Member Reconsideration

Univera Healthcare must gather all the information it needs to make a decision about the member's appeal. If Univera Healthcare requires the member's assistance in gathering this information, Univera Healthcare will contact the member directly.

A member has the right to obtain and include additional information as part of their appeal. For example, a member may already have documents related to the issue, or they may want to obtain their provider's records or the provider's written opinion to help support the request. The provider may ask the member to submit a written request in order to obtain such information.

How and When to Request a Reconsideration

A member, or (upon providing oral or written notice to the member) a physician who is treating a member and is acting on their behalf, may request a standard reconsideration orally (by telephone), via the Univera Healthcare website, by fax or in writing by filing a signed request with Univera Healthcare. Except in the case of an extension of the filing time frame, a member must file the request for reconsideration within 60 calendar days from the date of the notice of the Organization Determination. If a request for reconsideration is filed after the 60-calendar day timeframe and good cause for late filing is not provided, Univera Healthcare will dismiss the Reconsideration Request.

Reconsideration by Univera Healthcare

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 50.7.1

Standard Pre-Service Reconsiderations

Univera Healthcare normally has 30 calendar days from the date of receipt of the request for standard reconsideration to process a member's request for reconsideration for a pre-service matter. The time frame will be extended by up to 14 calendar days by the Medicare health plan if the member requests the extension or also may be extended by up to 14 calendar days if Univera Healthcare justifies a need for additional information and documents how the delay is in the interest of the member. A faster, 72-hour appeal is also available if waiting 30 days for a standard appeal could seriously harm the member's health or ability to function (see *Expedited 72-hour Appeals*, below).

For Part B Pre-Service Reconsiderations, the time frame is seven (7) calendar days by the Medicare health plan.

Standard Payment Reconsiderations

Univera Healthcare has 60 calendar days from the date of receipt of the request for standard reconsideration to process a member's appeal regarding claims payment or reimbursement or post service matter. The expedited process is not available for these types of appeals.

Expedited 72-hour Reconsiderations

The member, any physician, or the member's authorized representative may request a "fast" appeal rather than a "standard" appeal for a decision about medical care where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function. If **any** physician asks for a fast decision on a member's behalf or supports a member in their request for one, and the physician indicates that waiting for a standard decision could seriously harm the member's life, health or ability to regain maximum function, Univera Healthcare will automatically grant the member a fast decision.

If the member requests a fast appeal without support from a physician, Univera Healthcare will decide if the member's health requires it. If Univera Healthcare decides that the member's medical condition does not meet the requirements for a fast appeal, Univera Healthcare will provide the member with prompt oral notice of the denial and the member's rights and mail the member a letter within three calendar days that explains that, if the member gets a physician's support for a "fast" appeal, Univera Healthcare will automatically make a fast decision. The letter will also explain how the member may file an expedited Grievance if the member disagrees with Univera Healthcare's decision to deny the member's request for a fast appeal.

Once Univera Healthcare denies a member's request for a fast initial decision, Univera Healthcare will make its decision within the standard time frame (as explained in ***Standard Pre-Service Reconsiderations***, above).

> **Note:** If, after requesting an appeal, a member wishes to withdraw the appeal, they must do so verbally by contacting Customer Care or by sending a written notice to Medicare Advocate Unit. (For Univera Healthcare address and phone numbers, see the *Contact List* in this manual.)

Following the Reconsideration

If, following standard or expedited reconsideration, Univera Healthcare does not rule fully in the member's favor, Univera Healthcare must submit a written explanation with a complete case file to the Independent Review Entity (IRE) contracted with CMS. The member's appeal also must be forwarded to the IRE if Univera Healthcare fails to provide the member with a reconsidered determination within the time frames specified above.

9.9 Quality Improvement Organization (QIO) Review

Medicare Advantage members have a right to request a review of their discharge or Univera Healthcare's decision to end coverage for services received from a hospital, skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF).

A Medicare Advantage member may ask the Quality Improvement Organization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for the member's services. A QIO is a group of physicians and health professionals paid by the federal government to monitor and help improve the quality of care provided to Medicare patients.

Participating providers shall cooperate with the activities of the QIO in connection with any review of the provision of covered services to members, including providing QIOs with pertinent patient care data such as information on health outcomes and information on Medicare member satisfaction.

New York State QIO

There is one Care Quality Improvement Organization (QIO) in each state. The QIO for New York State is Livanta. Contact information for Livanta is included on the *Contact List* in this manual.

QIO Review of Hospital Discharge

A member may request an immediate QIO review if the member disagrees with Univera Healthcare's determination not to cover a continued hospital stay. A QIO review allows members to remain in the hospital without incurring financial liability (except any applicable copayments or deductibles) while the review is being conducted. This review takes the place of the regular appeal process available through Univera Healthcare, as described in paragraphs 9.8, above. The steps involved in requesting a QIO review are as follows:

1. Upon admission to the hospital and prior to discharge, the hospital gives the member an "Important Message from Medicare" (IM), which includes the member's appeal rights. Please refer to Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 100.1 for detailed instructions on issuing the IM.
2. If the member believes they are being discharged too soon, the member contacts the QIO listed on the IM. In order to be considered timely, the request must be made no later than midnight of the day of discharge. The request may be in writing or by telephone and must be requested before the member leaves the hospital.
3. The QIO calls Univera Healthcare on the same day the member contacts the QIO and requests information on the case.

4. The entity that made the decision to discharge the patient (e.g., the hospital) completes a Detailed Notice of Discharge (DNOD) form (CMS-10066) that includes the clinical rationale for the discharge.
5. The hospital delivers the DNOD to the member (or their representative) by noon of the day after the QIO notifies Univera Healthcare of the appeal.
6. Univera Healthcare and/or the Hospital forward the DNOD and all supporting case documentation to the QIO by noon of the day after the QIO notifies Univera Healthcare of the appeal.
7. The QIO makes a determination on the case and notifies Univera Healthcare, the hospital and the member of its decision within one calendar day after it receives all pertinent information on the case. The QIO will communicate its decisions by telephone, followed by written notice.

Univera Healthcare is financially responsible for coverage of services during the QIO review. When the member makes a timely request for an appeal, they are not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the member receives notification of the determination by the QIO. Liability for further inpatient hospital services depends on the QIO decision:

- Unfavorable determination: If the QIO does not agree with the member, liability for continued services begins at noon of the day after the QIO notifies the member that the QIO agreed with the discharge determination.
- Favorable determination: If the QIO agrees with the member, the patient is not financially responsible for continued care until Univera Healthcare and hospital once again determine that the member no longer requires inpatient care and secure the concurrence of the physician, and the hospital notifies the member with a follow-up copy of the IM.

If the member makes an untimely request for an appeal (after midnight on the day of discharge or after they left the hospital), the member may request an expedited reconsideration by Univera Healthcare, but the member may be held responsible for charges incurred after the day of discharge. If the appeal is overturned, Univera Healthcare must continue covering the care and/or refund the member for any expenses the member incurred during the review.

A member who is dissatisfied with the QIO decision can request a reconsideration from the QIO within 60 days of receiving notification of the original QIO decision. The QIO must issue its reconsidered determination as expeditiously as the member's health requires but no later than 14 days from the date of receipt of the request. The member's financial liability is determined by the QIO's decision. If the member is no longer in the hospital, he or she may appeal directly to an Administrative Law Judge, the MAC or a federal court.

Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC)

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 100.2 and Chapter 30 of the Medicare Claims Processing Manual, Section 260

The NOMNC is an Office of Management and Budget (OMB)-approved standardized notice. The NOMNC is a written notice designed to inform Medicare members that their covered Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), care is ending. All Medicare members receiving covered SNF, HHA or CORF services must receive a NOMNC upon

termination of services, even if they agree that services should end. Although Univera Healthcare is responsible for either making or delegating the decision to end services, SNFs, HHAs (except for certain circumstances), and CORFs are responsible for delivering the notices to Medicare members no later than two days prior to the proposed termination of services.

Completing the NOMNC

Providers must insert the following patient-specific information in the NOMNC prior to delivery to the Medicare member:

- The member's name
- The date that coverage of services ends

The name, address and telephone number of Univera Healthcare or provider that delivers the notice must appear above the title of the form. Univera Healthcare or provider's registered logo is not required but may be used. If Univera Healthcare's name and contact information are not in the space above the title of the form, they must be displayed elsewhere on the form for the member's use in case an expedited appeal is requested, or the member or QIO seeks Univera Healthcare's identification. The notice *must* also identify and provide the telephone number of the appropriate QIO. All other required elements of the notice are included in the standardized material on the notice. The provider also has the option to include additional information in the space provided on the notice. The NOMNC may be modified for mass printing to indicate the kind of service being terminated if only one type of service is provided, such as skilled nursing, home health, or comprehensive outpatient rehabilitation facility.

Providers may not rewrite, re-interpret, or insert non-OMB approved language into the body of the NOMNC except where indicated.

NOMNC Delivery Requirements

Providers must ensure the NOMNC is validly delivered in accordance with the following:

1. The member must be able to understand the purpose and contents of the NOMNC and understand that he or she may appeal the termination decision.
2. The member must sign and date the NOMNC to acknowledge receipt whether or not the member agrees that coverage for services should end. If the member refuses to sign the notice, the notice is still valid, as long as the provider documents that the notice was given but the member refused to sign.
3. If the member is physically unable to sign or needs assistance of an interpreter or assistive device to read or sign, the provider should document the use of such assistance to validate the delivery.
4. The CMS believes valid delivery is best accomplished by face-to-face contact with the Medicare member. The provider must deliver the NOMNC in person unless the member is unable to comprehend the contents of the notice.
5. If the member is not able to comprehend the contents of the notice, it must be delivered to and signed by the member's representative.

NOMNC Delivery Requirements When a Member's Representative is Unavailable

Providers are required to develop procedures to use when the member is incapable or incompetent, and the provider cannot obtain the signature of the member's representative through direct personal contact.

If the provider is personally unable to deliver a NOMNC to a person acting on behalf of a member, then the provider **must**:

1. Telephone the representative to advise him/her when the Medicare member's services are no longer covered.
2. Describe the purpose of the call, which is to inform the representative about the member's right to file an appeal.
3. Identify him/herself and provide a contact number for him/herself and Univera Healthcare.
4. Describe how to get a copy of a detailed notice describing why the member's services are not being provided.
5. Describe the member's appeal right to appeal to the QIO.
6. Inform the representative of the date and time by which the appeal must be filed to take advantage of the appeal right.
7. Identify the QIO required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the QIO requires in order to receive the appeal in a timely fashion; and
8. Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE, that can provide additional assistance to the representative in further explaining and filing the appeal.

The date the provider conveys this information to the representative is the date of the receipt of the NOMNC. The provider must confirm the telephone contact by written notice mailed on that same date. The provider must place a dated copy of the written notice in the member's medical file and document the telephone contact with the representative.

When direct phone contact cannot be made, the provider must send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. The provider must place a dated copy of the notice in the member's medical file. When the notice is returned by the post office with no indication of a refusal date, then the member's liability starts on the second working day after the provider's mailing date.

When to Deliver the Notice of Medicare Non-Coverage

SNFs, HHAs and CORFs must provide written notice (the NOMNC) to Medicare members no later than two days before the coverage of services will end. If, upon receiving the NOMNC, the member decides to appeal the end of coverage, they must contact the QIO to do an independent review of whether it is medically appropriate to end coverage of the services. QIOs have different names, depending on which state they are in. In New York state, the QIO is called Livanta.

The member must contact Livanta as soon as possible, but no later than noon of the day before the date that the member's coverage ends. Requests are to be by telephone or fax to:

Livanta Phone Number: 1-866-815-5440
Livanta TTY: 1-866-868-2289

Exclusions from NOMNC Delivery Requirements

Providers are not required to deliver the NOMNC if coverage is being terminated for any of the following reasons:

• When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).

• When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).

• When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF). Form Instructions 10123-NOMNC OMB Approval 0938-xxxx

• When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).

• When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).

• When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

• When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

When a Detailed Explanation of Non-Coverage (DENC) will be Issued

Univera Healthcare will issue a DENC explaining why services are no longer medically necessary to the member and provide a copy to the QIO no later than close of business (typically 4:30 P.M.) on the day of the QIO's notification that the member requested an appeal, or the day before coverage ends, whichever is later.

Complete instructions regarding the requirements for completing and delivering the NOMNC and DENC are available on the CMS website or from Customer Care.

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices

http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/NOMNCInstructions.pdf

http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/DENCInstructions.pdf

If a member misses the deadline for requesting an immediate appeal with the QIO, the member may still request an expedited appeal through Univera Healthcare. If the request does not meet the criteria for an expedited review, Univera Healthcare will review the decision under its rules for standard appeals.

9.10 Prescription Drugs Part D

Appealing Coverage Determinations (Redetermination)

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 50.

An appeal (redetermination) is any of the procedures that deal with the review of an unfavorable coverage determination. Members may file an appeal if they want Univera Healthcare to reconsider and change a decision made about what prescription drug benefits are covered or what will be paid for a prescription drug. Members cannot request an appeal if a coverage determination has not been issued. As with coverage determination exception requests, CMS requires the prescribing physician to submit a supporting statement if the member or their appointed representative requests an appeal relating to an exception request, such as a tiered cost-sharing or quantity limit appeal.

Members, or their appointed representative, must request a redetermination in writing within sixty (60) calendar days from the date of the coverage determination. They also can request an expedited or "fast appeal." These requests will be accommodated if Univera Healthcare determines, or the member's physician tells us, that waiting for a standard decision will seriously jeopardize the member's life or health. Once Univera Healthcare receives the redetermination request, Univera Healthcare has seven (7) days for a standard request for coverage or payment and 72 hours for an expedited request for coverage to notify the member of its decision.

The parties who may request a standard or expedited redetermination include a member, a member's representative or a member's prescribing physician or other prescriber.

A prescribing physician or other prescriber may act on behalf of a member in requesting a standard or expedited coverage determination, a standard or expedited redetermination or a standard or expedited IRE reconsideration without being the member's representative. In these situations, the physician does not have all of the rights and responsibilities of a member.

Under *42 CFR 423.580*, a non-representative physician or other prescriber may request a standard redetermination on a member's behalf only after he or she has provided notice to the member that he or she is making the appeal request (physicians or other prescribers are not required to provide such notice to member when requesting expedited redeterminations).

The Part D plan sponsor must provide written notice of its redetermination, whether favorable or adverse, as expeditiously as the member's health condition requires, but no later than seven (7) calendar days from the date the Part D plan sponsor receives the request for a standard redetermination.

Univera Healthcare
Participating Provider Manual

Section 10: Government Programs

Revised September 2024

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10.1 Child Health Plus Medicaid Managed Care

Univera Healthcare offers HMO programs, sponsored by New York state, that are intended to help ensure medical coverage for the uninsured. These programs are Child Health Plus (CHP), Univera Healthcare MyHealth[SM] and MyHealth Plus[SM] in Erie County. Covered benefits vary by program and are primarily determined by New York state. Please refer to the benefit chart at the end of this section for additional details.

In addition to every provision of this manual, the following provisions apply with regard to Child Health Plus and Medicaid Managed Care, also referred to as MMC (Univera Healthcare MyHealth[SM] and MyHealth Plus[SM]).

Applying for Child Health Plus or Medicaid Managed Care

Prospective members may contact Univera Healthcare for information about enrollment in any of these programs. The prospective members may schedule an appointment with a Univera Healthcare Marketplace Facilitated Enroller or Community IPA/ Navigators to provide in-person enrollment assistance. Prospective members may visit NY State of Health marketplace at info.nystateofhealth.ny.gov/IPANavigatorSiteLocations for a list of navigators in their area or contact Univera Healthcare to schedule an appointment with a Marketplace Facilitated Enroller.

Prospective Child Health Plus members can apply online through the NY State of Health Marketplace at https://nystateofhealth.ny.gov/, or by phone at 1-855-355-5777.

Applicants for each of the programs must meet certain income guidelines. Income guidelines vary by program and may change from year to year.

Restrictions

Members of these HMO government programs must follow all the rules and guidelines of a typical HMO. This includes selecting a primary care physician (PCP) who coordinates all their care, including obtaining referrals to specialists and obtaining preauthorization for specified services. Information regarding referral and preauthorization requirements is included in the *Benefits Management* section of this manual.

These requirements may vary from the requirements of Univera Healthcare's commercial HMO and point-of-service health benefit programs.

For services to be covered, members must use providers who participate in Univera Healthcare's government program network, or by approval to an out-of-network provider. Not all providers participate in all programs.

If Univera Healthcare's panel of providers does not include a health care provider with the appropriate training and experience to meet a member's particular health care needs, the member's PCP must submit a letter of medical necessity to request service from an out-of-network provider. Univera Healthcare may grant a referral, pursuant to a treatment plan approved by Univera Healthcare's medical staff in consultation with the PCP, the non-participating provider, and the member.

In such event, Univera Healthcare will arrange for the covered services to be provided at no additional cost to the member beyond what the member would otherwise pay for services received within Univera Healthcare's provider network. In no event shall Univera Healthcare be required to permit a member to receive services from a non-participating specialist, except as approved above.

Univera Healthcare conducts utilization review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a member are medically necessary. For these programs, medically necessary means that the health care and services are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote the normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability.

Restricted Recipient Program

New York State mandates that individuals enrolled in the state Medicaid Restricted Recipient Program (RRP) join a managed care health plan. Restricted recipients are individuals who have been identified as abusers or misusers of the Medicaid program.

These individuals can be restricted to providers in one or more of the following categories:

- Physician, physician group
- Nurse practitioner
- Clinic
- Inpatient hospital
- Dental, dental clinic
- Pharmacy (Effective 4/1/2023, pharmacy restrictions are implemented and managed by OMIG)
- Ancillary services providers

As a result, Univera Healthcare can only make payment to the provider of record in these categories, or to a provider who has received a referral from the restricted member's PCP. The PCP of record for a restricted member is required to notify Univera Healthcare each time they refer a restricted patient for any service that will be rendered outside of their practice. This applies to all services, not only those in restricted categories.

It will be very important that the provider verify member eligibility for restricted recipients. MMC restricted recipients will have **"RRP"** listed after the last name on their member identification card. A restricted recipient can also be verified by calling Customer Care.

How to Select or Change PCP

Members may select or change their PCPs by:

- Calling the customer care numbers on their ID cards.
- Faxing a *PCP Selection Form* (available via our website) to Univera Healthcare. Providers may have the member complete it in the office and fax it to Univera Healthcare at the fax number listed on the form. (The fax number is also included in the *Contact List* in this manual.)

Family Planning

All claims for MMC family care planning and reproductive services must be billed to Univera Healthcare and not Medicaid fee-for-service.

Univera Healthcare MyHealth℠ and MyHealth Plus℠

Univera Healthcare MyHealth℠ and MyHealth Plus℠ are HMO health benefit programs for New York State residents who are eligible for Medicaid and who live in Erie County.

- The program maintains the benefit structure of Medicaid but requires members to follow all of the HMO rules and guidelines. (Medical management requirements may vary slightly from Univera Healthcare's commercial health benefit programs.)
- Some services are not part of the benefit package but rather are covered under the Medicaid fee-for-service program.
- Emergency and non-emergency transportation services are carved out of the MMC benefit. Non-emergency transportation is handled by Medical Answering Services (MAS). Each county has a specific MAS contact phone number. Please visit the MAS website at www.medanswering.com for county-specific contact phone numbers.
- Members who participate in Univera Healthcare MyHealth℠ and MyHealth Plus℠ have no premiums, deductibles, copays or coinsurance. (Limited copays apply to pharmacy items and services, and medical supplies).
- The pharmacy benefit is administered through Express Scripts, Inc., an independent company. Please contact Univera Healthcare for provider customer service and prior authorization related to the pharmacy benefit.
- The dental benefit is managed through Healthplex, Inc., an independent company (phone 1-800-468-9868).
- A member's eligibility for Univera Healthcare MyHealth℠ and MyHealth Plus℠ is always month-to-month, from the first of the month through the last day of the month.
- Please refer to the Univera Healthcare MyHealth Plus℠ manual for information related to that product. Participating providers in Univera Healthcare's MMC provider network can provide care to members that reside in a county that offers Univera Healthcare MyHealth℠.

Child Health Plus

Child Health Plus is a New York State program designed to cover children under age 19, who are residents of New York, whose families have no comparable insurance coverage, and who are ineligible for Medicaid.

The amount of the monthly premium is based on income and family size. There are no deductibles, copayments or coinsurance.

Additional information is available by calling 1-800-698-4543, or by visiting the New York State Department of Health (NYSDOH) website, https://www.health.ny.gov/health_care/child_health_plus/.

Prospective Child Health Plus members can apply online through the NY State of Health Marketplace at https://nystateofhealth.ny.gov/, or by phone at 1-855-355-5777.

Univera Healthcare offers Child Health Plus in Erie County. Members may see providers in Erie County and affiliated provider offices as long as the provider participates in Univera Healthcare's Child Health Plus provider network.

The pharmacy benefit is administered through Express Scripts, Inc., an independent company. Please contact Univera Healthcare for provider customer service and prior authorization related to the pharmacy benefit. See the *Pharmacy Management* section of this manual for additional information.

10.2 General Requirements

Minimum Office Hours

In keeping with requirements established by the New York State Department of Health (NYSDOH), PCPs who serve Child Health Plus, Univera Healthcare MyHealth℠ and MyHealth Plus℠ members must practice a minimum of 16 hours at each office location.

The NYSDOH will waive this requirement under certain circumstances:

- Univera Healthcare must submit a waiver regarding a specific physician to the Medical Director of the NYSDOH Office of Managed Care.
- The physician must be able to fulfill the responsibilities of a PCP, as defined in the *Benefits Management* section of this manual.
- The physician must be available at least eight hours a week.
- The physician must be practicing in a Health Professional Shortage Area (HPSA) or in a similarly determined shortage area.
- The waiver request must demonstrate that there are systems in place to guarantee continuity of care and fulfillment of the appointment availability and 24-hour access standards defined in the *Quality Improvement* section of this manual or on our website:
    - Provider.UniveraHealthcare.com/resources/clinical/quality-improvement
- The NYSDOH notifies Univera Healthcare when a waiver has been granted.

Identifying Members

Members of Child Health Plus, Univera Healthcare MyHealth℠ and MyHealth Plus℠ have identification cards that include the Univera Healthcare logo. Providers can determine in which government program the member is enrolled by specific designations noted on the ID card.

Program	ID card designation
Child Health Plus	Group code "C"
MMC	Univera Healthcare MyHealth℠
Restricted Recipient	The letters "RRP" entered into the "Title" field. **Example:** JOHN A. DOE **RRP**
Health and Recovery Plan (HARP)	MyHealth Plus℠

Checking Eligibility

Providers may check eligibility for Univera Healthcare MyHealth℠, Child Health Plus and MyHealth Plus℠ members using the inquiry methods described in this manual. In addition, eligibility information for Univera Healthcare MyHealth℠ and MyHealth Plus℠ members is available via the Medicaid eligibility verification system, *ePACES,* www.emedny.org/epaces. The code for Univera Healthcare MyHealth℠ membership is "MR" and MyHealth Plus℠ is "EE." Under the ePaces Eligibility Response Details Section field "Medicaid Managed Care" the Plan name is listed as Excellus Health Plan Inc.

Prior to rendering services, always check the member's identification card and visit Provider.UniveraHealthcare.com to verify eligibility and coverage.

Other options for checking eligibility are the Medicaid telephone system, or the PC Medicaid eligibility software. Providers should have the member's name, date of birth and CIN number available before calling.

> **Note:** Univera Healthcare recommends that providers check eligibility at every visit as members may lose eligibility for government programs from month to month.
>
> **Also Note:** If the member's PCP is not listed correctly on the member ID card, the member may make a change by calling the Customer Care number on the ID card at the time of the appointment. Another option is for the provider to have the member complete the *PCP Selection Form* and fax it to the number on the form, available online at:
>
> - Provider.UniveraHealthcare.com/resources/forms

Speaking with Members

Note: A complete list of Member Rights and Responsibilities is included in Section 1 of this manual.

Univera Healthcare expects participating providers to maintain certain standards when speaking with members.

Participating providers must:

- Provide complete and current information concerning diagnosis, treatment and prognosis in terms a member can understand. When it is not advisable to give such information to the member, make the information available to an appropriate person acting on the member's behalf.
- Prior to initiating a service, inform a member if the service is not covered and specify the cost of the service. Providers must notify the member in writing prior to providing a service that is not covered, informing the member that they will be liable for payment.
- Prior to initiating a procedure or treatment, provide the information a member needs to give informed consent. Tell the member to contact Customer Care for information about accessing services not covered by Univera Healthcare. (For contact information, see the *Contact List* in this manual.)
- Disclosure of affiliation to patients. According to the Medicaid contract, participating providers must advise patients of their affiliation with all managed care plans. Participating providers may display Univera Healthcare's marketing materials, provided that appropriate notice is clearly posted for all health plans with which they have a contract.

Interpretation Services

Univera Healthcare reimburses outpatient providers for interpretation services for Medicaid Managed Care members.

- Available for eligible Medicaid Managed Care members with limited English proficiency and communication services for members who are deaf and hard of hearing.
- Services may be facilitated face-to-face or by telephone.
- Services are coordinated by the provider and are not the responsibility of the member.
- The need for interpretation services must be documented in the member's medical record.
- The interpretation service must be provided during the medical visit by a third-party interpreter, who is either employed by or contracted with the Medicaid provider.

False Claims Act Reminder

Univera Healthcare expects participating providers to understand the state and federal requirements regarding false claims recovery. We have policies and procedures for the detection and prevention of fraud and abuse, including detailed information about the False Claims Act.

Our policy is posted to our website, UniveraHealthcare.com. Providers participating with Univera Healthcare MyHealth℠, Child Health Plus and MyHealth Plus℠ are also obligated to report and return overpayments to the plan within 60 days of the time when the overpayments are identified. To view our overpayment self-disclosure policy, visit our website.

Disclosure of Ownership and Control Information

Univera Healthcare contracts with Medicaid, and section 18.6(b) of Federal Regulation 42 CFR 455.104 requires that we obtain ownership and control disclosures from providers who participate in MMC.

We are required to collect a disclosure from any individual or corporation with an ownership or control interest in a provider who contracts with us to provide Medicaid services. This requirement does not apply to individual or group practitioners. We are required to collect a disclosure from any individual or corporation with an ownership or control interest of 5 percent or more in a provider who contracts with us to provide Medicaid services.

Applies to: MMC providers (other than an individual practitioner or group of practitioners). Affected providers include facilities/institutions, ancillary and suppliers. Not-for-profit organizations are not excluded from this regulation.

Examples include but are not limited to: hospital, skilled nursing, free standing, home health, independent reference laboratory, ambulance and durable medical equipment providers.

Excluded Providers: Individual practitioner or group of practitioners, any state or federal government provider is excluded from this regulation.

Collection of Provider Disclosure

Disclosure of ownership and control information will be collected at any of the following times:

(1) Upon the provider submitting the provider application

(2) Upon the provider executing the provider agreement

(3) Upon a change in ownership which must be reported within 35 days of the change

Changes in Ownership and Control

Providers must notify us of any changes to their ownership and control within 35 days by completing the Disclosure of Ownership and Controlling Interest Statement. This form can be downloaded from our website, Provider.UniveraHealthcare.com/resources/forms, in the Administration section.

Provider Enrollment in the New York State Medicaid Program

As a reminder, effective January 1, 2018, per Section 5005 of the 21st Century Cures Act, federal law requires that Medicaid Managed Care, Health and Recovery Plan and Children´s Health Insurance Program network providers must be enrolled with New York State‘s Medicaid program. The Medicaid provider enrollment process is for the State to ensure appropriate and consistent screening of providers and improve program integrity. FFS-enrollable provider types in the Univera Healthcare provider network must enroll in Medicaid or will be removed from our provider network. Enrollment as a Medicaid provider does not require the provider to see Medicaid fee for service patients. For any questions, please refer to:

- https://www.emedny.org/info/ProviderEnrollment/index.asp

10.3 Perinatal, Postpartum and Newborn Care

New York State Requirements

Univera Healthcare is obligated by the NYSDOH to have participating providers follow the standards defined by New York Public Health Law, with appropriate detail as defined by the Medicaid Prenatal Care Standards, which can be reviewed on the NYSDOH website:

Medicaid Perinatal Care Standards (ny.gov)The NYSDOH recommends that any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day.

The standards incorporate evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid coverage, regardless of provider or delivery system. They integrate updated standards and guidance from the American College of Obstetrics (ACOG) and the American Academy of Pediatrics (AAP), and reflect expert consensus regarding appropriate care for low income, high-risk pregnant women.

The standards provide a comprehensive model of care that integrates the psychosocial and medical needs and reflects the special needs of Medicaid population. The following topics are covered:

A. Requirements
B. Access to Care
C. Prenatal Risk Assessment, Screening and Referral for Care
D. Psychosocial Risk Assessment, Screening, Counseling and Referral for Care
E. Nutritional Screening, Counseling and Referral for Care
F. Health Education
G. Development of a Care Plan and Care Coordination
H. Prenatal Care Services
I. Postpartum Services

The NYSDOH has provided the following contact information to request further information:

- Ambulatory Care Payment Information:
  General Policy, Rates Weights, Carve Out Payment Rules or Implementation Issues:
  518-473-2160 or apg@health.state.ny.us

APG website: www.health.ny.gov/health_care/medicaid/rates/apg/baserates.htm

- Billing, Remittances and Onsite Training: 1-800-343-9000
  Grouper Software, Pricer Product Support, 3M HIS Sales:
  1-800-435-7776 or 1-800-367-2447, or 3mhis.com
- Local Departments of Social Services: www.health.ny.gov/health_care/medicaid/ldss.htm
- Perinatal Care Standards Development: Office of Health Insurance Programs, 518-486-6865 or fcg01@health.state.ny.us
- Perinatal Care and Managed Care: Division of Managed Care, Office of Health Insurance Programs, 1-518-473-1134 or omcmail@health.state.ny.us
- Presumptive Eligibility: Medicaid Coverage and Enrollment, Office of Health Insurance Programs, 1-518-474-8887

Univera Healthcare has policies and standards addressing many of the areas listed above, as well as clinical guidelines that address some of the standards specific to obstetrics.

Clinical Guideline for Perinatal and Postpartum Care

Univera Healthcare has adopted the American College of Obstetrics (ACOG) and NYSDOH's guidelines for perinatal and postpartum care, which are meant to serve as a reference for physicians and health professionals who provide services to pregnant members of Univera Healthcare's programs. These standards can be found on the NYSDOH website:

- https://www.health.ny.gov/health_care/medicaid/standards/perinatal_care/

Univera Healthcare's perinatal and postpartum guidelines address the following, as well as other care specific to obstetrics:

- Comprehensive risk assessment, including but not limited to genetic, nutritional, psychosocial and historical and emerging obstetrical/fetal and medical/surgical risk factors.
- Nutrition assessment and referral.
- Perinatal diagnostic treatment services and postpartum services, including recommendations for HIV testing and counseling and post-HIV-test counseling.
- Coordination of care between providers of perinatal care and the PCP, pediatrician and other related providers.
- Management and coordination of care for high-risk pregnancies.
- After-hours emergency consultations.
- Postpartum services that include referral to and coordination with a neonatal care provider for pediatric care services.
- MMC Enrollees:

  Women's Services do not require a referral if the member presents with or needs any of the following:
  - pregnancy
  - OB/GYN services

- family planning services
- midwife services
- breast or pelvic exam

Family Planning Services do not require a referral for the following:

- advice for birth control
- birth control prescriptions
- male or female condoms
- pregnancy tests
- sterilization
- abortion

MMC members may also choose to see a non-participating provider for family planning services. These services can be billed to Medicaid fee-for-service. Members may contact the NYS Growing Up Healthy Hotline at 1-800-522-5006 for the names of available family planning providers.

Medicaid Prenatal Care Medical Record Review

The Medicaid Prenatal Care Medical Record Review process is designed to assess the practitioner's compliance with the NYS Prenatal Standards. A sample of medical records is assessed on an annual basis. To assess the quality of medical record keeping practices, an 80 percent performance goal has been established by Univera Healthcare.

- The Prenatal Standards are based on current medical practice guidelines and reflect requirements put forth by regulatory and accrediting bodies. Standards are assigned points for the purpose of scoring provider compliance.
- A random sample of records is reviewed annually for Medicaid members who had a delivery in the 12 months prior to the review period.
- Comprehensive obstetrical medical records are requested from practitioners and reviewed at Univera Healthcare.
- Annually, aggregate reports of compliance with standards are presented to the Quality Program Oversight Committee (QPOC) identify opportunities for improvement. Actions, interventions and follow-up are implemented based on the results of the annual review.

See the *Quality Improvement* section of this manual for additional details.

Newborn Coverage

The newborn child of a Child Health Plus member does not automatically receive health coverage. To enroll the newborn of a Child Health Plus member, the parent or guardian must complete an application. For information about insurance options for the newborn, the parent or guardian may call the Customer Care number on their ID card (for contact information, see the *Contact List* in this manual), or they may contact NY State of Health Marketplace through its website, https://nystateofhealth.ny.gov/, or by phone at 1-855-355-5777.

The newborn child of a Univera Healthcare MyHealth[SM] member is entitled to coverage for one year. Providers may encourage pregnant women to contact their Medicaid Case Worker at the local Department of Social Services or the NY State of Health Marketplace to enroll the unborn child prior to birth.

10.4 Early and Periodic Screening, Diagnostic and Treatment

Overview

The federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). It requires that any medically necessary health care service listed at Section 1905(a) of the Social Security Act be provided to an EPSDT recipient, even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan.

The EPSDT manual is available for reference on the NYSDOH website at emedny.org under *Provider Manuals*.

New York's Child Teen Health Program

New York State follows EPSDT guidelines through its Child Teen Health Program (C/THP). Care and services are provided in accordance with the periodicity schedule and guidelines developed by the NYSDOH. They generally follow the recommendations of the Committee on Standards of Child Health, American Academy of Pediatrics. The guidelines also emphasize recommendations such as those described in Bright Futures to guide health care providers and improve health outcomes for members. C/THP promotes the provision of early and periodic screening services and well care examinations, with diagnosis and treatment of any health or behavioral health and substance use problems identified during these exams.

Clinical Guidelines

Univera Healthcare has established clinical guidelines for preventive care as a reference for physicians and other health professionals who provide services to pediatric and adolescent members of its programs. They are located online at:

- Provider.UniveraHealthcare.com/policies/guidelines/clinical-practice

The clinical guidelines recommend care for infants, children and adolescents in accordance with EPSDT guidelines.

Health Plan and Provider Requirements

Univera Healthcare and its providers must comply with the C/THP program standards and do at least the following for eligible members:

- Educate pregnant women and families with under age 21 enrollees about the program and its importance to a child's or adolescent's health.
- Educate network providers about the program and their responsibilities.
- Conduct outreach, including by mail, telephone and through home visits (where appropriate), to ensure that children are kept current with respect to their periodicity schedules.
- Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals and conduct follow-up with children and adolescents who miss or cancel appointments.
- Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen.
- Achieve and maintain an acceptable compliance rate for screening schedules.

The package of services includes administrative services designed to assist families to obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.

10.5 Vaccines for Children (VFC)

All providers administering vaccines to children under age 19 covered by Univera Healthcare MyHealth℠ or Child Health Plus must participate in the New York Vaccine for Children (NYVFC) program. NYVFC provides the vaccines free of charge. For more information about VFC and how to obtain vaccines, providers should call VFC directly. The eligible vaccines are listed on the Centers for Disease Control and Prevention website. (The telephone number for NYVFC and the website for the CDC VFC program are included on the *Contact List* in this manual.) See the *Billing and Remittance* section of this manual for information about submitting claims.

10.6 Vision Care

Because members of government programs do not need a referral or preauthorization to access vision care services, it is very important for practitioners who provide vision care services to check eligibility and benefits by calling Customer Care. Benefit limitations and other requirements vary among the government programs. Member eligibility for covered services will be based on the information the provider supplies to Customer Care at the time of the call and on the member's current benefit history.

Covered Services

Routine Eye Exams

Univera Healthcare MyHealth℠ and MyHealth Plus℠ members are eligible for one routine eye examination every 24 months. Child Health Plus members may have one routine eye exam every 12 months. These limitations apply only to routine eye exams such as routine visual acuity or refraction tests. They do not apply to non-routine tests for individuals with conditions such as diabetes that can affect their vision.

Lenses and Frames

The benefit for government program members is limited to medically necessary basic lenses and frames. This includes bifocal or trifocal lenses when medically necessary. It does not include contact lenses (see *Exclusions*, below).

Univera Healthcare MyHealth℠ members are eligible to receive one set of basic lenses and frames every 24 months. Child Health Plus members are eligible to receive one set of basic lenses and frames every 12 months. **Participating providers must have a selection of frames available that are within the allowed amount.**

If medically necessary, Univera Healthcare MyHealth℠, MyHealth Plus℠ and Child Health Plus members may be eligible to receive an additional pair of glasses within the benefit time frames.

Exclusions

Univera Healthcare does not cover:

- Routine exams and lenses/frames that are beyond the limitations stated above.
- Lenses/frames from practitioners who have not agreed to accept Univera Healthcare's allowance (in other words, do not participate in the government program network).
- Safety glasses.
- Added features such as progressive lenses, anti-reflective coatings, photosensitive, tints, transition lenses or other specialty lenses, unless determined medically necessary.
- Contact lenses, unless determined medically necessary (See the Medical Policy *Contact Lenses for Medicaid, Child Health Plus Contracts* available on Univera Healthcare's website or from Customer Care). The prescribing vision care provider must obtain prior approval and submit a letter of medical necessity to Univera Healthcare. The letter must include a diagnosis and the member's medical history.

Upgrades

Medicaid Managed Care

Univera Healthcare does not permit vision allowance upgrades for members of Univera Healthcare MyHealth[SM] or MyHealth Plus[SM]. Univera Healthcare will reimburse a vision care provider only if they dispense basic frames and/or basic lenses to Univera Healthcare MyHealth[SM] or MyHealth Plus[SM] members.

The practitioner must inform the member that the benefit is only for basic frames and lenses. If the member selects lenses other than basic lenses and/or a frame that exceeds the allowance, the practitioner must collect the full cost of those items directly from the member.

However, if the upgrade is for only the lenses or only the frames, Univera Healthcare will reimburse the provider for whichever component is basic (lenses or frames). The member is responsible for the full cost of the upgraded component.

Child Health Plus

Child Health Plus members may choose to upgrade at their own expense and Univera Healthcare will reimburse the practitioner at the allowance for basic frames and/or lenses. **This does not mean that the member may choose contact lenses instead of eyeglasses.** (See *Exclusions* above.) If the member selects lenses other than basic lenses and/or a frame that exceeds the allowance, the practitioner must collect the balance directly from the member.

Replacement and Repair of Lenses and Frames

Coverage for Univera Healthcare MyHealth[SM], Child Health Plus and MyHealth Plus[SM] members includes the replacement of lost or destroyed eyeglasses, if appropriately documented. The replacement of eyeglasses must duplicate the original prescription and frame.

10.7 MMC Long-Term Care (Residential Health Care Facility Services – Nursing Home)

Rehabilitation:

Univera Healthcare MyHealth℠ and MyHealth Plus℠ (Health and Recovery Plan, or HARP) cover short-term rehabilitation stays in a skilled nursing home facility.

Long-Term Placement:

Univera Healthcare MyHealth℠ covers long-term placement in a nursing home facility for members 21 years of age and older. Individuals already in nursing homes for permanent long-term care are not eligible for enrollment in MyHealth Plus℠.

Covered nursing home services include:

- medical supervision
- 24-hour nursing care
- assistance with daily living
- physical therapy
- occupational therapy
- speech/language pathology and other services

To receive the nursing home services previously listed, the services must be ordered by a physician and authorized by Univera Healthcare MyHealth℠ or MyHealth Plus℠.

Members must also be found financially eligible for long-term nursing home care by their County Department of Social Services before state Medicaid and/or Univera Healthcare will pay for the services.

When a member is eligible for long-term placement, they must select a nursing home that participates with the Univera Healthcare MyHealth℠ network.

Members who wish to live in a nursing home that does not participate with the Univera Healthcare MyHealth℠ network may transfer to another health plan that works with the nursing home where they prefer to receive care.

10.8 HIV Care

Univera Healthcare recommends that providers follow the HIV guidelines established by the NYSDOH AIDS Institute. These guidelines pertain to prevention and medical management of adults, children, and adolescents with HIV infection. These guidelines are available at the NYSDOH AIDS Institute website, hivguidelines.org. Providers may also refer to the discussion of NYSDOH requirements for HIV Counseling, Testing and Care of HIV Positive Individuals in the *Quality Improvement* section of this manual.

Individuals may obtain HIV information and referrals by calling the NYSDOH's Anonymous HIV Counseling and Testing Program at 1-800-541-AIDS.

10.9 Personal Care Services

Personal care services are a benefit for MMC members only. Services are defined as some or total assistance with personal hygiene, dressing, feeding, nutritional and environmental support functions. Services must be essential to the maintenance of the patient's health and safety in their own home, as determined by an assessment performed by Univera Healthcare or the New York Independent Assessor (NYIA), in accordance with the regulations of the NYSDOH. All agencies providing personal care services must be licensed or certified to operate as a home care agency by the NYSDOH and must participate in the Univera Healthcare provider network. Services must be prior authorized. See: "Personal Care Aide (PCA) and Consumer Directed Personal Assistant (CDPA) Services for MMC Contracts" medical policy for medical criteria. Effective May 1, 2022, the NYIA began conducting assessments for adults (18+) that are requesting Personal Care Services for the first time. All other assessments will be performed by Univera Healthcare until NYSDOH directs the NYIA to take over (this is yet to be determined).

10.10 Health Home

The Medicaid Health Home program provides reimbursement for care management to approved Health Home providers for the services listed below:

- care coordination and health promotion
- comprehensive care management
- transitional care from inpatient to other settings, including follow-up care
- individual and family support, which includes authorized representatives
- referrals to community and social support services
- use of health information technology to link services

These services are provided to enrollees with behavioral health and/or chronic medical conditions who are determined eligible for Health Home services.

Univera Healthcare has assigned a single point of contact for each Health Home and that point of contact will communicate protocols with each Health Home's single point of contact.

Univera Healthcare collaborates with Health Homes and network PCPs to establish consistent BH screening for all members, with particular focus on those with high-risk medical conditions including but not limited to: tobacco use disorder, stroke, myocardial infarction, cancer, HIV and chronic pain. Univera Healthcare screening activities will especially screen for depression, anxiety and substance use disorders.

10.11 Health and Recovery Plan (HARP) Care Recovery Model

The Health and Recovery Plan (HARP) is product designed to address the severely and persistently mentally ill through a care recovery model that emphasizes and supports a member's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance disorders through empowerment, choice, treatment, educational, vocational, housing and health and well-being goals.

Univera Healthcare MyHealth Plus℠ is a HARP managed care product that manages physical health, mental health and substance use disorder services in an integrated way for adults with significant behavioral health needs (MH/SUD). HARPs must be qualified by New York State and must have specialized expertise, tools and protocols.

For additional information, visit the New York State's Office of Mental Health's website at http://www.omh.ny.gov/omhweb/bho/, or review the Health and Recovery Plan Manual on our website, Provider.UniveraHealthcare.com.

10.12 Personal Emergency Response System (PERS)

The Medicaid Uniform Assessment System (UAS) assessment is completed simultaneously with the nursing and social assessment for personal care. Services that are deemed medically necessary will be reimbursed monthly. All PERS services must be provided by a Univera Healthcare-designated agency.

Preauthorization Requirements

All personal care services and PERS requests must receive preauthorization to be eligible for reimbursement. Please contact Customer Care at 1-866-265-5983.

Claim Submission

Attn: Claims
PO Box 211256
Eagan, MN 55121

10.13 Sterilization Procedures

Important: Sterilization procedures, whether incidental to maternity or not, require completion of a patient consent form in accordance with Medicaid guidelines covering informed consent procedures for hysterectomy and sterilization specified in 42 CFR Part 441, sub-part (F), and 18NYCRR Section 505.13.

Informed Consent for Sterilization

Patients must be at least 21 years of age at the time of informed consent and mentally competent, and they must complete and sign LDSS-3134, *Sterilization Consent Form,* at least 30 days, but not more than 180 days prior to a bilateral tubal ligation or vasectomy procedure, or any other medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of having a child.

"Informed consent" means that:

- The patient gave consent voluntarily after the provider planning to perform the procedure has:
  - Offered to answer any questions.
  - Told the patient that they are free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting their right to future care or treatment and without loss or withdrawal of any of their federally-funded benefits.
  - Told the patient that there are alternative methods of family planning and birth control.
  - Told the patient that the sterilization procedure is considered to be irreversible.
  - Explained the exact procedure to be performed on the patient.
  - Described the risks and discomforts the patient may experience including effects of any anesthesia.
  - Described the benefits and advantages of sterilization; and
  - Advised the patient that the sterilization will not be performed for at least 30 days following the informed consent, and
- The provider planning to perform the procedure:
  - Made arrangements to ensure that the above information was effectively communicated to a blind, deaf or otherwise disabled person.
  - Provided an interpreter if the patient did not understand the language on the consent form or the person who obtained informed consent; and
  - Permitted the patient to have a witness present when consent was given.

*NYSDOH has determined that the Sterilization Consent Form (LDSS-3134) is **not required** where sterilization is an ancillary result of a procedure, such as gender reassignment surgery.

Hysterectomy

Hysterectomy is covered only in cases of medical necessity and not solely for the purpose of sterilization. Patients must be informed that the procedure will render them permanently incapable of reproducing. A patient must complete LDSS-3113, *Acknowledgement of Receipt of Hysterectomy Information*, at least 30 days prior to the procedure. Prior acknowledgment may be waived when a woman is sterile prior to the hysterectomy or in life-threatening emergencies where prior consent is impossible.

Retention of Forms Required for Payment

The performing provider must retain a copy of the completed *Sterilization Consent Form* or *Acknowledgement of Receipt of Hysterectomy Information* form.

New York State requires the retention of this record type for 10 years after the date of service pursuant to Section 19.4(a) of the MMC Model Contract. As a participating provider with Univera Healthcare, it must be maintained on our behalf. The Plan will conduct post payment audits against any filed claims for sterilization or hysterectomy services. Providers will be expected to produce a copy of the form at that time. Failure to produce the form will result in a retraction of payment **per New York State requirements**.

Where to Get Forms

Providers must request blank forms, *Sterilization Consent Form* or *Acknowledgment of Receipt of Hysterectomy Information*, from the NYSDOH by completing a *Request for Forms or Publications* form and faxing or mailing it to the NYSDOH. For contact information, see *Sterilization and Hysterectomy Consent Forms* on the *Contact List* in this manual.

10.14 Submitting Claims to Univera Healthcare

Submit claims for government programs to Univera Healthcare using the same method as claims for other health benefit programs — electronically or on paper. Information about billing and reimbursement is included in the *Billing and Remittance* section of this manual. The address for paper claim submittal is on the *Contact List* in this manual.

10.15 Member Payments – Medicaid

The following sections are a direct reprint from the April 2006 NYSDOH *Medicaid Update*. The update is a reminder to all hospitals, freestanding clinics and individual practitioners about requirements of the Medicaid program related to requesting compensation from Medicaid recipients, including Medicaid recipients who are enrolled in a MMC plan. Providers may collect applicable copayments but may not deny treatment if the member does not have the copayment at the time.

Acceptance and Agreement

When a provider accepts a Medicaid recipient as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a MMC enrollee, agrees to bill the recipient's managed care plan for services covered by the MMC/Family Health Plus/HIV SNP Model Contract.

- The provider is prohibited from requesting any monetary compensation from the recipient, or their responsible relative, except for any applicable copayments.
- A provider may charge a Medicaid recipient, including a MMC recipient enrolled in a managed care plan, **only** when both parties have agreed **prior to the rendering of the service** that the recipient is being seen as a private pay patient.
- This agreement must be mutual and voluntary.

It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

A *provider who participates in Medicaid fee-for-service* may not bill Medicaid fee-for-service for any services included in a recipient's managed care plan, with the exception of family planning services, *when the provider does not provide such services under a contract with the recipient's health plan.*

A provider who does not participate in Medicaid fee-for-service, but who has a contract with one or more managed care plans to serve MMC members **may not bill Medicaid fee-for-service** for any services. Nor may any Univera Healthcare non-participating provider bill a recipient for services that are covered by the recipient's MMC contract, unless there is prior agreement with the recipient that they are being seen as a private patient as described above. *The provider must inform the recipient that the services may be obtained at no cost to the recipient from a provider that participates in the recipient's managed care plan.*

Claim Submission

The prohibition on charging a Medicaid recipient applies:

- when a participating Medicaid provider or a MMC participating provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required time frame; or
- when a claim is submitted to CSC or the recipient's managed care plan, and the claim is denied for reasons other than that the patient was not eligible for Medicaid on the date of service.

Collections

A Medicaid recipient, including a MMC enrollee, **must not be referred to a collection agency** for collection of unpaid medical bills or otherwise billed, *except for applicable copayments*, **when the provider has accepted the recipient as a Medicaid patient.**

Providers, however, may use any legal means to collect applicable unpaid copayments.

Emergency Medical Care

A hospital that accepts a Medicaid recipient as a patient, including a Medicaid recipient enrolled in a managed care plan, accepts the responsibility of making sure that the patient receives all medically necessary care and services.

Other than for legally established copayments, a Medicaid recipient **should never be required to bear any out-of-pocket expenses** for:

- medically necessary inpatient services; or
- medically necessary services provided in a hospital-based emergency room (ER).

This policy applies regardless of whether the individual practitioner treating the recipient in the facility is enrolled in the Medicaid program.

When reimbursing for ER services provided to MMC enrollees, health plans must apply:

- The Prudent Layperson Standard
- Provisions of the MMC Model Contract; and,
- NYSDOH directives

Claim Problems

If a problem arises with a claim submission for services covered by Medicaid fee-for-service, the provider must first contact CSC. If the claim is for a service included in the MMC benefit package, the enrollee's managed care plan must be contacted. If CSC or the managed care plan is unable to resolve an issue because some action must be taken by the recipient's local department of social services (e.g., investigation of recipient eligibility issues), the provider must contact the local department of social services for resolution.

For questions regarding MMC, please call the Office of Managed Care at 518-473-0122. For questions regarding Medicaid fee-for-service, please call the Office of Medicaid Management at 518-473-2160.

10.16 Member Complaints and Action Appeal Policy and Procedure

Note: The following guidelines apply to members with coverage under Univera Healthcare MyHealth℠ and MyHealth Plus℠. They do not, however, apply to members in the Child Health Plus health benefit program. (See the *Benefits Management* section of this manual for procedures for Child Health Plus members.)

Univera Healthcare encourages all members to voice both positive and negative comments regarding care and services they have received. All member concerns are documented at the member's request, and Univera Healthcare responds in a timely manner. If a member has a concern that cannot be resolved immediately on the telephone, Univera Healthcare informs the member of the right to file a formal complaint or to designate a representative to file a complaint on the member's behalf. Univera Healthcare describes these rights in the member handbook.

Assistance is available from Univera Healthcare to file member complaints; complaint appeals and action appeals. Members should call the number listed on their Univera Healthcare identification card to request assistance.

In no event will Univera Healthcare retaliate or take any discriminatory action against a member because the member has filed a complaint.

Univera Healthcare is required to make the complaint procedures accessible to members who do not speak English as a primary language. Upon request, Univera Healthcare will provide a written copy of the complaint procedure, readable at a fourth-grade level.

The following subsection addresses:

- The review of issues (including quality of care and access to care complaints) not associated with medical necessity or experimental/investigational determination (complaints & complaint appeals).
- The review of issues that involve a contractual benefit, not associated with medical necessity or experimental/investigational determination (action appeal).
- The review of issues that involve a medical necessity or experimental/investigational determinations (utilization review action appeals).

Medicaid Complaint Procedure

A. Complaints

1. A member or a member's representative may call Customer Care or come in person to register a complaint. (See Member Complaints on the *Contact List* in this manual.) Alternatively, a member or a member's representative may submit a complaint in writing to the Customer Care department at Univera Healthcare address listed on the *Contact List*. Complaints must be filed within 60 business days of the initial determination.

   If the complaint was filed orally, an Advocacy Associate will document a summary of the complaint form and submit the form to the member for signature, except for expedited cases. Investigation of the complaint will continue during this process.

2. Customer Care representatives are available to document the member's complaint during regular business hours. After regular business hours and on weekends, the member may call and leave a message at 1-800-650-4359. If a member leaves a message or submits a complaint in writing, a Customer Care representative will telephone the member to verify receipt of the complaint. The representative will contact the member on the next business day after receipt of the oral complaint. An acknowledgement is sent within 15 days upon receipt of a written complaint.
3. An Advocacy Associate records the member's complaint and initiates a thorough review.
4. Time frames for response to a complaint:
    a) Within 15 calendar days of receipt of the complaint, an Univera Healthcare representative will send the member a written acknowledgment, including the name, address and telephone number of the individual or department handling the complaint. This acknowledgment will inform the member of the status of the complaint and advise whether any additional information is required for Univera Healthcare to process the complaint.
    b) Additional required information may include, but is not limited to, such items as medical records, a chronology of events, or legal documents related to the complaint.
    c) Once Univera Healthcare has received all necessary information, it will resolve the complaint on the following schedule:
        i. **Within 48 hours after receipt of all necessary information, but no more than seven days from receipt of the complaint** when a delay would significantly increase the risk to the member's health **(Expedited Complaint)**. Univera Healthcare will notify the member of its decision by telephone within two business days, with a written notice to follow within 24 hours after the determination.
        ii. All other complaints shall be resolved within 45 days after the receipt of all necessary information and no more than 60 days from receipt of the complaint. Univera Healthcare shall maintain reports of all complaints that are unresolved after 45 days.

B. Complaint appeals

Members have 60 business days after receipt of the complaint determination notice to file an appeal. An acknowledgement of the appeal must be sent within 15 days. Once Univera Healthcare has received all the necessary information, it will resolve the complaint appeal on the following schedule:

a) Whenever a delay would significantly increase the risk to a member's health, complaints will be resolved, and the member will be notified no more than two business days after receipt of all of the necessary information.
b) All other complaints will be resolved, and the member notified within 30 days after the receipt of all the necessary information.

C. Determinations

a) Appropriate administrative staff will decide the complaint or complaint appeal.
b) If the complaint relates to a clinical matter, the reviewer will be, or will consult with, a licensed, certified or registered health care professional.
c) Univera Healthcare will notify the member in writing of the determination. The notice will include detailed reasons for the determination, the clinical rationale (if applicable), the procedure for complaints, and the option to contact the Department of Health regarding the complaint, including the toll-free telephone number.

D. Investigation and Documentation of Complaints

1. **Research/Investigation**: All complaints are investigated thoroughly. The research/investigation phase includes but is not limited to the following interventions:
   a) Contact with appropriate provider and/or supervisor for intervention.
   b) Review written records to gather information.
   c) Obtain responses from appropriate staff as necessary.
   d) Contact with Medical Director(s) for all concerns regarding quality of care and treatment issues.
2. **Documentation**: All complaints are documented.
   a) All research/investigative activities and results are documented by the Advocacy Associate on the Grievance Tracking database.
   b) Documentation includes the names of the individuals who have been contacted for intervention or for informational purposes regarding the complaint.
   c) Any action taken and communication with a member is also documented on the database. The final resolution will include information received in the research phase and any additional explanatory information that will assist the member in their understanding of the process.

E. Records

The Advocacy Unit maintains a file on each complaint that includes the following:

a) The date that Univera Healthcare received the complaint.
b) Documentation compiled by the Advocacy Associate relating to the complaint.
c) The date of and a copy of the acknowledgment sent to the complainant.
d) A copy of the response to the complaint, including the date of determination and the titles and/or credentials of the personnel who reviewed the complaint.

F. Record/Information Request Process

In cases where additional information is deemed necessary, the following guidelines will apply.

For standard complaints:

- Univera Healthcare will identify and request information **in writing** from the member and provider within 15 business days of receipt of the incomplete information, stating what information must be supplied.
- If additional information is not received, Univera Healthcare will send a statement in writing that the determination could not be made and the date the additional information time frame expires.

For expedited complaints:

- Univera Healthcare will expeditiously identify and request information via **phone or fax** to the member and provider followed by written notification to the member and provider.

Medicaid Action Appeal Procedure

A member may appeal adverse determinations. The Advocacy Unit is responsible for appeals related to adverse determinations. The member may make a verbal request for appeal of an adverse determination by calling the phone number listed on their identification card. Written appeal requests should be submitted to the Advocacy Department, P.O. Box 4717, Syracuse, NY 13221.

An Advocacy Associate will prepare and present all action appeals related to medical necessity or experimental or investigational to a Medical Director who was not involved in the initial determination. For action appeals involving contractual benefit denials, an Advocacy Associate who was not involved and who is not a subordinate to the person who worked on the initial decision will prepare and respond to the appeal. When necessary, the Advocacy Associate will obtain a Clinical Peer Review for the Medical Director's consideration. For information related to action appeal notification and determination time frames, visit our website (see below). Select the *Benefits Management* section for a chart titled *UM Initial Determination Time Frames - Medicaid & Safety Net Products.*

- Provider.UniveraHealthcare.com/resources/forms

For MMC products (Univera Healthcare MyHealth℠, Univera Healthcare MyHealth Plus℠), the NYSDOH defines medically necessary as "healthcare and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote the normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic or congenital condition, injury or disability."

In general, denials, complaints and action appeals must be peer-to-peer, which means that the credentials of the licensed clinician denying the care must be at least equal to that of the recommending clinician. In addition, the reviewer should have clinical experience relevant to the denial (e.g., denial of rehabilitation services must be made by a clinician with experience providing such service or at least in consultation with such a clinician, and a denial of specialized care for a child cannot be made by a geriatric specialist).

In addition:

- A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21.
- A physician certified in addiction treatment must review all inpatient level of care/continuing stay denial for SUD treatment.
- Any appeal of a denied BH medication for a child should be reviewed by a board-certified child psychiatrist.
- A physician must review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family/caregiver.

A. Definition

For purposes of this policy, a Clinical Peer Reviewer means:

1. A physician who possesses a current and valid non-restricted license to practice medicine; or
2. A health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certificate or registration, or where no provision for a

license, certificate or registration exists, and is credentialed by the national accrediting body appropriate to the profession.

3. For behavioral health decisions, peer-to-peer reviews must include a physician who is board-certified in general psychiatry for review of all inpatient level of care denials for psychiatric treatment. A physician certified in addiction treatment must review all inpatient level of care denials for substance use disorder (SUD) treatment.

B. Procedure

A member, the member's designee and, in connection with retrospective determinations, a member's health care provider, may appeal an Adverse Determination rendered by Univera Healthcare through the internal appeal process described below.

1. The member has the right to designate a representative to assist him/her in the action appeal process. The member must contact Customer Care either verbally or in writing to appoint a representative.
2. The member has 60 business days after receiving notice of an initial adverse determination to request an action appeal.
3. If the action appeal was filed orally, an Advocacy Associate will document a summary of the action appeal on a complaint form, with the exception of expedited cases and submit the form to the member for signature. Investigation of the action appeal will continue during this process.
4. The member has the right to present evidence (within a limited time stated by Univera Healthcare) and allegations of fact or law, in person as well as in writing.
5. The case file, including medical records and any other documents and records, is considered during the action appeal process. The plan is required to send the member or their designee a copy of the case file for examination before and during the action appeal process.

C. Time Frames

1. Fast-Track Action Appeals

a) In any case except one involving retrospective review, a fast-track appeal may be available if:

(i) The adverse determination involves continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, home health care services following discharge from an inpatient hospital admission, potential court-ordered mental health or substance use disorder services; or

(ii) The health care provider believes an immediate appeal is warranted.

(iii) If a fast-track appeal is requested but we determine that it does not meet the conditions described above, we will notify the member verbally and in writing within two days that the expedited appeal has been declined, however, we will immediately initiate a standard appeal.

b) A Clinical Peer Reviewer other than the Clinical Peer Reviewer who rendered the initial adverse determination will review the appeal. Univera Healthcare will provide reasonable access to its Clinical Peer Reviewer within one business day of receiving notice of the taking of an expedited appeal.

c) Univera Healthcare will decide the fast-track appeal and notify the member and their health care provider of the determination as expeditiously as possible, but no later than **72 hours** after receipt of the appeal or **two business days** after receipt of all necessary information, whichever is less, with the exception of concurrent substance use review, which will be handled within 24 hours of receipt. If Univera Healthcare fails to make a determination within these time frames, the request will be deemed approved. The time frame for a determination may be extended for up to 14 days upon member or provider request, or if Univera Healthcare demonstrates (and notifies the member) that additional information is needed and that the delay is in the best interest of the member. If Univera Healthcare requires additional necessary information to conduct the appeal, we will notify the member or the member's designee and the member's health care provider immediately, by telephone or facsimile, to identify and request the necessary information, followed by written notification.

d) Univera Healthcare will make reasonable effort to provide oral notice of the determination to the enrollee and provider at the time the determination is made and will provide written confirmation of the decision within two business days of the determination. If Univera Healthcare upholds the initial adverse determination, written confirmation will be a final adverse determination.

2. Standard Appeals

When a fast-track appeal is not available, the member has the right to a standard appeal. Univera Healthcare will decide the standard appeal and notify the member or their designee as fast as the member's condition requires, and no later than **30 calendar days** from receipt of the appeal. Written notice of the determination will be provided to the member (and member's provider if they requested the review) within two business days after the determination is made. The time frame for a determination may be extended for up to 14 days upon member or provider request, or if Univera Healthcare demonstrates (and notifies the member) that additional information is needed and that the delay is in the best interest of the member.

a) Univera Healthcare will send the member an acknowledgment of their appeal within 15 calendar days, indicating the address and telephone number of the person or department responsible for rendering a decision. If we require additional information necessary to conduct the appeal, we will notify the member or the member's designee and the member's health care provider, in writing, within 15 calendar days of receipt of the appeal, to request the necessary information. In the event that only a portion of the necessary information is received, Univera Healthcare will request the missing information, in writing, within five business days of receipt of the partial information.

b) For action appeals involving clinical matters, a Clinical Peer Reviewer other than the Clinical Peer Reviewer who rendered the initial Adverse Determination will review the appeal. Action appeals for non-clinical matters shall be determined by qualified personnel at a higher level than the personnel who made the original decision.

c) If Univera Healthcare fails to make a determination within 30 calendar days after receipt of all necessary information, the request will be deemed approved, unless an extension has been requested.

3. Action Appeal Notices

The action appeal notification will include:

a) The date that the action appeal was filed and a summary of the action appeal, along with the date that the action appeal was completed.

b) The result and the reasons for the determination, and if the initial Adverse Determination is upheld, including the clinical rationale, if any.

c) If the determination was not in favor of the member, a description of the member's fair hearing rights, if applicable.

d) The right of the member to contact the NYSDOH, including the toll-free telephone number.

e) For action appeals involving medical necessity or an experimental or investigational treatment, the notice must also include:

i. A clear statement that the notice constitutes a final adverse determination and that specifically uses the terms "medical necessity" or "experimental/investigational;"

i. Univera Healthcare's contact person and their telephone number.

ii. The member's coverage type.

iii. The name and full address of the Univera Healthcare's utilization review agent.

iv. The utilization review agent's contact person and their telephone number.

v. A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service. Where the denial was for out-of-network services or a referral, the name of provider with the training and experience to provide the requested service.

vi. A statement that the member is eligible for an external appeal and the time frames for filing, and if the action appeal was fast-tracked, a statement that the member may choose to file a standard action appeal with Univera Healthcare or file an external appeal.

vii. A copy of "Standard Description and Instructions for Health Care Consumers to Request an External Appeal;"

viii. Right of the member to complain to the NYSDOH at any time, including toll-free phone number.

ix. Description of member's fair hearing rights (see below); and

x. A statement that the notice is available in other languages and formats for special needs and how to access these formats.

f) For action appeals regarding prescription medications that are classified as antipsychotics, immune-suppressants, anti-retroviral therapy, anticonvulsants or antidepressants, a clear statement to include:

i. that the requested medication must be provided when the prescriber demonstrates that, in their reasonable professional judgment, consistent with the FDA approved labeling or Official Compendia, the medication is medically necessary and warranted to treat the member.

ii. whether the appeal is upheld because the necessary information was not provided, and the time for review has expired, or the prescriber's reasonable professional judgment has not been adequately demonstrated and the time for review has expired.

g) For action appeals involving personal care services, long-term support services and/or a residential health care facility, the number of hours per day, number of hours per week and the personal care services function:

i. that was previously authorized.

ii. that was requested by the member or the member's representative.

iii. that was authorized in the new authorization period, if any.

iv. the original authorization period and the new authorization period.

4. Fair Hearing

MMC members may request a fair hearing if Univera Healthcare denies coverage and the member exhausts the external appeal process. The member, after exhausting the internal appeal process, may request a fair hearing from the state and still file an external appeal, or vice versa. In some cases, the member may be able to continue to receive the terminated, suspended or reduced services until the fair hearing is decided. If the member asks for both a fair hearing and an external appeal, the decision of the Fair Hearing Office will control. Refer to the *Fair Hearing* subsection below for additional information.

5. Waiving Internal Appeal Process

If the member and Univera Healthcare jointly agree to waive the internal appeal process, Univera Healthcare must provide a written letter agreeing to the waiver that includes information regarding the filing of an external appeal within 24 hours of the agreement to waive its internal appeal process.

D. Record Request Process

In cases where additional information is deemed necessary, the following guidelines will apply.

For standard appeals: Univera Healthcare will identify and request information **in writing** from the member and provider within the applicable case time period but no later than 15 calendar days of receipt of the request.

For fast-track appeals: Univera Healthcare will expeditiously identify and request information via **phone or fax** to the member and provider followed by **written notification** to the member and provider.

E. External Appeal

A member, a member's designee and a member's health care provider may request in conjunction with a concurrent or retrospective appeal an adverse determination rendered by Univera Healthcare through the external appeal process. Only a member or the member's designee may file in conjunction with a pre-service determination. An external appeal must be submitted within 60 days (for a provider) or four months (for a member) of receipt of the final adverse determination of the first level appeal, which is the only level of appeal now offered.

An external appeal may be filed when:

1. The member has had coverage of a health care service, that would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary, **and**

2. Univera Healthcare has rendered a final adverse determination with respect to such health care service, **or**
3. Both Univera Healthcare and the member have jointly agreed to waive any internal appeal.

An external appeal may also be filed:

1. when the member has had coverage of a health care service denied on the basis that such service is experimental or investigational, **and**
2. he denial has been upheld on appeal **or** both Univera Healthcare and the member have jointly agreed to waive any internal appeal,
3. **and** the member's attending physician has certified that the member has a life-threatening or disabling condition or disease (a) for which standard health care services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by Univera Healthcare or (c) for which there exists a clinical trial,
4. **and** the member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or (b) a clinical trial for which the member is eligible. The physician certification mentioned above will include a statement of the evidence relied upon by the physician in certifying their recommendation,
5. **and** the specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.

An external appeal may also be filed:

1. if a health service is out-of-network and an alternate recommended treatment is available in-network, and the health plan has rendered a final adverse determination with respect to an out-of-network denial,
2. **and** the insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network health service, and recommends a health service that, based on two documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment.

An external appeal may also be filed:

1. if the insured has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service, and the member's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health services sought, certifies that the in-network health care provider or providers recommended by the health plan do not have the

training and experience necessary to meet the particular health care needs of the member and who is able to provide the requested service,

2. **or** an initial adverse determination on a formulary exception for a closed formulary product has been issued (please note that MMC, Health and Recovery Plan and Child Health Plus do not currently have a closed formulary).

A member or the member's designee may request a fair hearing and ask for an external appeal. If both a fair hearing and an external appeal are requested, the decision of the fair hearing officer will be the one that is followed.

An external appeal may be filed after an appeal determination has been upheld. However, if the member or member's designee wants an external appeal, they will lose their right to an external appeal if they do not file an external appeal application within the filing time frame.

Fair Hearing

In addition to the grievance and appeal guidelines outlined above, a member with coverage under Univera Healthcare's Univera Healthcare MyHealth[SM] and MyHealth Plus[SM] may request a fair hearing regarding adverse determinations concerning enrollment, disenrollment and eligibility, and regarding the denial, termination, suspension or reduction of a clinical treatment or other benefit package service. This hearing allows the member to present their case in person and ask the attendees questions regarding the member's case.

Fair hearing rights and the related form are included with member notices of final adverse determinations.

If the member believes that an action taken by Univera Healthcare is wrong, they can ask for a fair hearing by telephone or in writing. (See *Contact List* in this manual.)

The member must ask for a fair hearing within 120 days from the date of the appeal resolution. Once the fair hearing is requested, the State will send the member a notice with the time and place of the hearing. The member has the right to bring a person to help, such as a lawyer, a friend, a relative, or someone else. At the hearing, this person can give the hearing office something in writing or just orally state why the action should not be taken. This person can also ask questions of any other people at the hearing. The member also has the right to bring people to speak in their favor. If the member has any papers that will help their case (pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc.), they should bring them.

The member has the right to see their case file to help get ready for the hearing, and the case file will be provided directly to the member free of charge. The case file must be provided directly to the member by Univera Healthcare free of charge. The member may call or write to the New York State Office of Temporary and Disability Assistance, Fair Hearing Section, (as listed under fair hearings on the *Contact List* in Section 2 of this manual). The Office of Temporary and Disability Assistance will give the member— and the hearing officer— free copies of the documents from the member's file. The member should ask for these documents before the date of the hearing. The documents will be mailed to the member by Univera Healthcare, within a reasonable time before the date of the hearing.

The member has the right to request continuation of benefits while the fair hearing is pending. If Univera Healthcare's action is upheld at the hearing, the member may be liable for the cost of any continued benefits.

10.17 MMC Health and Behavioral Health for Children Under Age 21

The New York State Office of Addiction Services and Supports (OASAS), Office of Children and Family Services, (OCFS), Office of Mental Health (OMH), Office of People with Developmental Disabilities (OPWDD) and the Department of Health (DOH) released final MMC Organization Children's System Transformation Requirements and Standards in October 2017.

These standards outline the key components of the Children's Medicaid Transformation, which is subject to policy and billing guidance issued by New York state. In addition, the time frames for the transformation are subject to approval by the Centers for Medicare & Medicaid Services (CMS).

Expanded Children Services into Medicaid Managed Care

New York State Medicaid Plan services formerly covered under fee-for-service (FFS) are now included in the managed care benefit package to integrate children and youth's access more fully to physical health (PH) and behavioral health (BH) care.

Services include:

- Licensed Behavioral Health Practitioners
- Crisis Intervention
- Other Licensed Practitioner (OLP)
- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation Services (PSR)
- Children's Crisis Residence
- Family Peer Support Services
- Youth Peer Support

These services are available to any Medicaid enrollee under 21 years of age who meets medical necessity criteria (MNC).

A major goal of this transition and transformation is the elimination of care/service delivery silos to encourage and promote a care delivery system where MMC organizations, service providers, care managers, family peers, youth peers, multiple child serving systems of care (e.g., education, child welfare, juvenile justice, developmental disabilities) and state and local government agencies work together to support the physical, social and emotional development of children and youth while increasing health and wellness outcomes during childhood and into adulthood.

Care for Medically Fragile Children

Univera Healthcare must contract with providers who have expertise in caring for medically fragile children, to ensure that medically fragile children, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from Univera Healthcare for out-of-network providers when participating providers cannot meet the child's needs. Please refer to subsection 4.4 of this Participating Provider Manual for additional information regarding Univera Healthcare's referral requirements.

MMC Benefits

As of July 1, 2021, Foster Care Children in New York state moved from a fee-for-service model to Medicaid Managed Care. Univera Healthcare has a dedicated children's team to address the managed care implementation. Univera Healthcare works collaboratively with local departments of social services and 29-I Health Facilities or Voluntary Foster Care Agencies to ensure physical and behavioral health needs are met for this vulnerable population. If eligible, the foster care members participate in the newly carved in behavioral health benefits including Home and Community based services (HCBS) and Child and Family Treatment Support Services (CFTSS).

The following table represents the current delivery of benefits that are included in the Children's System Transformation for the MMC population under age 21. The benefit effective dates shown below are subject to CMS approval.

Service	Delivery System Before Transition	MMC Benefit Package Effective Date
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	Fee-for-Service	July 1, 2019
Community First Choice Option (CFCO) State Plan Services for children meeting eligibility criteria	Fee-for-Service	July 1, 2019
Children's Crisis Intervention	Fee-for-Service/1915(c) Children's Waiver service	January 1, 2019 to December 31, 2019 Demonstration service for children eligible for aligned children's HCBS January 1, 2020 Children and Family Treatment and Support Services (CFTSS)
Children's Day Treatment	Fee-for-Service	TBD
Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed	Current MMC benefit for individuals age 21 and over	July 1, 2019
Continuing Day Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	Fee-for-Service	July 1, 2019
Community Psychiatric Support and Treatment (CPST)	N/A (new CFTSS service)	January 1, 2019
Crisis Intervention Demonstration Service	MMC Demonstration Benefit for all ages	Current MMC Demonstration Benefit for all ages
Family Peer Support Services	Fee-for-Service/1915(c) children's waiver service	January 1, 2019 to June 30, 2019 Demonstration service for children eligible for aligned children's HCBS

Service	Delivery System Before Transition	MMC Benefit Package Effective Date
		July 1, 2019 (as a new CFTSS service for children)
Inpatient Psychiatric Services	Current MMC Benefit	Current benefit
OMH and OASAS Licensed Outpatient Clinic Services	Current MMC Benefit	Current Benefit
Medically Managed Detoxification (hospital-based)	Current MMC Benefit	Current Benefit
Medically Supervised Inpatient Detoxification	Current MMC Benefit	Current Benefit
Medically Supervised Outpatient Withdrawal	Current MMC Benefit	Current Benefit
OASAS Inpatient Rehabilitation Services	Current MMC Benefit	Current Benefit
OASAS Opioid Treatment Program (OTP) Services (for OASAS hospital-based programs)	Fee-for-Service	July 1, 2019
OASAS Outpatient and Residential Addiction Services	MMC Demonstration Benefit for all ages	Current MMC Demonstration Benefit for all ages
OASAS Outpatient Rehabilitation Programs (for OASAS hospital-based programs)	Fee-for-Service	July 1, 2019
OASAS Outpatient Services (for OASAS hospital-based programs)	Fee-for-Service	July 1, 2019
OMH State-Operated Inpatient	Fee-for-Service	TBD
Other Licensed Practitioner (OLP)	N/A (New CFTSS service)	January 1, 2019
Partial Hospitalization	Fee-for-Service	July 1, 2019
Personalized Recovery-Oriented Services (minimum age is 18 for medical necessity for this adult oriented service)	Fee-for-Service	July 1, 2019
Psychosocial Rehabilitation (PSR)	N/A (New CFTSS service)	January 1, 2019
Rehabilitation Services for Individuals in Community Residences	Fee-for-Service	TBD
Residential Rehabilitation Services for Youth (RRSY)	Fee-for-Service	TBD
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly foster care Medicaid Per Diem)	Office of Children and Family Services (OCFS) Foster Care	July 1, 2019

Service	Delivery System Before Transition	MMC Benefit Package Effective Date
Residential Treatment Facility (RTF)	Fee-for-Service	TBD
Teaching Family Home	Fee-for-Service	TBD
Youth Peer Support and Training	Fee-for-Service/1915(c) Children's Waiver service	January 1, 2019 to December 31, 2019 Demonstration service for children eligible for aligned children's HCBS January 1, 2020 (as a new CFTSS service)

Univera Healthcare will authorize these services, if applicable, in accordance with established time frames as described in the MMC Model Contract, the Office of Health Insurance Programs Principles for Medically Fragile Children, under early and periodic screening, diagnostic and treatment (EPSDT), HCBS, and Community First Choice Option (CFCO) rules, and with consideration for extended discharge planning.

Appointment Availability Standards

Providers must adhere to the appointment availability standards established by the NYSDOH. Maintaining these minimum standards ensures patient access to care. Univera Healthcare will conduct an annual audit to ensure compliance with these standards. The appointment availability standards on the following pages apply to MMC transition for children under the age of 21.

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Mental Health Outpatient Clinic		Within 24 hours of request	Within 1 week	Within 5 days of request	Within 5 days of request
Intensive Psychiatric Rehabilitation Treatment (IPRT)			2-4 weeks	Within 24 hours	
Partial Hospitalization				Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation				

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Comprehensive Psychiatric Emergency Program (CPEP)	Upon presentation				
Inpatient Addiction Treatment Services (hospital or community based)	Upon presentation	Within 24 hours		Within 5 days of request	Within 5 days of request
Medically Managed Withdrawal Management	Upon presentation				
Medically supervised withdrawal (Inpatient/ Outpatient)	Upon presentation				
Residential Addiction Services Stabilization in Residential Setting		Within 24 hours of request	Two to four weeks	Within five days of request	Within five days of request
Residential Addiction Services Rehabilitation in Residential Setting		Within 24 hours of request	Two to four weeks	Within five days of request	Within five days of request
Outpatient Addiction Treatment Services/ Intensive Outpatient Treatment (IOP)		Within 24 hours of request	Within one week of request	Within five days of request	Within five days of request
Outpatient Rehabilitation Services		Within 24 hours of request	Within one week of request	Within five days of request	Within five days of request

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Outpatient Withdrawal Management		Within 24 hours of request		Within five days of request	Within five days of request
Medication Assisted Treatment (MAT)		Within 24 hours of request		Within five days of request	Within five days of request
Opioid Treatment Program (OTP)		Within 24 hours of request	Within one week of request	Within five days of request	Within five days of request
Other Licensed Practitioner (Children)		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Crisis Intervention (Children)	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	
Crisis Intervention (Adult)	Upon Presentation	Within 24 hours of request		Immediate	
Community Psychiatric Support and Treatment (Children)		Within 24 hours for intensive in-home & crisis response services under definition	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
Family Peer Support Services (Children)		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support (Children)			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Peer Supports		Within 24 hours for symptom	Within one week	Within five days	

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
		management			
Psychosocial Rehabilitation (Children)		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/ Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Crisis Respite (Children)	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 1 week of request	Within 1 week of request	
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support (Children)			Within 5 business days of request		Within 5 business days of request
Habilitation (Children)			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	
CPST, Habilitation,			Within 2 weeks	Within 5 days of request	Within 5 days of request

Service Type	Emergency	Urgent	Non-urgent	Follow-up to Emergency or Hospital Discharge	Follow-up to Residential Services, Detention Discharge or Discharge from Justice System Placement
Family Support and Training, and Psychosocial Rehabilitation (adult)					

Provider Training and Education

Univera Healthcare offers a comprehensive provider training and support program for providers serving children under the age of 21. The training program offers network providers an opportunity to gain appropriate knowledge, skills and expertise as well as receive technical assistance in complying with the requirements under managed care. The provider training plan is reviewed annually and coordinated with the regional planning consortiums to develop a uniform provider training curriculum that addresses clinical components necessary to meet the needs of children under the age of 21.

Initial orientation and training are provided for all providers new to Univera Healthcare's network. Additional training opportunities will be made available (at least annually) at a variety of times and modalities to ensure that providers have an opportunity to participate.

Materials and training schedules are available on our website (see below) and communicated in our provider newsletter.

- Provider.UniveraHealthcare.com/resources/management/staff-training

Training will include:

- Technical assistance on billing, coding, data interface, documentation requirements, provider profiling programs, and utilization management requirements, credentialing and re-credentialing.
- Preauthorization expectations, utilization and documentation requirements, processes for assessments for HCBS eligibility (targeting criteria, risk factors and functional limitations), and plan of care (POC) development and review.

Additional training opportunities:

- Navigating Children's Services includes: unique needs of special populations, including serious emotional disability, substance use disorder, transitional aged youth, early intervention, medically fragile children and those involved in the child welfare system.
- Cultural competency.
- Family-driven, youth-guided, person-centered treatment planning and service provision.
- Recovery and resilience principles.

- Multidisciplinary teams with member/family member/caregiver engagement and meaningful participation and member choice.
- Requirements of early and periodic screening, diagnostic and treatment, and completion of required foster care initial health assessments for developing a comprehensive POC.
- Trauma-informed care.
- Common medical conditions and medical challenges in the medically fragile population.

Behavioral Health and Medical Integration

Univera Healthcare promotes behavioral health and medical integration for children, including at-risk populations defined by the state of New York.

Education and Training

Univera Healthcare provides education and training opportunities to in-network behavioral health/physical health providers and Health Homes to enhance care coordination. These trainings focus on coordinated person-centered care and the roles/responsibilities of an integrated team, advantages of health care integration and highlight benefits to the member of community integration.

Care Coordination

Univera Healthcare's Care Management program will help meet the needs of children and adolescents with behavioral and physical health needs by providing linkages to an integrated continuum of supports and community-based services. Where applicable, Care Managers will contact physical health providers to suggest a behavioral health consultation. The Case Manager will assist the member with arranging for the behavioral health consult and follow-up to ensure the consult was conducted. In addition, Univera Healthcare provides post discharge care coordination and support to the member, their identified family, and providers. Care Managers will work to engage members in outpatient services post discharge. Care Managers will also collaborate with Health Homes and HCBS providers to ensure appropriate assessments and referrals are made for HCBS services, where applicable.

Children's Home and Community-Based Services

Home and Community-Based Services (HCBS) are designed to provide Medicaid Managed Care members with specialized supports to remain in the community and avoid residential and inpatient care. Services previously delivered under agency-specific 1915(c) waivers have been aligned and carved into MMC:

HCBS benefits include:

- Accessibility Modifications (Scheduled to carve out on 7/1/24)
- Adaptive and Assistive Equipment (Scheduled to carve out on 7/1/24)
- Caregiver/Family Advocacy and Supports
- Community Self-Advocacy Training and Support
- Environmental Modifications (Scheduled to carve out on 7/1/24)
- Habilitation
- Palliative Care
- Prevocational Services
- Respite (Planned/Crisis)
- Supported Employment
- Vehicle Modifications (Scheduled to carve out on 7/1/24)

Prior to rendering services, always verify the member's eligibility and coverage.

All HCBS under the 1115 MRT Waiver are available to any individual under the age of 21 who is determined to be eligible. Eligibility is based on target criteria, risk factors and functional limitations.

Individuals under the age of 21 who are eligible for HCBS may also enroll with a Health Home. Members choosing not to enroll in a Health Home will have care managed by the plan and eligibility determined by an independent entity. Health Home is a care management service model for individuals enrolled in Medicaid with complex, chronic medical and/or behavioral health needs. Health Home care managers provide person-centered, integrated physical health and behavioral health care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high need Medicaid members with chronic conditions.

Referral Process for HCBS and HCBS Eligibility Assessment

The eligibility assessment for Home and Community-Based Services will be conducted by the Health Home Care Manager (HHCM) or by the State's Independent Entity for children that have chosen not to enroll with a Health Home. HCBS eligibility will be determined using new target population, risk factor and functional eligibility criteria that has been applied to Child and Adolescent Needs and Strengths New York (CANS-NY) or by the Office for People with Developmental Disabilities (OPWDD) Level of Care/Medical Care Screen for children with developmental disabilities who may be medically frail or in foster care, which determines if the member is eligible for HCBS.

If eligibility is determined, the HHCM and/or the State's Independent Entity will develop a comprehensive POC that includes HCBS, as well as all the other services a member needs inclusive of the child and family's goals.

Upon contact from the Health Home/State Independent Entity, Univera Healthcare will call HCBS designated providers to confirm referral readiness. Once the member chooses providers, referral(s) should be made, as authorized by Univera Healthcare, if required. The HHCM/State Independent Entity should work to keep the member engaged and ensure linkage: reminders, phone calls, offering transportation, etc. The HCBS provider does an assessment, works with Univera Healthcare by submitting authorization

request including scope, duration, and frequency, and communicates with HHCM/State Independent Entity. The Managed Care Plan will confirm that the POC is updated and implemented.

Sharing and Integration of HCBS and Health Home Information

Univera Healthcare's information systems will be inclusive of functionality for the children's population. All information and data transmitted by HCBS/Health Home providers related to a member receiving HCBS and/or Health Home services will be integrated into the member's electronic record, including member assessments, care management notes, discharge plans, member requests at POC meetings, and care plans. Analysis of the POC and completion of the assessment/s serve multiple purposes. They are used to create authorizations for HCBS services when applicable, and also to track and provide data related to HCBS assurances and sub-assurances, assessment elements, level of care/level of need designation, POC elements, qualified provider, health and welfare, and fiscal accountability monitoring for children receiving HCBS, including amount, duration and scope of services authorized and reimbursed.

HCBS Review and Approval of the Plan of Care

The plan of care (POC) must be developed in a conflict-free manner, meaning that the person conducting the assessment and developing the POC cannot direct referrals for service only to their agency or network; they must have a choice among available providers. Once the POC is completed, a health home care manager will work in collaboration with the individual to identify the HCBS to be included in the POC. At least one HCBS must be included in the POC for eligible individuals. If the individual does not meet the functional need for 1915i-like services through the eligibility tool, the POC cannot include 1915i-like services.

Reassessment for HCBS is conducted on an annual basis, or after a significant change in the member's condition, such as an inpatient admission or a loss of housing. Health Homes will provide care management and will have a role in the assessment of individuals for Home and Community-Based Services. Provider agencies will deliver the HCBS services as described in this manual. Provider agreements should include procedures for monitoring HCBS utilization for each enrollee. Univera Healthcare will use a data-driven approach to identify service utilization patterns that deviate from any approved POC and will also conduct outreach to review such deviations and will also require appropriate adjustments to either service delivery or the POC.

CMS requires state oversight to determine that 1) the assessment is comprehensive and compliant with federal regulations and state guidance, 2) the planning process is person-centered and addresses services and support needs in a manner that reflects individual preferences and goals, 3) the services were actually provided, and 4) the person is assessed at least annually or when there is a change in condition (e.g., loss of housing, inpatient admission) to appropriately reflect service needs.

CMS requires that the state managed care plans and providers monitor and provide reporting for individuals enrolled in Home and Community-Based Service waivers to demonstrate that these individuals are receiving appropriate services. HCBS must be managed in compliance with the CMS HCBS Final Rule, as well as any applicable New York state guidance.

Health Plan Acceptance of the Plan of Care

To help ensure a smooth transition of HCBS and long-term services and supports (LTSS) authorizations for individuals in receipt of HCBS, Univera Healthcare accepts POCs in accordance with CMS approval and timelines:

- 1) for its enrolled population; or
- 2) for an individual under age 21 for whom the Health Home Care Manager or independent entity has obtained consent to share the POC with Univera Healthcare and the family has demonstrated the health plan selection process has been completed.

Univera Healthcare will continue to accept plans of care for individuals under the age of 21 who are in receipt of HCBS in advance of the effective date of enrollment when Univera Healthcare is notified by another health plan, a Health Home Care Manager, or the independent entity that there is consent to share the POC with Univera Healthcare and the family has demonstrated the health plan selection process has been completed, or for a child in the care of a LDSS/licensed VFCA, health plan selection has been confirmed by the LDSS/VFCA.

Authorization of Covered HCBS and LTSS Services

Univera Healthcare will continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the date of transition of children's specialty services newly carved into MMC. Service frequency, scope, level, quantity, and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC will be developed.

During the initial 180 days of the transition, Univera Healthcare will authorize any children's specialty services newly carved into MMC that are added to the POC under a person-centered process without conducting utilization review.

For 24 months from the date of transition of the children's specialty services carve-in, for fee-for-service individuals under the age of 21 who are in receipt of HCBS at the time of enrollment, Univera Healthcare will continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the effective date of enrollment. Service frequency, scope, level, quantity, and existing providers at the time of enrollment will remain unchanged (unless such changes are requested by the individual, or the provider refuses to work with the health plan) for no less than 180 days, during which time, a new POC will be developed.

Quality Management Committee

The Behavioral Health Quality Management Committee (BHQM) is responsible for carrying out the planned activities of the BHQM Program. The BHQM will expand existing QM committee functions to meet the quality requirements and standards for the populations, benefits, and services for individuals under the age of 21, as described in the Children's System Transformation Requirements and Standards.

The committee meets quarterly to review quality of care measures, accessibility to care, and other issues of concern. Membership and attendance will be documented and include, at a minimum, Univera Healthcare's Behavioral Health Medical Director and Clinical Director, and Director of Quality Improvement. In addition, the BHQM will include advisory representation from members, family members, youth, and family peer support specialists and child-serving providers.

Access and Continuity of Care

To ensure access and continuity of care for MMC members, Univera Healthcare will allow children to continue with their care providers, including medical, behavioral health and HCBS providers, for a continuous episode of care. This requirement will be in place for the first 24 months of the MMC transition. It applies only to episodes of care that were ongoing during the transition period from FFS to MMC.

To preserve continuity of care, enrollees will not be required to change Health Homes or Health Home Care Management Agencies at the time of the transition. Univera Healthcare will be required to pay on a single case basis for enrollees in a Health Home when the Health Home is not under contract with Univera Healthcare.

If an individual enrolled in foster care is placed in another county, and the Univera Healthcare product in which they are enrolled operates in the new county, Univera Healthcare must allow for the individual to transition to a new primary care provider and other health care providers without disrupting the care plan that is in place.

If an individual enrolled in foster care is placed outside of Univera Healthcare's service area, Univera Healthcare must allow that individual to access providers with expertise in treating individuals involved in the foster care system, as necessary, to ensure continuity of care and the provision of all medically necessary benefit package services.

Foster Care Initial Health Assessments

Univera Healthcare is committed to ensuring network adequacy to meet the time frames for completion of required foster care initial health assessments. A series of assessments (see the table below) provide a complete picture of the health needs of an individual in foster care and is the basis for developing a comprehensive POC.

The table on the next page outlines the time frames for initial health activities, to be completed within 60 days of placement.

An "X" in the Mandated Activity column indicates that the activity is required within the indicated time frame.

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Performed By
24 hours	Initial screening/ screening for abuse/ neglect	X	X	Health practitioner (preferred) or child welfare caseworker or health staff
5 days	Initial determination of capacity to consent for HIV risk assessment & testing	X	X	Child welfare caseworker or designated staff
5 days	Initial HIV risk assessment for child without capacity to consent	X	X	Child welfare caseworker or designated staff

Time Frame	Activity	Mandated Activity	Mandated Time Frame	Performed By
10 days	Request consent for release of medical records & treatment	X	X	Child welfare Caseworker or health staff
30 days	Initial medical assessment	X	X	Health practitioner
30 days	Initial dental assessment	X	X	Health practitioner
30 days	Initial mental health assessment	X		Mental health practitioner
30 days	Family planning education and counseling and follow- up health care for youth age 12 and older (or younger, as appropriate)	X	X	Health practitioner
30 days	HIV risk assessment for child with possible capacity to consent	X	X	Child welfare caseworker or designated staff
30 days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	X	Child welfare caseworker or health staff
45 days	Initial developmental assessment	X		Health practitioner
45 days	Initial substance use assessment			Health practitioner
60 days	Follow-up health evaluation			Health practitioner
60 days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent and assessed to be at risk for HIV infection	X	X	Child welfare caseworker or health staff
60 days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	X	Child welfare caseworker or health staff

Credentialing

Univera Healthcare will accept New York state designation for the credentialing process. When contracting with New York State-designated HCBS and CFTSS providers, Univera Healthcare may not separately credential individual staff members in their capacity as employees of these facility programs. Univera Healthcare must still conduct program integrity reviews to ensure that provider staff is not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. Univera Healthcare will still collect and accept program integrity-related information from these providers, as required in the MMC Model Contract, and requires that such providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program or on the CMS Preclusion List.

Please refer to section 3.3 this Participating Provider Manual for additional information related to Univera Healthcare's credentialing process and criteria.

Utilization Management

> **Note:** Please refer to the benefit listing included at the end of Section 10 for a list of services requiring preauthorization/concurrent review authorization.

Utilization management requirements help to ensure that a person-centered POC meets individual needs and that concurrent review protocols consider various factors.

The Plan's utilization management program aims to ensure that treatment is specific to the member's condition, effective, and most clinically appropriate level of care. It also ensures that:

- member care meets medical necessity criteria.
- treatment is specific to the member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care.
- services provided comply with our quality improvement requirements; and utilization management policies and procedures are systematically and consistently applied; and
- focus for members and their families' centers on promoting resiliency and hope.

To accomplish these objectives, participating providers must collaborate with us and adhere to program requirements and guidelines.

The utilization management team includes qualified behavioral health professionals with the appropriate level education, training and experience to conduct utilization management reviews. The team is under the direction of our licensed behavioral health medical directors, and staff meets regularly with the medical directors when there are any questions or concerns.

Our utilization review decisions are made in accordance with currently accepted behavioral health care practices, considering special circumstances of each case that may require deviation from the screening criteria. Our medical necessity criteria are used for the approval of medical necessity; plans of care that do not meet medical necessity guidelines are referred to a licensed physician advisor or psychologist for review and peer-to-peer discussion.

We conduct utilization management in a timely manner to minimize any disruption in the provision of behavioral health care services. The timeliness of decisions adheres to specific and standardized time

frames yet remains sufficiently flexible to accommodate urgent situations. The decision-making process is based on appropriateness of care and service and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in under-utilization.

Coverage is not an entitlement, but rather is available when medical necessity is satisfied. Member benefit limits apply for a calendar year, regardless of the number of different behavioral health practitioners providing treatment for the member. Providers must work closely with our utilization management team to ensure judicious use of a member's benefit, and to carefully explain the treatment plan to the member in accordance with the member's benefit plan through Univera Healthcare.

The plan uses McKesson's InterQual Level of Care Criteria for both inpatient and outpatient mental health services, as well as New York state guidelines, and the LOCADTR 3.0 tool for substance use services. This multi-faceted approach to medical necessity criteria allows staff and the department to facilitate services and develop programs that can address most aspects of the member's behavioral health experience.

The New York State MMC Model Contract requires that plans utilize the OASAS-provided LOCADTR 3.0 tool for making substance use disorder level of care decisions. The tool is accessible through the Health Commerce System (HCS). The LOCADTR is a web-based tool that utilizes a series of clinical questions to determine individual risk and resources. Following the several logic pathways, answers to the questions lead to an initial LOCADTR recommended level of care. In most cases, this process will result in a level of care both recommended by the provider and approved by Univera Healthcare.

In addition, Univera Healthcare has established evidenced-based utilization management criteria, workflows and processes for rehabilitation and recovery services, including ACT, PROS, and BH HCBS. This will be achieved through collaboration across the service delivery system, including provider participation on utilization management and quality improvement committees, provider input on utilization management plan development and criteria, and enrollee feedback.

For LOCADTR 3.0 resources, visit https://oasas.ny.gov/locadtr.

InterQual criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. Both LOCADTR and InterQual criteria are reviewed annually. We are committed to the delivery of appropriate service and coverage, and offer no organizational incentives, including compensation, to any employed or contracted utilization management staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and utilization management staff is encouraged to bring inappropriate care or service decisions to the attention of the medical director.

Provider Reimbursement

Providers who historically delivered Care Management services under one of the 1915(c) waivers being eliminated, and who will provide care management services that are being transitioned to Health Homes, may receive a transitional rate for no more than 24 months. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.

Univera Healthcare is required to contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified

residential program to ensure access to and continuity of care for patients placed outside of the Plan's service area.

Univera Healthcare must pay at least the Medicaid FFS fee schedule for 24 months, or as long as New York state mandates, whichever is longer, for the following services/providers:

- CFTSS services, including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
- OASAS clinics (Article 32 certified programs)
- All OMH-licensed ambulatory programs (Article 31 licensed programs)
- Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

Univera Healthcare will ensure that all HCBS are paid according to the New York state fee schedule as long as Univera Healthcare is not at risk for the service costs (e.g., for at least two years, or until HCBS are included in the capitated rates).

Univera Healthcare will execute single case agreements with non-participating providers to meet clinical needs of children when in-network services are not available. The Plan must pay at least the FFS fee schedule for 24 months for all single case agreements.

Appendix: Prepaid Benefit Package Grid

PREPAID BENEFIT PACKAGE

From **Appendix K** of the MEDICAID MANAGED CARE/
FAMILY HEALTH PLUS/
HIV SPECIAL NEEDS PLAN/
HEALTH AND RECOVERY PLAN
MODEL CONTRACT
as amended March 1, 2019

Note: If cell is blank, there is no coverage.

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
1.	Inpatient Hospital Services	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see § 6.8 of this Agreement]	Covered, unless admit date precedes Effective Date of Enrollment [see §6.8 of this Agreement]
2.	Inpatient Stay Pending Alternate Level of Medical Care	Covered	Covered	Covered
3.	Physician Services	Covered	Covered	Covered
4.	Nurse Practitioner Services	Covered	Covered	Covered
5.	Midwifery Services	Covered	Covered	Covered
6.	Preventive Health Services	Covered	Covered	Covered
7.	Second Medical/Surgical Opinion	Covered	Covered	Covered
8.	Laboratory Services	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered. Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered, Effective 4/1/14, HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
9.	Radiology Services	Covered	Covered	Covered
10.	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors.	Covered. Coverage excludes hemophilia blood factors.
11.	Smoking Cessation Products	Covered	Covered	Covered
12.	Rehabilitation Services (not including Psychosocial Rehabilitation, or PSR)	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to enrollees under age 21, enrollees who are developmentally disabled, and enrollees with traumatic brain injury.	Covered. Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to enrollees under age 21, enrollees who are developmentally disabled, and enrollees with traumatic brain injury.	Covered, Outpatient physical, occupational and speech therapy limited to 20 visits each per calendar year. Limits do not apply to enrollees who are developmentally disabled, and enrollees with traumatic brain injury.
13.	EPSDT Services/Child Teen Health Program (C/THP)	Covered	Covered	
14.	Home Health Services	Covered	Covered	Covered
15.	Private Duty Nursing Services	Covered	Covered	Covered
16.	Hospice	Covered	Covered	Covered

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
17.	Emergency Services Post-Stabilization Care Services (see also Appendix G of this Agreement)	Covered Covered	Covered Covered	Covered Covered
18.	Foot Care Services	Covered	Covered	Covered
19.	Eye Care and Low Vision Services	Covered	Covered	Covered
20.	Durable Medical Equipment (DME)	Covered	Covered	Covered
21.	Audiology, Hearing Aids Services & Products	Covered	Covered	Covered
22.	Family Planning and Reproductive Health Services	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement
23.	Non-Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to phase-in schedule
24.	Emergency Transportation	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.	Covered if included in Contractor's Benefit Package as per Appendix M of this Agreement until benefit is transferred to MFFS according to a phase-in schedule.

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
25.	Dental and Orthodontic Services	Covered	Covered	Covered
26.	Court-Ordered Services	Covered, pursuant to court order (see also §10.9 of This Agreement).	Covered, pursuant to court order (see also §10.9 of this Agreement).	Covered, pursuant to court order (see also §10.9 of this Agreement).
27.	LDSS Mandated SUD Services	Covered, pursuant to Welfare Reform / LDSS mandate (mandate (see also § 10.7 of this Agreement)	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)	Covered, pursuant to Welfare Reform / LDSS mandate (see also § 10.7 of this Agreement)
28.	Prosthetic/Orthotic Services/Orthopedic Footwear	Covered	Covered	Covered
29.	Mental Health Services	Covered	Covered on the effective date of the Behavioral Health Benefit Inclusion.	Covered
30.	SUD Inpatient Detox Services	Covered	Covered	Covered
31.	SUD Inpatient Rehabilitation and Treatment Services	Covered	Covered on the effective date of Behavioral Health Benefit Inclusion	Covered
32.	SUD Residential Addiction Treatment Services	Covered	Covered	Covered
33.	SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	Covered	Covered	Covered
34.	SUD Medically Supervised Outpatient withdrawal	Covered	Covered	Covered
35.	Buprenorphine Prescribers	Covered	Covered	Covered
36.	Experimental and/or Investigational Treatment	Covered on a case by case basis	Covered on a case-by-case basis	Covered on a case-by-case basis

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
37.	Renal Dialysis	Covered	Covered	Covered
38.	Residential Health Care Facility (Nursing Home) Services (RHCF)	Covered, except for Enrollees under age 21 in Long Term Placement Status.	Covered, except for Enrollees under age 21 in Long Term Placement Status.	
39.	Personal Care Services	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.	Covered. When only Level I services provided, limited to 8 hours per week.
40.	Personal Emergency Response System (PERS)	Covered	Covered	Covered
41.	Consumer-Directed Personal Assistance Services	Covered	Covered	Covered
42.	Observation Services	Covered	Covered	Covered
43.	Medical Social Services	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP
44.	Home Delivered Meals	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP	Covered only for those Enrollees transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP
45.	Adult Day Health Care	Covered	Covered	Covered
46.	AIDS Adult Day Health Care	Covered	Covered	Covered
47.	Tuberculosis Directly Observed Therapy	Covered	Covered	Covered
48.	Crisis Intervention Services	Covered	Covered	Covered

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
49.	Psychosocial Rehabilitation (PSR)			Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
50.	Community Psychiatric Support and Treatment (CPST)			Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
51.	Habilitation Services			Covered on a non-risk basis as directed by the State (see Appendix T of this agreement).
52.	Family Support and Training			Covered on a non-risk basis as directed by the State (see Appendix T of this Agreement).
53.	Short-term Crisis Respite			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
54.	Intensive Crisis Respite			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
55.	Education Support Services			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
56.	Peer Supports			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).

*	Covered Services	MMC Non-SSI/Non-SSI Related	MMC SSI/SSI-Related	HARP
57.	Pre-vocational Services			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
58.	Transitional Employment			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
59.	Intensive Supported Employment (ISE)			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
60.	Ongoing Supported Employment			Covered on a non-risk basis as directed by the State (see also Appendix T of this Agreement).
61.	Care Coordination for the HARP Program and HARP-Eligible Enrollees in the HIV SNP Program			Covered. (see § 10.41 of this Agreement.)

Univera Healthcare
Participating Provider Manual

Section 11: Dual Eligible Special Needs Plan (D-SNP)

This section of the manual is intended for providers who participate in Medicare Advantage D-SNP and Integrated Benefit Dual (IB-DUAL) programs. The following provisions in this section are additional requirements above and beyond outlined in Section 9 for Medicare Advantage and Section 10 for Government Programs.

Revised September 2024

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11.1 Definition of Terms

For the purposes of this section:

Dual Eligible Special Needs Plan (D-SNP) is a type of Medicare Advantage (MA) plan that is specifically designed to integrate and coordinate care for beneficiaries who are eligible for both Medicare and Medicaid Managed Care (MMC) coverage.

IB-Dual is Integrated Benefits for Dually Eligible Enrollees Program or "IB-Dual"; a program that provides Medicaid and Medicare services for Dual Eligibles enrolled in Mainstream or HARP and also enrolled in an aligned D-SNP of the same organization.

11.2 Program Summary

Univera Healthcare has contracted with the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health (NYSDOH), to offer Dual Eligible Special Needs Plans (D-SNP) to dual eligible individuals. For a list of available plans, refer to Section 1: Introduction, for further details.

11.3 Eligibility and Enrollment

Source: Medicare Managed Care Manual Chapter 2 sections 20, 50, 50.1

Enrollment in, or voluntary disenrollment from, a D-SNP program is a beneficiary election and is subject to federal government regulations. CMS has established periods in which a *beneficiary may make an election. For some such periods, there is a limit on the number of elections* that may be made.

A beneficiary may enroll in a D-SNP program if they have Medicare Part A and B, a permanent resident of our service area, full dual eligible (qualified Medicare beneficiary (QMB) plus or full benefit dual eligible (FBDE)) and enrolled in Medicaid Managed Care product, including Health and Recovery Plan, with our Health Plan).

Univera Healthcare may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS and NYSDOH.

11.4 General Coverage Information

The following paragraphs detail *some* of the general benefits that, according to CMS, MA benefit packages must include. Members of MA health benefit programs may receive many other benefits in addition to those listed here. For details, see the product descriptions on Univera Healthcare's website.

> **Note:** For benefit information specific to any MA member, call Customer Care. Telephone numbers are included in the *Contact List* located in Section 2: Administration Information.

According to CMS, all MA benefit packages must offer coverage that includes:

- No waiting periods or exclusions from coverage due to pre-existing conditions
- Ambulance services dispatched through 911 or its local equivalent where other means of transportation would endanger the member's health (42 CFR 410.40)
- Emergency and urgently needed services supplied without prior authorization, whether the services are obtained from participating or non-participating providers
- Maintenance and post-stabilization care services: that is, covered services related to an emergency medical condition and that are provided after the member is stabilized either to maintain the member's stabilized condition or, under certain circumstances to improve or resolve the member's condition
- Medically necessary dialysis from any qualified provider that the member selects when they are temporarily absent from Univera Healthcare's service area and cannot reasonably access Univera Healthcare's contracted dialysis providers
- Screening mammography and influenza vaccinations that require no referral and no copayment
- Original Medicare covered services, such as inpatient medical, surgical and psychiatric hospitalization that are only covered for the duration of the benefit period

In addition to the above Medicare Advantage benefits, D-SNP enrolled members will have access to additional benefits through their integrated Medicaid, or HARP benefit packages.

11.4 Provider Obligations

Medicaid Management Information System (MMIS)

If you are an enrollable provider type with New York state (NYS) and do not have a Medicaid Management Information System (MMIS) number, you cannot receive Medicaid cost share payments from the Health Plan. The Medicaid claim will deny as "RB7 denial of Provider Not Par with NYS Fee for Service," a cost share payment will not be issued, and **you will not be allowed to balance bill the D-SNP member**.

To enroll, or to find out if you are already actively enrolled with the NYS Medicaid program:

- Visit www.emedny.org and click on the Provider Enrollment tab at the top of the page
- Select your provider type and scroll down to locate the applicable request
- Click on the topic and follow the instructions to complete

You may also contact the eMedNY Call Center at 1-800-343-9000.

Model of Care

Every D-SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance. Approvals can be one to three years based on scoring guidelines.

MOC:

- Is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the D-SNP and addressed through the plan's care management practices
- Provides the basic framework under which the D-SNP will meet the needs of each of its enrollees
- Serves as the foundation for promoting D-SNP quality, care management, and care coordination processes

Annual D-SNP MOC Training Requirement

CMS requires all contracted medical providers and staff receive basic training about the D-SNP MOC. This training and completion of an attestation are required for contracted and non-contracted providers that routinely see our members; and annually thereafter.

As a participating provider, your role is to participate in the Interdisciplinary Care Team, communicate with the member's assigned case manager, maintain an Individualized Care Plan in the member's medical record, and complete the annual MOC training.

The MOC training can be accessed using the following steps:

1. Go to Provider.UniveraHealthcare.com/login
2. Enter your Username and Password and click Log In
3. Click on the drop-down arrow next to Resources and click on Staff Training
    a. For the recorded training, in the Presentations & Guidebooks tab, click on the link to the Model of Care Training
    b. To request a virtual presentation with your Provider Relations representative, click on Request Other Training found on the right-hand side of the Attend Training or Presentations & Guidebooks tabs. Complete the required fields and click submit.

Training Attestation

After completion of the training, individual providers can attest on their own behalf, or by a designee granted authority by the practice to attest on behalf of all practice providers and applicable office staff.

Under the **Resources** section, click on the link to the attestation, complete the brief form and click submit.

11.5 Claims and Reimbursement

Members enrolled in our D-SNP product will have a single member card, representing the integrated benefits offered through MA and MMC. Providers will submit one claim for the services rendered. The Health Plan will fully adjudicate both the Medicare and Medicaid payment, unless the service is carved-out to Fee for Service (FFS). Providers will be reimbursed based on their currently contracted reimbursement rates.

Since Medicare is primary, providers will be reimbursed based on 100% of their currently contracted MA rate as the allowed amount, after which the member obligation is calculated. Member obligation (or cost share) will then pay under the plan's Medicaid benefit up to but not to exceed the Medicaid fee for service reimbursement rate. Since the plan will fully adjudicate both the Medicare and Medicaid benefit, the provider will not need to bill Medicaid separately unless the service is carved out to FFS.

Facilities billing for services split paid under Medicare and Medicaid should include, in the proper format, the Medicaid Value Code (e.g., 24) and Rate Code (e.g., 1432.00) to enable secondary processing.

For the behavioral health services listed below, we are required to reimburse the higher of the Medicare or Medicaid rate. For these services, providers will be reimbursed the Medicaid rate if it is higher than Medicare. For more information on billing behavioral health services under managed care, please refer to Billing Behavioral Health (BH) Services Under Managed Care (ny.gov).

- Mental Health Outpatient Treatment and Rehabilitative Services
- Personalized Recovery Oriented Services (PROS) (Clinic component)
- Outpatient Medically Supervised Stabilization and Withdrawal (Detox)
- Outpatient Chemical Dependence (CD) Clinic (aka Outpatient Addiction Rehab)
- Outpatient CD Rehabilitation (aka Outpatient Addiction Day Rehab)
- Opioid Treatment Program

11.6 Identifying Members

Members enrolled in our D-SNP will have a single member card representing the integrated benefits offered through MA and MMC and will have HMO D-SNP listed on the card.

11.7 Integrated Member Grievances, Organization Determinations and Appeals

Source: Code of Federal Regulations CFR 42, Section 422.629

Relative to integrated grievances, integrated Organization Determinations and integrated appeals, the rights of an Univera Healthcare D-SNP member include, but are not limited to, the following:

Integrated Grievances

- The right to have grievances heard and resolved in accordance with Medicare and Medicaid guidelines.
- The right to request from Univera Healthcare quality of care grievance data.
- The right to file a quality-of-care grievance with a Quality Improvement Organization (QIO).

Integrated Organization Determinations

- The right to a timely Organization Determination.
- The right to request an expedited Organization Determination or an extension, and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.
- The right to a written notice from Univera Healthcare of its own decision to take an extension on a request for an Organization Determination, which explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension.

- The right to receive information from Univera Healthcare regarding the member's ability to obtain a detailed written notice from Univera Healthcare regarding the member's services.
- The right to receive from Univera Healthcare a detailed written notice of Univera Healthcare's decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment, which includes the member's right to appeal.

Integrated Appeals

- The right to request and receive appeal data from Univera Healthcare.
- The right to request an expedited reconsideration.
- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE).
- The right to automatic reconsideration by an IRE for a Medicare-only covered service or item when Univera Healthcare upholds its original adverse determination in whole or in part.
- The right to request a Level 2 appeal, called a Fair Hearing from the State for a Medicaid-only covered service or item when Univera Healthcare upholds its original adverse determination in whole or in part.
- The right to an Administrative Law Judge (ALJ) hearing for a Medicare-only covered service or item if the IRE upholds the original adverse determination in whole or in part, and the remaining amount in controversy meets the appropriate threshold requirement.
- The right to request Medicare Appeals Council (MAC) review for a Medicare-only covered service or item if the ALJ hearing decision is unfavorable to the member in whole or in part.
- The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review for a Medicare-only covered service or item is unfavorable to the member, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement.
- The right to request a QIO review of a termination of Medicare-only coverage of inpatient hospital care.
- The right to request a QIO review of a termination of Medicare-only services in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities.
- The right to request and be given timely access to the member's case file and a copy of that case, subject to federal and state laws regarding confidentiality of patient information (Univera Healthcare has the right to charge the member a reasonable amount for duplicating the case file material).
- The right to challenge local and national coverage determinations.

For more information about these and other member rights, contact Customer Care (see the *Contact List* in this manual).

11.8 Integrated Grievances

A member may file a grievance with Univera Healthcare for the following types of issues:

- Problems with the quality of the medical care or services provided, including quality of care during a hospital stay.
- Disagreement with Univera Healthcare's denial to give an expedited appeal.
- Disagreement with Univera Healthcare's decision to extend the time frame for making an initial decision or appeal, in which case the member may request an expedited grievance.
- The member believes they are being encouraged to disenroll from Univera Healthcare's D-SNP plan.
- Difficulty getting through on the telephone or problems with Customer Care.
- Problems with waiting on the phone, in a provider's waiting room, or in a provider's examination room.
- Problems with getting appointments when needed, or in a timely fashion.
- Disrespectful or rude behavior by providers, receptionists or other staff.
- Cleanliness or condition of providers' offices, clinics or hospitals.
- Physician behavior and demeanor, adequacy of facilities and other similar member concerns
- Involuntary disenrollment situations, and
- Timeliness of services.

Procedure

Note: The grievance procedures presented in this section of the manual do not apply whenever the Medicare Reconsideration/Appeals Procedures are applicable.

1. Members may register grievances orally, in writing, via fax, via webpage or in person at any time, after the event.
2. Univera Healthcare will respond to most grievances in writing within thirty (30) calendar days from the date the request is received. However, if the member is filing the grievance because Univera Healthcare has determined not to give the member an expedited initial decision or an expedited appeal on a request for service, or if Univera Healthcare extends the time frame of an initial decision or appeal, Univera Healthcare will respond within twenty-four (24) hours from receipt of the request.

All decision notifications will include information about the basis of Univera Healthcare's decision. Grievances involving clinical decisions will be made by qualified clinical personnel. Members have the right to have a representative file and/or pursue a Grievance on their behalf.

11.9 Integrated Organization Determinations

Source: Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Updated August 2022

> **Note:** The following paragraphs apply ONLY to D-SNP programs. For information about Univera Healthcare's utilization review process applicable to other health benefit programs, see the *Benefits Management* section of this manual.

An *Organization Determination* is any determination (i.e., an approval or denial) made by Univera Healthcare for a member of a D-SNP health benefit program regarding:

- Payment for temporarily out of the area renal dialysis services.
- Payment for emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health care services furnished by a provider that the D-SNP member believes are covered under Medicare or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Univera Healthcare.
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services that a D-SNP member believes should be furnished or arranged for by Univera Healthcare.
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment, or
- Failure of Univera Healthcare to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay adversely affects the health of the member.

In circumstances where there is a question whether or not Univera Healthcare will cover an item or service, the enrollee, enrollee's representative, or the provider on behalf of the enrollee has the right to request a pre-service organization determination (prior authorization) from Univera Healthcare. Such pre-service requests to the plan (even if to an agent or contractor of the plan, such as a network provider) are requests for an organization determination and must comply with the applicable regulatory requirements. Whenever an enrollee contacts Univera Healthcare to request a service, the request itself indicates that the enrollee believes the D-SNP plan should provide or pay for the service. However, when a provider declines to furnish a service requested by an enrollee, this is not an organization determination *because* the provider is making a treatment decision *(which may be based on the provider's judgment about whether the item or service should be part of the enrollee's treatment plan or whether the provider is willing to furnish the item or service, regardless of coverage by the plan).*

If the enrollee wishes to request information about coverage of the benefit, the enrollee must contact the D-SNP plan to make a coverage request for the service in question, or the provider may make the coverage request on the enrollee's behalf. The plan must educate enrollees and providers that when there is a disagreement with a provider's decision to decline to furnish a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive an organization determination from the plan *about whether coverage of the benefit would be provided; such determination about coverage would likely address if the item or service is medically necessary*. *Further, enrollees have the right to seek treatment from other providers (such as from another provider in the network).*

The following sections describe the procedures Univera Healthcare has established for making timely Organization Determinations regarding the benefits a member is entitled to receive under their D-SNP plan.

Please note, a member or a provider acting on a member's behalf has the right to request a pre-service Organization Determination if there is question about whether particular health care item or service is covered by Univera Healthcare. CMS and Department of Health (DOH) considers participating providers to be agents of Univera Healthcare and they are responsible for knowing what health care items or services are covered or not covered before the health care items or services are furnished to members. If a participating provider is uncertain about whether a particular health care item or services is a covered benefit or whether the member may obtain those services from a non-participating provider, the participating provider is required to use the Organization Determination prior to furnishing the health care item or service or prior to sending the member to a non-participating provider.

Once an "Integrated Organization Determination" has been made, the appeals process may be triggered if a member believes that Univera Healthcare's decision is unfavorable. In the presence of any adverse Organization Determination — that is, when Univera Healthcare determines that it will not provide or pay for a requested service, in whole or in part, or if Univera Healthcare discontinues or reduces a service — Univera Healthcare must send the member a written denial notice that includes appeal rights.

If a member of a D-SNP program disputes an Organization Determination, Univera Healthcare will follow the procedures outlined in paragraphs 11.13 Integrated Appeals Process and 11.14 Right to Integrated Reconsideration.

If a member complains about any other aspect of Univera Healthcare, (e.g., the manner in which care was provided), the grievance process described above will apply. Generally, Univera Healthcare will consider complaints about quality of care as grievances, but such complaints may also be received and acted upon by a Quality Improvement Organization (QIO).

11.10 Standard Integrated Organization Determinations

Source: Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Updated August 2022

When a D-SNP member requests a service, Univera Healthcare must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date Univera Healthcare receives the request for a standard Organization Determination.

Univera Healthcare may extend the time frame up to an additional 14 calendar days if the enrollee or provider requests the extension; or the plan can show that the extension is in the enrollee's interest; and there is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received When Univera Healthcare grants itself an extension to the deadline, it must notify the member, in writing, of the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with Univera Healthcare's decision to grant an extension. Univera Healthcare must notify the member, in writing, of its determination as expeditiously as the member's health condition requires, but no later than the expiration of any extension that occurs. Part B Drug requests must be completed within 72 hours from when the request is received. Part B Drug timeframes cannot be extended.

If Univera Healthcare fails to provide the member with a timely notice of an adverse determination, this failure itself constitutes an adverse organizational determination and may be appealed.

11.11 Expedited (or "Fast") Integrated Organization Determinations

Source: Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Updated August 2022

A D-SNP member or any physician (regardless of whether the physician is affiliated with Univera Healthcare) may request that Univera Healthcare expedite an Organization Determination when the member or their physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

> **Note:** Expedited Organization Determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. However, if the case includes both a payment denial and a pre-service denial, the member has a right to request an expedited appeal for the pre-service denial.

Univera Healthcare will evaluate a request for an expedited determination and will promptly determine whether to approve the request. If the member's physician initiated the request for a fast determination, or if the member initiated the request for a fast determination with the support of their physician, who indicates applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function (the physician does not have to use these exact words), Univera Healthcare automatically will expedite the determination.

If Univera Healthcare decides to expedite the request, it must render a decision as expeditiously as the member's health condition might require, but no later than 72 hours after receiving the member's request. Part B Drug requests must be completed within 24 hours from when the request is received. Part B Drug timeframes cannot be extended.

If Univera Healthcare denies a request for a fast determination, Univera Healthcare will provide oral notice of the determination, with a written notice to follow within three (3) calendar days and will automatically transfer the request to a standard Organization Determination within a fourteen (14) calendar-day timeframe. Univera Healthcare may take an additional 14 calendar days if the member requests the extension, or if it is to the member's benefit when it is a non-participating provider requesting services. The notice will state that the request will be processed using the time frame for standard determinations, and that the member has the right to resubmit the request for an expedited determination or file with Customer Care an expedited grievance regarding this decision. The notice also will provide instructions on how to file a grievance.

11.12 Notification of Integrated Adverse Determinations

Source: Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Updated August 2022

Notification by Provider

Whenever a member contacts Univera Healthcare to request a service, the request itself indicates that the member believes that Univera Healthcare should provide or pay for the service. Thus, the request constitutes a Request for a Determination, and Univera Healthcare's response to the request constitutes an Organization Determination. However, if a provider declines to give a service that a member has

requested or offers alternative services, this is not an Organization Determination (the provider is making a treatment decision). In this situation, the member must contact Univera Healthcare to request an Organization Determination for the service in question, or the provider may request the Organization Determination on the member's behalf. Univera Healthcare must educate members and practitioners that when there is a disagreement with a practitioner's decision to deny a service or a course of treatment, in whole or in part, the member has a right to request and receive an Organization Determination from Univera Healthcare regarding the services or treatment being requested.

Notification by Univera Healthcare

If Univera Healthcare decides to deny, discontinue or reduce services or payment, in whole or in part, and the member believes the services should be covered, then Univera Healthcare must give the member a written notice of its determination. This written notice will include:

- The specific reason for the denial that considers the member's presenting medical condition, disabilities, and special language requirements, if any.
- Information regarding the member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member's behalf.
- For service denials, a description of both the standard and expedited reconsideration processes and the time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeal process.
- For payment denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
- Notice of the member's right to submit additional evidence in writing or in person.
- An explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

11.13 Integrated Appeals Process

Source: Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Updated August 2022

There are various levels of appeal available to members of D-SNP health benefit programs following the receipt of notification of an adverse Integrated Organization Determination. These levels are to be followed sequentially only if the original denial continues to be upheld by the reviewing entity.

- Reconsideration of an adverse Organization Determination made by Univera Healthcare.
- The right to request and receive appeal data from the health plan.
- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE).
- The right to automatic reconsideration by an Independent Review Entity (IRE) when Univera Healthcare upholds its original adverse determination in whole or in part.
- Hearing by an Administrative Law Judge (ALJ), if the amount in controversy meets the appropriate threshold requirement as set forth in Section 70 of Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance. The right to request Medicare

Appeals Council (MAC) review; and Federal Court Review if the amount in controversy is at least that established each year by the federal government.

- The right to challenge local and national coverage determinations. Individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the Department of Appeals Board (DAB) of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs.

An initial, revised or integrated reconsideration determination made by Univera Healthcare can be reopened:

- Within one year for any reason
- Within four years for just cause
- At any time for clerical correction or in cases of fraud; and
- At any time for a decision under the coverage (National Coverage Determination – NDC) appeals process

IRE, ALJ and MAC may reopen reconsideration, hearing or review decisions, respectively, for good cause within 180 days from the date of decision, or at any time if the decision was procured by fraud or similar fault.

11.14 Right to Integrated Reconsideration

A member has the right to an appeal (also called a "reconsideration") if they do not agree with Univera Healthcare's decision about medical care or services (i.e., after receiving an adverse Integrated Organization Determination).

A member may appeal if they believe:

- Univera Healthcare has processed a claim with member liability.
- Univera Healthcare will not approve or give care it should cover, or a provider will not provide care or referrals the member thinks he or she needs.
- Univera Healthcare is stopping care that the member still needs.

Note: If a member is discharged from a hospital and the member feels it is too soon, the member must request an immediate QIO review for Medicare covered services only. The member may remain in the hospital without becoming financially liable until the QIO makes its decision.

Who May Request Integrated Reconsideration?

Standard Pre-Service Reconsideration

- A member may act on their own behalf
- A member's representative

- The members treating physician acting on behalf of the member* or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider); or
- Any other provider or entity (other than the D-SNP plan) determined to have an appealable interest in the proceeding.

*If the member's records indicate that they have not previously visited the requesting physician, the D-SNP plan should undertake reasonable efforts to confirm that the member has received appropriate notification of the appeal.

Standard Payment Reconsideration

- A member may act on their own behalf
- A member's representative
- Non-contract provider (A non-contract provider, on his or her own behalf, may request a reconsideration for a denied claim only if the non-contract provider completes a Waiver of Liability (WOL) statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal).
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the D-SNP plan) determined to have an appealable interest in the proceeding.

Expedited Reconsideration

- A member may act on their own behalf
- A member's representative
- Any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the member.

Representatives Filing on Behalf of the Member

Individuals who represent member's may either be appointed or authorized (for purposes of this guidance, both are referred to as "representatives") to act on behalf of the enrollee in filing a grievance, requesting an initial determination, or in dealing with any of the levels of the appeals process.

- A member may appoint an authorized representative to act on their behalf. The member must submit Form CMS-1696, Appointment of Representative (AOR), or an equivalent written notice (hereinafter, collectively referred to as a representative form).
- A court-appointed guardian, individual with durable power of attorney, a health care proxy, a person designated under a healthcare consent statute, or an Executor of an estate may act as the member's representative to the extent provided under New York state law.

Support for Member Integrated Reconsideration

Univera Healthcare must gather all the information it needs to decide the member's appeal. If Univera Healthcare requires the member's assistance in gathering this information, Univera Healthcare will contact the member directly.

A member has the right to obtain and include additional information as part of their appeal. For example, a member may already have documents related to the issue, or they may want to obtain their provider's records or the provider's written opinion to help support the request. The provider may ask the member to submit a written request in order to obtain such information.

How and When to Request an Integrated Reconsideration

A member, or upon providing oral or written notice to the member, a physician who is treating a member and is acting on their behalf, may request a reconsideration, orally (by telephone), Univera Healthcare website, by fax, or in writing by filing a signed request with Univera Healthcare. Except in the case of an extension of the filing time frame, a member must file the request for reconsideration within 60 calendar days from the date of the notice of the Integrated Organization Determination. If a request for reconsideration is filed after the 60-calendar day timeframe and good cause for late filing is not provided, Univera Healthcare will dismiss the Reconsideration Request.

Integrated Reconsideration by Univera Healthcare

Source: Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans Updated August 2022

Standard Pre-Service Reconsiderations

Univera Healthcare normally has 30 calendar days from the date of receipt of the request for standard reconsideration to process a member's request for reconsideration for a pre-service matter. The time frame will be extended by up to 14 calendar days by the D-SNP health plan if the member requests the extension or also may be extended by up to 14 calendar days if Univera Healthcare justifies a need for additional information and documents how the delay is in the interest of the member. A faster, 72-hour appeal is also available if waiting 30 days for a standard appeal could seriously harm the member's health or ability to function (see *Expedited 72-hour Reconsiderations*, below).

For Part B Pre-Service Reconsiderations, the time frame is seven (7) calendar days by the D-SNP health plan.

Standard Payment Reconsiderations

Univera Healthcare has 60 calendar days from the date of receipt of the request for standard reconsideration to process a member's appeal regarding claims payment or reimbursement or post service matter. The expedited process is not available for these types of appeals.

Expedited 72-hour Reconsiderations

The member, any physician, or the member's authorized representative may request a "fast" appeal rather than a "standard" appeal for a decision about medical care where applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function. If **any** physician asks for a fast decision on a member's behalf or supports a member in their request for one, and the physician indicates that waiting for a standard decision could seriously harm the member's life, health or ability to regain maximum function, Univera Healthcare will automatically grant the member a fast decision.

If the member requests a fast appeal without support from a physician, Univera Healthcare will decide if the member's health requires it. If Univera Healthcare decides that the member's medical condition does not meet the requirements for a fast appeal, Univera Healthcare will provide the member with prompt oral notice of the denial and the member's rights and mail the member a letter within three calendar days that explains that, if the member gets a physician's support for a "fast" appeal, Univera Healthcare will automatically make a fast decision. The letter will also explain how the member may file an expedited Integrated Grievance if the member disagrees with Univera Healthcare's decision to deny the member's request for a fast appeal.

Once Univera Healthcare denies a member's request for a fast initial decision, Univera Healthcare will make its decision within the standard time frame (as explained in ***Standard Pre-Service Reconsiderations***, above).

> **Note:** If, after requesting an appeal, a member wishes to withdraw the appeal, they must do so verbally by contacting Customer Care or by sending a written notice the Medicare Advocate Unit. (For Univera Healthcare address and phone numbers, see the *Contact List* in this manual.)

Following the Reconsideration

If, following standard or expedited reconsideration, Univera Healthcare does not rule fully in the member's favor, Univera Healthcare must submit a written explanation with a complete case file to the Independent Review Entity (IRE) contracted with CMS. The member's appeal also must be forwarded to the IRE if Univera Healthcare fails to provide the member with a reconsidered determination within the time frames specified above.

Continuing Benefits While an Integrated Reconsideration Is Pending

The following applies to cases where a member, a member's representative or a provider is appealing an applicable integrated plan's decision to reduce, terminate, or suspend a previously authorized Medicare Part C or Medicaid-covered service or item.

- The request for continuation and the integrated reconsideration are both filed timely:
  - For the service or item to continue, the member must make the continuation request by the later of the following: Within 10 calendar days after the applicable integrated plan send the notice of its integrated organization determination or the intended effective date of the integrated organization determination.
  - Members must file integrated reconsiderations within 60 calendar days from the date of the notice of the initial determination. For requests received after the 60-day filing timeframe, good cause exceptions for late filing must be submitted.

- The service or item was ordered by an authorized provider.
- The integrated appeal involves the termination, suspension or reduction of previously authorized services, and
- The period covering the initial authorization has not yet expired.

11.15 Quality Improvement Organization (QIO) Review

MA D-SNP members have a right to request a review of their discharge or Univera Healthcare's decision to end coverage for services received from a hospital, skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF).

A MA D-SNP member may ask the Quality Improvement Organization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for the member's services. A QIO is a group of physicians and health professionals paid by the federal government to monitor and help improve the quality of care provided to Medicare patients.

Participating providers shall cooperate with the activities of the QIO in connection with any review of the provision of covered services to members, including providing QIOs with pertinent patient care data such as information on health outcomes and information on Medicare member satisfaction.

New York State QIO

There is one Care Quality Improvement Organization (QIO) in each state. The QIO for New York State is Livanta. Contact information for Livanta is included on the *Contact List* in this manual.

QIO Review of Hospital Discharge

A member may request an immediate QIO review if the member disagrees with Univera Healthcare's determination not to cover a continued hospital stay. A QIO review allows members to remain in the hospital without incurring financial liability (except any applicable copayments or deductibles) while the review is being conducted. This review takes the place of the regular appeal process available through Univera Healthcare, as described in paragraphs 9.8, above. The steps involved in requesting a QIO review are as follows:

1. Upon admission to the hospital and prior to discharge, the hospital gives the member an "Important Message from Medicare" (IM), which includes the member's appeal rights. Please refer to *Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section* 100.1 for detailed instructions on issuing the IM.
2. If the member believes they are being discharged too soon, the member contacts the QIO listed on the IM. In order to be considered timely, the request must be made no later than midnight of the

day of discharge. The request may be in writing or by telephone and must be requested before the member leaves the hospital.

3. The QIO calls Univera Healthcare on the same day the member contacts the QIO and requests information on the case.
4. The entity that made the decision to discharge the patient (e.g., the hospital) completes a Detailed Notice of Discharge (DNOD) form (CMS-10066) that includes the clinical rationale for the discharge.
5. The hospital delivers the DNOD to the member (or their representative) by noon of the day after the QIO notifies Univera Healthcare of the appeal.
6. Univera Healthcare and/or the Hospital forward the DNOD and all supporting case documentation to the QIO by noon of the day after the QIO notifies Univera Healthcare of the appeal.
7. The QIO makes a determination on the case and notifies Univera Healthcare, the hospital and the member of its decision within one calendar day after it receives all pertinent information on the case. The QIO will communicate its decisions by telephone, followed by written notice.

Univera Healthcare is financially responsible for coverage of services during the QIO review. When the member makes a timely request for an appeal, they are not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the calendar day after the date the member receives notification of the determination by the QIO. Liability for further inpatient hospital services depends on the QIO decision:

- Unfavorable determination: If the QIO does not agree with the member, liability for continued services begins at noon of the day after the QIO notifies the member that the QIO agreed with the discharge determination.
- Favorable determination: If the -QIO agrees with the member, the patient is not financially responsible for continued care until Univera Healthcare and hospital once again determine that the member no longer requires inpatient care and secure the concurrence of the physician, and the hospital notifies the member with a follow-up copy of the IM.

If the member makes an untimely request for an appeal (after midnight on the day of discharge or after they have left the hospital), the member may request an expedited reconsideration by Univera Healthcare, but the member may be held responsible for charges incurred after the day of discharge. If the appeal is overturned, Univera Healthcare must continue covering the care and/or refund the member for any expenses the member incurred during the review.

A member who is dissatisfied with the -QIO decision can request a reconsideration from the QIO within 60 days of receiving notification of the original QIO decision. The QIO must issue its reconsidered determination as expeditiously as the member's health requires but no later than 14 days from the date of receipt of the request. The member's financial liability is determined by the QIO's decision. If the member is no longer in the hospital, he or she may appeal directly to an Administrative Law Judge, the MAC or a federal court.

11.16 Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC)

Source: Part C & D Enrollee Grievance, Organization/Coverage Determinations, and Appeals Guidance, Section 100.2 and Chapter 30 of the Medicare Claims Processing Manual, Section 260

The NOMNC is an Office of Management and Budget (OMB)-approved standardized notice. The NOMNC is a written notice designed to inform Medicare members that their covered Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), care is ending. All Medicare members receiving covered SNF, HHA or CORF services must receive a NOMNC upon termination of services, even if they agree that services should end. Although Univera Healthcare is responsible for either making or delegating the decision to end services, SNFs, HHAs (except for certain circumstances), and CORFs are responsible for delivering the notices to Medicare members no later than two days prior to the proposed termination of services.

Completing the NOMNC

Providers must insert the following patient-specific information in the NOMNC prior to delivery to the Medicare member:

- The member's name
- The date that coverage of services ends

The name, address and telephone number of Univera Healthcare or provider that actually delivers the notice must appear above the title of the form. Univera Healthcare or provider's registered logo is not required but may be used. If Univera Healthcare's name and contact information are not in the space above the title of the form, they must be displayed elsewhere on the form for the member's use in case an expedited appeal is requested, or the member or QIO seeks Univera Healthcare's identification. The notice *must* also identify and provide the telephone number of the appropriate QIO. All other required elements of the notice are included in the standardized material on the notice. The provider also has the option to include additional information in the space provided on the notice. The NOMNC may be modified for mass printing to indicate the kind of service being terminated if only one type of service is provided, such as skilled nursing, home health, or comprehensive outpatient rehabilitation facility.

Providers may not rewrite, re-interpret, or insert non-OMB approved language into the body of the NOMNC except where indicated.

NOMNC Delivery Requirements

Providers must ensure the NOMNC is validly delivered in accordance with the following:

1. The member must be able to understand the purpose and contents of the NOMNC and understand that he or she may appeal the termination decision.
2. The member must sign and date the NOMNC to acknowledge receipt whether or not the member agrees that coverage for services should end. If the member refuses to sign the notice, the notice is still valid as long as, the provider documents that the notice was given but the member refused to sign.
3. If the member is physically unable to sign or needs assistance of an interpreter or assistive device to read or sign, the provider should document the use of such assistance to validate the delivery.

4. CMS believes valid delivery is best accomplished by face-to-face contact with the Medicare member. The provider must deliver the NOMNC in person unless the member is unable to comprehend the contents of the notice.
5. If the member is not able to comprehend the contents of the notice, it must be delivered to and signed by the member's representative.

NOMNC Delivery Requirements When a Member's Representative is Unavailable

Providers are required to develop procedures to use when the member is incapable or incompetent, and the provider cannot obtain the signature of the member's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of a member, then the provider **must**:

1. Telephone the representative to advise him/her when the Medicare member's services are no longer covered.
2. Describe the purpose of the call, which is to inform the representative about the member's right to file an appeal.
3. Identify him/herself and provide a contact number for him/herself and Univera Healthcare.
4. Describe how to get a copy of a detailed notice describing why the member's services are not being provided.
5. Describe the member's appeal right to appeal to the QIO.
6. Inform the representative of the date and time by which the appeal must be filed to take advantage of the appeal right.
7. Identify the QIO required to receive the appeal, including any applicable name, address, telephone number, fax number or other method of communication the QIO requires in order to receive the appeal in a timely fashion; and
8. Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE, that can provide additional assistance to the representative in further explaining and filing the appeal.

The date the provider conveys this information to the representative is the date of the receipt of the NOMNC. The provider must confirm the telephone contact by written notice mailed on that same date. The provider must place a dated copy of the written notice in the member's medical file and document the telephone contact with the representative.

When direct phone contact cannot be made, the provider must send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. The provider must place a dated copy of the notice in the member's medical file. When the notice is returned by the post office with no indication of a refusal date, then the member's liability starts on the second working day after the provider's mailing date.

When to Deliver the Notice of Medicare Non-Coverage

SNFs, HHAs and CORFs must provide written notice (the NOMNC) to Medicare members no later than two days before the coverage of services will end. If, upon receiving the NOMNC, the member decides to appeal the end of coverage, they must contact the QIO to do an independent review of whether it is medically appropriate to end coverage of the services. QIOs have different names, depending on which state they are in. In New York state, the QIO is called Livanta.

The member must contact Livanta as soon as possible, but no later than noon of the day before the date that the member's coverage ends. Requests are to be by telephone or fax to:

Phone:
1-866-815-5440
TTY: 1-866-868-2289

Fax:
Appeals: 1-855-236-2423
All other reviews: 1-844-420-6671

Exclusions from NOMNC Delivery Requirements

Providers are not required to deliver the NOMNC if coverage is being terminated for any of the following reasons:

1. The member's benefit is exhausted
2. Denial of an admission to an SNF, HHA or CORF
3. Denial of non-Medicare covered services
4. A reduction or termination of services that do not end the skilled stay

When a Detailed Explanation of Non-Coverage (DENC) will be Issued

Univera Healthcare will issue a DENC explaining why services are no longer medically necessary to the member and provide a copy to the QIO no later than close of business (typically 4:30 P.M.) on the day of the QIO's notification that the member requested an appeal, or the day before coverage ends, whichever is later.

Complete instructions regarding the requirements for completing and delivering the NOMNC and DENC are available on the CMS website or from Customer Care.

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices

http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/NOMNCInstructions.pdf

http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/DENCInstructions.pdf

If a member misses the deadline for requesting an immediate appeal with the QIO, the member may still request an expedited appeal through Univera Healthcare. If the request does not meet the criteria for an expedited review, Univera Healthcare will review the decision under its rules for standard appeals.

11.17 Prescription Drugs Part D

For information regarding appealing coverage determinations (redetermination) please refer to Section 9.10 Prescription Drugs Part D.