Healthy U
Healthy Advantage
Healthy Advantage Plus
Healthy Preferred
Healthy Premier
Grand Valley Preferred
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The provider manual is broken into six main sections: A general section containing policies and procedures that apply to all UUHP products, and five additional sections, one for each of the five products offered by UUHP. Where policies and procedures (p&p) contained within one of the five product sections overlaps with the same p&p in the General Section, the p&p in the Product Section supersedes that part of the p&p in the General Section.

This provider manual is considered an attachment to and thereby part of all executed University of Utah Health Plans Provider Services agreements as referenced thereto and incorporated therein.
Welcome to the University of Utah Heath Plans (UUHP). We value and honor the distinctive connection that you share with our members.

UUHP was organized in 1998 with the formation of Healthy U (a Medicaid Managed Care Plan) as a managed care entity to handle the administrative functions of Healthy U. Our initial enrollment was approximately 3,000 members. Since our inception, we have grown to over 48,000 Healthy U members, and have added several lines of business.

In subsequent years we became the claims administrator for the other University and State projects – UNI HOME, as well the University’s behavioral health benefits.

We partner with Molina Health to administer Healthy Advantage and Healthy Advantage Plus. Healthy Advantage is a Special Needs Medicare Advantage plan. As a special needs plan, Healthy Advantage serves the needs of members who are enrolled in Medicare Parts A&B, as well as in one of the State’s Medicaid plans. Healthy Advantage Plus HMO is a Medicare Part C plan that offers exceptional healthcare for Utah seniors. UUHP oversees all operational managed care plan functions; including provider relations, credentialing, quality improvement programs, member services, claims processing as well as utilization and case management services. Molina Healthcare oversees the prior authorizations and provider directories for Healthy Advantage and Healthy Advantage Plus.

Healthy Premier is a commercial plan that we offer to employer groups and individuals throughout the state of Utah and surrounding areas. Healthy Preferred is a commercial plan that we offer to employer groups, primarily along the Wasatch Front, for their employees.

Grand Valley Preferred is a commercial plan that we offer to employer groups in the state of Colorado.

As a member of the University Health Care team, we hold ourselves to the highest standards in the services we provide to our members and to the providers who care for our members. Our goal is not to just operate at industry standards, but to exceed them in every possible way. Our goal is to provide exceptional customer service.

We welcome your comments and suggestions on how we can better serve you and your staff.
## UUHP Contact Information

### UUHP Address Information

<table>
<thead>
<tr>
<th>Mailing Address</th>
</tr>
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</table>
| University of Utah Health Plans  
6053 Fashion Square Dr. Suite 110  
Murray, UT 84107 |

<table>
<thead>
<tr>
<th>Claims Submission</th>
</tr>
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<tr>
<td><strong>EDI</strong></td>
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<tr>
<td>Trading Partner Number: HT000179-002</td>
</tr>
<tr>
<td><strong>Paper Claims</strong></td>
</tr>
</tbody>
</table>
| University of Utah Health Plans  
PO Box 45180  
Salt Lake City, UT 84145-0180 |

### UUHP Telephone and Fax Numbers

<table>
<thead>
<tr>
<th><strong>Healthy Premier and Healthy Preferred</strong></th>
<th><strong>Healthy U</strong></th>
<th><strong>Healthy Advantage and Healthy Advantage Plus</strong></th>
</tr>
</thead>
</table>
| Claim Inquiries / Customer Service       | 801-587-6480 Opt 4  
Fax 801-281-6121 | 801-587-6480 Opt 1  
Fax 801-281-6121 | 801-587-6480 Opt 5  
Fax 801-281-6121 |
| Eligibility                             | 801-587-6480 Opt 4  
Fax 801-281-6121 | 801-587-6480 Opt 1  
Fax 801-281-6121  
State Medicaid Hot Line  
801-538-6155 | 801-587-6480 Opt 5  
Fax 801-281-6121 |
| Utilization Management                  | 801-587-6480 Opt 2  
Fax 801-281-6121 |                      | 866-472-9479  
Fax 866-472-9481  
Or 844-251-1450  
Fax 866-472-9479 |
| Quality Improvement                     | 801-587-2777  
Fax 801-281-6121 | | 866-472-9479 |
| Provider Relations & Contracting        | 801-587-2838 Option 2  
Provider.relations@hsc.utah.edu  
Fax 801-281-6121 | | |
| Provider Credentialing                  | 801-587-2838 Option 3  
Provider.credentialing@hsc.utah.edu  
Fax 801-281-6121 | | |
| Rx Formulary                            | N/A | 866-472-9479 |
| EDI                                     | 801-587-2638 or 801-587-2639  
http://uhealthplan.utah.edu/EDI/ | | |
Provider Responsibilities

Provision of Covered Services

Providers must be aware of Healthy U, Healthy Premier, Healthy Preferred, Healthy Advantage, Healthy Advantage Plus and Grand Valley Preferred covered services and inform enrollees of covered services; as well as other programs and resources available to enrollees for prevention, education and treatment. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Service Delivery / Non-Discrimination

Providers are required contractually to render covered services to University of Utah Health Plan members in an appropriate, timely, cost-effective manner, consistent with customary medical care standards and practices. Services will be delivered in a culturally and linguistically appropriate manner, thereby including those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless and individuals with physical or mental disabilities. To arrange translation services please contact the UUHP member services at (801) 587-6480, option 1. Practitioners and Providers may openly discuss with members all appropriate or medically necessary treatment options, regardless of benefit coverage limitations.

Provider shall also, in compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990, and the University of Utah Policy and Procedures 1999, provide access and treatment without regard to race, color, sex, sexual orientation, religion, national origin, disability or age. Additionally provider shall not, within their lawful scope of practice, discriminate against members from high-risk populations or who require treatment of costly conditions. Any provider with concerns regarding the provision of services or employment on the basis of disability, or compliance questions should be referred to the Civil Rights Coordinator; at telephone number 801-587-6480, option 1.

Doctors are not Rewarded for Denying Care

UUHP reminds our practitioners/providers that decisions about utilization management (effective use of services) are based only on whether care is appropriate and whether a Member has coverage. UUHP does not reward doctors or others for denying coverage or care. UM decisions are based only on appropriateness of care and service and existence of coverage. UUHP does not reward practitioners/providers or other individuals for issuing denials of coverage or service care; and UM decision-makers do not receive financial incentives.

Physical Facilities

Providers shall maintain physical facilities that are clean/sanitary, accessible to disabled members in accordance with the ADA, have adequate fire and safety features, adequate waiting and exam room space, equipped with the appropriate medical equipment, devices and supplies commensurate with the type of services offered, and the appropriate, secure storage of medical records and other PHI. Providers must write prescriptions on tamper-resistant prescription pads, in accordance with Section 7002(b) of the U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007.
Medical Records

Participating providers shall maintain confidential, correct, legible and complete medical records for all UUHP members. Medical records and other PHI are to be stored in a secure location.

To fulfill activities such as, but not limited to, payment of claims, quality improvement, State and/or Federal reporting, credentialing, and HEDIS, UUHP may conduct medical record audits. The audits may include, but are not limited to, evaluation of the following:

- legibility,
- patient identifying information,
- entries dated and timed,
- completed problem list,
- completed medication list,
- clear notation of allergies,
- documentation of immunizations and preventive health screening as applicable,
- progress notes for each visit that include plans for follow up and/or return visits,
- providing appropriate supporting medical documentation to plan for referral and or prior authorization requests, and
- Advance directives.

UUHP encourages Specialists to provide consultation notes to the PCP in charge of the member’s health. Medical records must be provided at no cost to UUHP, and shall be made available for inspection by UUHP, its assigned representatives, and/or Federal & State agency representatives during reasonable business hours.

Patient records should be kept for at least seven (7) years. (A summary of factors reviewed in the UUHP Office Site Audit are found on page 13.)

Patient Confidentiality & HIPAA

Provider’s, their employees and business associates agree to safeguard the privacy and confidentiality of the University of Utah Health Plan members, and agree to abide by the rules and regulations set forth in the Federal Health Insurance Portability and Accountability Act of 1996 “HIPAA”.

Written authorization is required from the member for all uses and disclosures of Protected Health Information (PHI) EXCEPT uses and disclosures for Treatment, Payment and Heath Care Operations (TPO). Releases and disclosures of PHI should be done according to a standard of ‘minimum necessary’, meaning only the amount of information needed to fulfill a specific purpose or task should be released.

TPO may include, but is not limited to:

- Patient Referrals,
- Providing information to family or friends who care, or will be caring for a UUHP member,
- Proving the necessary information to UUHP for processing and payment claims, and or authorizations,
Complying with UUHP’s QA/QI activities, HEDIS reporting and/or other UUHP programs centered on the improvement and measurement of patient care.

UUHP is responsible to ensure members’ privacy and also adhere to stringent confidentiality regulations as required by Federal law. This means that the identity of any caller purporting to be a member must be verified before any information concerning the member is given. This will be accomplished by obtaining the member’s identification number and date of birth. Failing that, the member will be required to provide social security number, date of birth and address to ensure the member is actually on the line.

NOTE: Providers must supply Tax ID Number (TIN) and NPI when requesting patient information.

For more detailed information on HIPAA, please see CMS website at, http://health.utah.gov/hipaa/

Medical Necessity

Provider shall determine medical necessity for specialty, ancillary care or expanded services when required and making appropriate referrals within the Healthy Premier, Healthy Preferred, Healthy U, Healthy Advantage, Healthy Advantage Plus and Grand Valley Preferred provider networks.

Compliance with UUHP Policies and Procedures

Provider shall comply and participate with all UUHP Utilization Management Programs, Quality Improvement Programs, Credentialing & Re-credentialing activities, and Complaint/Grievance Policies and Procedures. Providers agree to allow UUHP to use their performance data. In addition, Provider shall abide by policies and procedures related to covered services, billing of enrollees, emergency services, and other Policies and Procedures as defined by University of Utah Health Plans with respect to each plan Provider participates in.

Compliance with State & Federal Regulations (Medicaid & Medicare Advantage)

Provider shall comply with all State & Federal Medicaid / Medicare regulations in providing services to enrollees in such plans.

Licensure & Insurance

Provider shall maintain current licensure, malpractice liability insurance, specialty board certification when applicable, hospital privileges, malpractice history, and other credentials, and releasing this information upon University of Utah Health Plans’ request.

Notification of Changes

Provider shall notify University of Utah Health Plans Provider Relations in writing immediately upon a change in status: address, malpractice, licensure, hospital privileges, Medicare / Medicaid sanctions and/or other disciplinary actions or other changes in your credentials. Updates can be sent to provider.relations@hsc.utah.edu or you can complete the online form at http://uhealthplan.utah.edu/for-providers/prov_update_form.php
Complaint Resolution

Cooperate with UUHP personnel to resolve any complaints identified by University of Utah Health Plan members, other providers or State Health Medicaid Program Representatives.
Access Standards

Appointment Wait times

UUHP is committed to ensuring that its members have timely access to the services they need. Providers are expected to assist UUHP in ensuring access to timely care by complying with the Access Standards below:

**Type of Care**  
<table>
<thead>
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<tr>
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<tr>
<td>Routine Care</td>
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<tr>
<td>Preventive Care</td>
<td>Within 60 Days</td>
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Appointment Scheduling

Providers are required to have implemented an appropriate scheduling system which allows for adequate allotments of time for different appointment types, and allows for adequate slots reserved for urgent / acute care.

The provider’s telephone system shall be adequate enough to handle the volume of calls coming into the office.

Office Wait Times

For scheduled appointments with PCPs and Specialists, members should not wait longer than 45 minutes before being taken back to an exam room. Once in the exam room, the member should not wait longer than 15 minutes before seeing the provider.

After Hours Care

UUHP requires all providers to have back up coverage during off hours or scheduled days out of the office and to have telephone coverage 24 hours per day, 7 days per week. The use of in-office recordings must state the operating hours of the office, whom to contact if after hours, and direct the member to call 911 if it is an emergency.

PCP providers are required to return member calls within two (2) hours of being contacted, or have a mechanism in place to direct members to the appropriate after hours care.
Practitioners

As a member of the University Health Care team, UUHP strives to uphold the high standards of health care adopted by the University. The purpose of the UUHP Credentialing Program is to ensure that the UUHP provider networks consist of high quality providers that have met clearly defined standards. The credentialing program was developed in coordination with the University Medical Staff Office, and follows the standards set forth by the National Committee for Quality Assurance (NCQA).

The decision to accept or reject a practitioner’s application is based on information generated through primary source verifications, complaints and grievances, malpractice history, board certifications. Other sources of information may be considered as appropriate and relevant at the sole discretion of the Credentialing Committee members. For unfavorable decisions, providers may consult the Practitioner Appeal Rights in the Credentialing Bylaws.

Initial credentialing and re-credentialing every three (3) years is required for all physicians and other types of health care professionals practicing under their own license as permitted by state law.

For a copy of the UUHP Credentialing Bylaws and policies, please contact provider credentialing at provider.credentialing@hsc.utah.edu or (801) 587-2838 Option 3.

Monitoring of Provider Sanctions and Disciplinary Actions

UUHP does on-going monitoring of provider sanctions and disciplinary actions. Reports from the Health & Human Services (HHS), Office of Inspector General (OIG) and the Department of Professional Licensing (DOPL) are reviewed regularly throughout the year. Providers with Medicare / Medicaid sanctions, or who have a business relationship with another provider or entity that has been debarred or excluded, will be terminated from the UUHP participating networks. Providers who have had restrictions placed upon their license to practice will be presented to the peer review committee for a decision on the appropriate action to be taken.

Credentialing documents and information are kept confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

For a copy, please contact provider credentialing at provider.credentialing@hsc.utah.edu or (801) 587-2838 Option 3.

Institutional & Supply Providers

UUHP ensures that all institutional and supply providers have met their respective certifications, that they have current licenses to operate in the State of Utah that they are in good standing with state and federal authorities, and have adequate liability coverage. Credentialing is completed upon initial contracting and then every three (3) years.

- Birthing centers must have clear, written plan of transfer and transition of care in emergency circumstances. The plan must include the name(s) of the Hospital and the OB/GYN practitioner(s) providing backup.

For a copy of the UUHP Credentialing Bylaws, please contact provider credentialing at provider.credentialing@hsc.utah.edu or (801) 587-2838 Option 3.
Office Site Audits are one method of ensuring that the providers with whom we contract provide, among other things, services in a clean and accessible environment that is appropriately staffed, have the appropriate medical equipment and devices for the services rendered, appropriate medical record keeping practices and take reasonable steps to safeguard the integrity and confidentiality of our members’ protected health information.

All offices must have completed the Site Audit Questionnaire with a signed attestation stating that the returned information is accurate prior to the execution of the agreement with University of Utah Health Plans (UUHP). Any ‘No’ responses will be addressed with the appropriate office staff member. Each office must score at least 90% to proceed with the contracting process. Updated questionnaires will be gathered as additional providers are added to the practice, or upon re-credentialing of existing providers if the most recent Site Audit Attestation is older than one year at the time of initial or re-credentialing. Additionally, a new Office Site Questionnaire must be completed upon the addition of or move to a new office location prior to that site becoming effective with UUHP.

Offices failing to submit a completed questionnaire and signed attestation will be removed from the provider panel.

An official site visit will be completed by a member of the Provider Relations & Utilization Management (must be an RN/LPN) teams upon receipt of a complaint regarding the environmental aspects of the office. The provider must correct the listed deficiencies within the time frames given to at least a score of 90% to remain a contracted provider.

The Site Audit Questionnaire shall address the following physical aspects of the office:

1) Physical accessibility
2) Physical appearance
3) Adequacy of waiting room space
4) Adequacy of exam room space
5) Privacy/HIPAA compliance
6) Registration process
7) Medical record keeping
8) Staff/patient interaction
9) Clinic Personnel Conduct
Claims Submission Requirements

Providers should submit claims on standard forms (CMS 1500 for professional services and UB04 for facility services), or the appropriate 837 HIPAA compliant transaction EDI file within one year (365) days from the date of service of the claim. All necessary information for correct processing of the claim should be included on or attached to the claim form, including:

- Enrollee/Patient Name.
- Identification Number of Patient/Subscriber.
- Patient’s Date of Birth.
- Patient’s Address.
- Provider’s Name.
- Provider’s Tax Identification Number.
- Provider’s NPI
- Provider’s Practice and Billing Addresses.
- Other Insurance Information (if applicable and known).
- Date(s) of Service of Claim.
- Medical Diagnosis ICD-10 Code(s) (Codes should be obtained from the Medical Diagnosis Code Handbook for the year corresponding to the date of service).
- Procedure codes (CPT) or Revenue codes identifying services on claim (CPT codes should be obtained from the CPT Code Handbook for the year corresponding to the date of service).
- Billed Charges for each service on claim.
- Supporting Documentation including operative reports, emergency room reports, medical records supporting diagnosis when requested, etc.
- Explanation of Benefits from Primary Payer (if applicable).

University of Utah Health Plans prefer you to submit claims electronically. If you need to submit a paper claim, please submit paper claims to the following address:

University of Utah Health Plans
P.O. Box 45180
Salt Lake City, Utah 84145-0180

Claims shall be processed and remittance advices sent to the provider in accordance with the timeliness provisions set forth in the providers participating provider agreement.

Claims Review and Audit

Provider acknowledges UUHP’s right to review Provider’s claims prior to payment for appropriateness in accordance with UUHP’s medical necessity policies and procedures, and in
accordance with industry standard billing rules including, but not limited to, current UB manuals and editors, CPT and HCPCs coding, CMS & Utah State Medicaid billing and payment rules & regulations, CMS, and/or other industry standard bundling and unbundling rules, National Correct Coding Initiatives (NCCI) Edits, and FDA definitions and determinations of designated implantable devices. Provider acknowledges UUHP’s right to audit and review on a line item basis, or other such as basis as deemed appropriate by UUHP, and UUHP’s right to exclude inappropriate line items, to adjust payment, and to reimburse Provider at the revised allowed level.

Remittance Advice

University of Utah Health Plans (UUHP) will send a summary remittance advice to the provider’s office for each claim period summarizing all claims processed for that provider by patient. Each claim is assigned a number and clearly identifies provider, patient, dates of service, billed charges, allowed amount, paid amount and reason codes for any processing decisions.

Provider payments will be issued via Electronic Funds Transfer (EFT) or via Virtual Credit Card. UUHP no longer issues paper checks for provider payments.

If you have a question on processing or payment of a claim, please contact a UUHP Member Service Representative. The representative can research the claim based on claim number, patient, provider and dates of service. The phone number is, 801-587-6480, option 1.

University of Utah Health Plans also offers on-line capability to verify processing or payment of a claim through U Link. If you would like to learn more about U Link, please contact Provider Relations at 801-587-2838 or provider.relations@hsc.utah.edu.

Timely Filing Requirement

Healthy Advantage and Healthy Advantage Plus Medicare: The timely filing for both primary and secondary claims is 365 days from the date of service. Any corrections to a claim must also be received and/or adjusted within the same 365 days from the date of service. The exception to this rule is if Medicare is the primary insurance. When Medicare is the primary insurance, all claims and adjustments must be submitted and completed within 180 days of the Medicare EOB. Any claim not submitted within the above timely filing requirements will be denied.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

Healthy U Medicaid: The timely filing for both primary and secondary claims is 365 days from the date of service. The exception to this rule is if Medicare is the primary insurance. When Medicare is the primary insurance, the claim must be submitted within 180 days of the Medicare EOB.
Healthy Premier, Healthy Preferred and Grand Valley Preferred: The timely filing limit for primary claims is 365 days from the date of service. The timely filing limit for secondary claims is 180 days from the primary payer’s EOB adjudication date.

Overpayments

In the event that UUHP determines that a claim has been overpaid, paid in duplicate or that services rendered were either not a covered benefit and/or not provided for under the agreement, UUHP will recover the balance due by way of offset or retraction from current and/or future claims (provisions for repayment of refunds included in the Provider’s agreement with UUHP shall supersede those contained in this manual). In addition, UUHP may refer this matter to the Utah Attorney General’s Office for collection. Providers will be notified in writing of overpayments identified through the Fraud, Waste and Abuse department and will be given sixty (60) days to dispute or refund the overpayment. If Provider fails to submit the balance due with sixty (60) days of notification, UUHP may recover the balance due by way of offset or retraction from current and/or future claims.

Please notify UUHP immediately if you discover an error requiring reprocessing of the claim.

Coordination of Benefits

UUHP may not be the primary payer in certain circumstances, including services covered by a property owner’s liability insurance policy, the Medicare Program, or an injury or illness caused by a third party. Healthy U Medicaid should always be treated as the payer of last resort. The provider should submit the claim to the payer or party primarily responsible for the claim. If the claim is subject to coordination of benefits, the remittance advice from the primary payer will need to be submitted with the claim if you are submitting a paper claim.

In the event a commercial plan or third party is primary, UUHP will pay the lesser of the remaining billed charges or the allowable amount had UUHP been the primary payer. Payment by UUHP will be reduced by the amount of reimbursement from the primary payer. If compensation is recovered from a third party payer, the provider is expected to refund any amounts paid by UUHP for covered medical services.

For specific questions regarding coordination of benefits, please contact a UUHP Customer Service Representative.

Electronic Data Interchange (EDI)

Electronic data interchange presents substantial advantages for providers and payers alike. By utilizing electronic claims submission, providers benefit by seeing an increase in efficiency, productivity and cash flow, whereas payers benefit in the reduction of data entry errors and faster turn-around times.

Of the electronic claims submitted to UUHP, 80% do not require processor intervention. Our average turn-around time for electronic claims (date claim is received electronically to the check being received in the provider’s office) is eight days.

UUHP presently accepts the following HIPAA-compliant transactions:

837 P (Professional Claims)
837 I (Institutional Claims)
270 (Eligibility Request)
276 (Claim Status Request)
University of Utah Health Plans
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UUHP is a member of the Utah Health Information Network (UHIN), a non-profit coalition of payers, providers and other interested parties, including state government, in Utah. Numerous options are available for electronic claims submission through UHIN. Please visit http://www.uhin.org/ for more information. If a provider is not a member of UHIN, other options are available for sending EDI claims.

The steps in setting up EDI with UUHP are relatively simple:

1. Make contact with EDI support
2. Review information on our website- http://uhealthplan.utah.edu/EDI/
3. Fill out Trading Partner Form and return by fax, email or online.
4. Send a Test File for review and sign off
5. Once the Test File is good, the provider can move to production right away

The entire process of setting up EDI, from initial contact to production ready, can take as little as a few days.

For more information or questions, please visit our website and/or contact:

EDI Information Coordinator
Phone: (801)587-2638 or (801)587-2639
Fax: (801)281-6121
Email Address: uuhpedi@hs.c.utah.edu
Website: http://uhealthplan.utah.edu/EDI/

Corrected Claims
Our claims processing system can no longer identify Claims stamped “Corrected”. Therefore, Corrected Claims must be identified by one of the following:

1. UB04 -3rd digit of the bill type 7 (XX7).
2. CMS 1500 – Modifier CC and 3rd digit of the bill type 7 (XX7).

Claims Appeal Process
UUHP has policies and procedures for claim appeals. Providers are required to follow the respective polices & procedures listed in the Appeals Process link under each specific plan when appealing claim remittances.

Appeal Rights
Medicare Advantage: Contracted Provider Appeals must be received within 120 days from the date on Notice of Action or EOB. Non-contracted Provider Appeals must be received within 60 days from the date on Notice of Action or EOB. Non contracted Provider disputes must be received within 120 days from the date on Notice of Action or EOB. Members or their authorized representatives may file an appeal up to 60 calendar days after the date of a denial.
Medicaid: Appeals must be received within 90 days from the date on Notice of Action or EOB.
Group Plans and Individual Plan Appeals: Members have 180 days to appeal from Notice of Action Letter/EOB.
UNI & Miners: Please contact appeal coordinators at (801) 587-6480 or (888) 271-5870.

Please note: Effective January 1, 2016, the University of Utah Health Plans (UUHP) will require that providers obtain consent from a Healthy U or commercial member, to appeal on their
behalf, for denied claims or referrals, relating to clinical services. A Clinical appeal means services that were denied in a pre-service review, or services that were billed and require medical review, that were denied.

**Instructions for Members/Providers to File an Appeal**

You, your legally authorized representative, or your provider may file your appeal. If you need help filing your appeal, call us at (801) 587-6480, option 1. If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or 1-800-346-4128.

**Español**

Si necesita esta carta en Español, por favor llamenos al (801) 587-6480 o 1-888-271-5870 opcion 1. Deaf or hard of hearing: If you speak Spanish, you can call Spanish Relay Utah at 1-888-346-3162. These are free public telephone relay services or TTY/TDD. Sordas o con problemas de audición: Si habla español, puede llamar al español Relay Utah al 1-888-346-3162. Estos son los servicios de transmisión telefónica pública libres o TTY / TDD.

**Submission Address**

Send the complete written appeal to this address:
Appeals Committee Chairperson
6053 South Fashion Square Dr., Suite 110
Murray, UT 84107

We will accept appeals by mail, fax, or phone. An Appeal Request Form is available on our web site at: uhealthplan.utah.edu. Appeals may be submitted by phone by calling Customer Service at (801) 587-6480, option 1 or 1(888) 271-5870, option 1. **Please note: Oral appeals must be followed by a written appeal within 5 business days or your appeal will be closed (except for expedited clinical appeals).** The right to appeal is still valid if received within timely filing rules for each plan, from the UUHP Notice of Action (NOA).

**Response Time**

How long will it take for a decision to be made?

- **Medicare Advantage:** 60 calendar days. **Medicaid:** 30 calendar days. **Individual and Group Plans: Pre-Service Appeal:** within 30 calendar days of receipt of the request. **Post-service Appeal:** within 45 calendar days of receipt of the request.

Sometimes we may need more information. If so, we may take an additional 14 calendar days to make our decision. If we need to take extra time, we will send you a letter or contact you directly.

If you or your provider believes your life or immediate health is in danger, you may ask for an expedited (quick) appeal by calling Customer Service at (801) 587-6480, option 1. If we agree the decision needs to be made quickly, we will make a decision in three working days. If we need more time to make the decision, we can take up to another 14 calendar days. If we need more time, we will send you a letter telling you why. Once we have made a decision, we will mail you an Appeal Resolution Letter, and call you if you requested an expedited appeal.

**Note:** You may refer to additional information in this manual under each plan for further appeal information. Providers are required to follow the respective polices & procedures listed in the Appeals Process link under each specific plan when appealing claim remittances. You may also refer to appeals information on our website at www.uhealthplan.utah.edu for specific
polices & procedures listed in the Appeals Process link under each plan or call customer service at (801) 587-6480 or (888) 271-5870 for assistance.

Claims Editing


Mid-Level Provider Reimbursement

UUHP follows Medicare Guidelines for reimbursement of mid-level providers.
Member Rights & Responsibilities

Member Rights

Be treated with respect and dignity and a right to privacy by practitioners/providers, nurses, medical staff, administrative staff and other employees.

Receive information about the Plans offered by UUHP, our practitioners/providers, our services, and Members’ rights and responsibilities.

Members also have the right to know about any procedures that need to be followed for the Member to get care.

Be informed about their health in a way that they can understand. If the Member is sick, they have the right to be told about their illness, care options and prospects for recovery.

Openly discuss with their practitioner / provider all appropriate or medically necessary treatment options, regardless of cost or benefit coverage.

Be involved in decisions about their healthcare. Members have the right to approve any medical service after receiving the information needed to make a choice. Members have the right to refuse medical treatment even when the practitioner/provider says the Member needs it.

Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

Privacy - Members have the right to keep their medical information and records confidential subject to Federal and State law.

See their medical record. Members also have the right to ask for corrections to it and receive a copy of it.

Voice complaints or appeals about the health plan or the care it provides. Members can call Member Services if they have a complaint.

Appeal University of Utah Health Plan decisions.

Receive a reasonable and timely response to a request for service, including evaluations and referrals.

Dis-enroll from one of the Plans offered.

Ask for a second opinion about their medical condition.

Receive interpreter services, and not be asked to bring a friend or family Member with them to act as an interpreter.

Request information about their Plan, their practitioners/providers, or their health in the Member’s preferred language.

Receive a copy of their Plan’s drug formulary on request.

Receive nondiscriminatory medical care from University of Utah Health Plan providers (applicable to provider’s scope of practice) regardless of age, gender, color, ethnic origin, sexual orientation, marital status, income status or medical diagnosis or condition.
Continue enrollment in their selected Plan without regard to adverse changes in health or medical condition.

Receive the appropriate, highest quality of medical care.

Members are free to exercise their rights without any fear of retaliation or being treated differently.

**Member Responsibilities**

Be familiar with and ask questions about their health benefits, plan requirements, covered services, and contact information. If Members have a question about their benefits, call Member Services.

Provide information to UUHP, its practitioners and providers, including their Member ID Card, or plan information as needed in order to provide care.

Obtain services only from participating providers unless in an emergency when participating providers are not available or closest provider or when services out-of-network have been approved by the plan.

Understand their health problems. Be active in making decisions with their practitioner to develop agreed upon treatment goals and do all they can to meet the goals.

Follow an agreed upon healthcare plan of care and healthcare instructions, or obtain a second opinion if they do not agree with the plan of care.

Build and keep a strong patient-provider relationship. Members have the responsibility to cooperate with their provider and staff. This includes being on time for visits or calling their provider if they need to cancel or reschedule an appointment.

Report fraud or wrong doing to University of Utah Health Plans or the proper authorities.

Pay their Premiums and co-payments as required by their health care coverage.

Notify University of Utah Health Plans Member Services immediately upon a change in status: marriage, divorce, death in the family or addition to the family. (If a “Healthy U” member, also notify the Utah Medicaid Department).

Make best effort to maintain good health through healthy lifestyle and obtaining necessary and appropriate medical care.

Always discuss health information in any newsletter or on any web site with your doctor to make sure it is appropriate for you. Never use this information to replace your doctor’s advice.
Provider Complaints

UUHP recognizes that we cannot assist our members in getting the health care they need without you. As such, our goal is to provide GREAT customer service to our providers.

To measure how well we are doing, UUHP asks for your comments in the spring of each year through our provider satisfaction questionnaire. This questionnaire asks one question: “On a scale of 1 to 10, with 10 being the highest, how would you rate our health plan?”

However, you do not have to wait for the questionnaire to tell us how we are doing. If something is not working, or if we’re doing a great job, please let us know.

On behalf of a Member

A complaint on behalf of a member about health plan benefits or health care services must be registered within one year of the service date.

Send a written complaint to:

University of Utah Health Plans
Grievance Coordinator
6053 Fashion Square Dr. Suite 110
Murray, UT 84107

Upon receipt of your complaint, the Grievance Coordinator will then send a letter of acknowledgement to the complainant.

Regarding Health Plan Policies

A complaint about health plan policies may be submitted at any time to the provider relations department.

Please call Provider Relations at:

- 801-587-2838
- Or Toll Free at 1-888-271-5870 (choose option 1).

Send a written complaint to:

University of Utah Health Plans
Provider Relations
6053 Fashion Square Dr. Suite 110
Murray, UT 84107 or email

Provider Relations at provider.relations@hsc.utah.edu. Upon receipt of your complaint, the Provider Relations representative will then send a letter of acknowledgement to the complainant.
The University of Utah Health Plans Department (UUHP) has in place a Utilization and Care Management Program with key components to conform to the Health Plan's requirements. It is our belief that this program is essential to meeting the requirements of internal and external customers.

UUHP shall cooperate with the providers in an interactive educational role. Our interest is to assure that together with the providers the UUHP systems and resources will support the highest quality of medical care and meet the service demands of the UUHP patients in an efficient manner.

Key Program Components

Key components of the Utilization / Care-Management program include pre-payment review, demand management, comprehensive case management, link to disease management, and outcome analysis. Utilization / Care Management requires the comprehensive coordinated care of a patient along the care continuum. This supports the role of the primary care physician in organizing and coordinating the managed care for his or her patients through multi-disciplinary resources. This also encourages and supports the development of effective alternatives to traditional modes of medical practice without compromising the quality of care rendered to UUHP patients.

Program Purpose

The UUHP Utilization / Care Management Department supports processes for delivery of health care services to patients in a way that assures timely access to quality healthcare, patient satisfaction, and continuous improvement in the quality of that healthcare. The UUHP Utilization / Care Management Program will insure that adequate resources and systems are in place to accomplish these goals.

UUHP is committed to providing timely access to high quality health care services in an effective manner that meets or exceeds patients’ needs and expectations. While supporting the delivery of these high quality services the Utilization / Care Management Program will monitor outcomes and data so as to provide a basis for continuous improvement and cost management.

The Utilization / Case Management Program will:

- Develop and operate a clinical management process which assures appropriate, timely and cost effective application of services. (Utilization Management)
- Encourage and facilitate the development of quality improvement processes. (Participate in QI initiatives)
- Serve as a resource for medical review (Pre-payment, Pre-existing reviews, Medical necessity)
- Educate providers about effective utilization review to assure appropriate patient access to, and use of medical care resources. (Participate in provider profiling)
- Consistently review data and processes for improvement opportunities. (Analyze trends, HEDIS, benchmarking)
Program Goals

The goal of the UUHP Utilization / Care Management Program is to provide oversight and management of utilization thereby guaranteeing the highest quality health care services are provided to all UUHP patients at the appropriate level of care and in the most timely and cost-effective manner.

This goal applies to health care services provided in both the in-patient and outpatient settings by providers in the UUHP contracted network. All UUHP patients shall have equal access to health care, appropriate to their medical plan, throughout the network.

The program is designed to achieve the following specific goals:

- Encourage provision of high quality health care services.
- Provide services that encourage prevention and early detection of disease.
- Encourage efficient and effective use of health care resources.
- Achieve high customer satisfaction.
- Provide service through a select and coordinated health care provider network.
- Promote provider and patient behavior that results in medical compliance and appropriate utilization of health care resources.
- Develop data measurement and outcome tools that foster the achievement of our purpose and goals.
- Benchmark our achievements to the best of national and regional standards while identifying areas for continuous improvement.

General Structure

The scope of the Utilization / Care Management program includes:

- Pre-payment Review
- Concurrent Review
- Discharge Planning
- Expedited Review
- Pre-existing Review
- Second Opinion Program
- Case Management
- Demand Management
- Disease Management
- Data Capture / Tracking / Trending of clinical indicators
Outcomes Analysis (identification of patterns of care)

Utilization / Case Management Authority, Activities, and Accountability

1) The authority for Utilization / Care Management lies with the University of Utah Hospital. The Utilization / Care Management function is carried out through The Quality Improvement Committee, The Operations Committee, the Director, Manager, and staff.

2) The UUHP General Medical Director and Quality Medical Director have direct authority over the Utilization / Case Management Program and Quality Improvement Program.

3) The adequacy of the Utilization / Care Management protocols and systems will be monitored to assure quality outcomes as well as appropriate utilization by providers. Systems and procedures will be used to identify, track and take action on over and under utilization, quality and risk issues.

4) The UUHP General Medical Director will ultimately be responsible for review and approval of all provider requests to assure appropriate and effective use of medical resources. Denials on the basis of medical considerations will only be issued by a Board Certified licensed and designated physician.

Utilization Management Clinical Criteria

1) The UUHP Utilization Management Department shall maintain a set of written utilization review decision guidelines, which are based on national norms and community standards as interpreted by local practicing physicians.

2) The established criteria will be applied and adjusted uniformly appropriate to an individual patient's circumstances with regard to such factors as age, co-morbidity or psychosocial considerations.

3) The criteria will be consistent with practice guidelines.

4) Additional health plan documents such as the Medicaid Provider Manuals, plan contracts, and benefit plan documents will be reviewed and considered as criteria.

Medical Information

1) When making a determination of coverage based on medical necessity the UUHP Utilization Management Department will obtain all relevant clinical information and consults from the treating physician(s).

2) Information to be collected to support the decision may include:
   - Member eligibility
   - Benefit coverage / level
   - Verification of other insurance, if applicable
   - All relevant clinical information
   - Limitations and/or exclusions
   - Clinical practice guidelines and medical necessity criteria

Pre-Payment Review:

1) The basic elements of pre-payment review include eligibility verification, benefit interpretation, and medical necessity review. Services are reviewed, and determinations are made by Utilization Management licensed professional staff, and Medical Directors. Only the Medical Director can deny a service for reasons of medical appropriateness or necessity.
2) The following Healthy U services will be reviewed for medical necessity prior to paying claims:

- Abortion services
- Cosmetic Procedures
- Durable medical equipment: over $5,000 of billed charges
- Home Health Care
- Hysterectomies and sterilization procedures inclusive of abdominal, vaginal or laparoscopic assisted
- Implants
- Inpatient Services over $50,000 or a length of stay over 30 days.
- Orthotics / Prosthetics
- Skilled Nursing Facility (please notify the plan when admitted)
- Synagis Immunization
- Transplant services: lung heart, liver, kidney, bone marrow, etc.

Admission and Concurrent Review (including discharge planning)

1) Hospital admissions and inpatient services are reviewed on a concurrent timeline to assure appropriateness, continued length of stay, and levels of care.

2) All reviews are conducted by a licensed health professional and referred to the Medical Director as necessary.

3) Any quality of care issues will be reported to the Quality Improvement Specialist.

4) There is a mechanism in place to provide utilization management / discharge planning functions seven days per week.

5) Any extensions and/or denials will be documented with supporting data.

6) Acute care hospital review requirements:
   
   a) Plan eligibility shall be identified at time of admission
   b) Urgent/emergent admissions shall be reviewed based on criteria standards and layperson definition.
   c) Aberrant days will be assigned as appropriate.
   d) As deemed necessary, the case manager will provide an onsite interview with the patient regarding discharge needs within the continuum of care.

Comprehensive Case Management

1) Patients are identified through health needs assessments at the earliest possible time for case management intervention.

2) The mechanism for identification may be through enrollment, primary care physician referral, claims history, high risk profiles, total costs, emergency room log, utilization discharge planning, social workers, member services, pharmacy, survey tools or notification by state or federal agencies.
3) A designated case manager will follow patients across the continuum of care in both in-patient and ambulatory settings.

4) Coordination of care by primary as well as specialty providers will be augmented by use of ancillary health care and community social services. This coordination may be facilitated by phone, email, or case conferences.

5) Demand management will expedite case management-like processes as emergent coordination of care issues arise.

6) The frequency and duration of case management services are defined by population in the specific case management policies.

Link to Disease Management

1) Case management will work collaboratively with disease management efforts to improve educational efforts and improve outcomes.

2) Led by the Quality Improvement Department Manager, disease management teams will be created to actively improve identification techniques and educational resources.

3) The case manager assigned to the diseased population will be a participant in the disease management team and act as the liaison to case management.

4) Referrals will actively be generated and passed between the disease management team and case management depending on evaluation and needs of the member.

Second Opinion Survey

1) Patients have a right to a second medical opinion in the following situations:
   a) When they are concerned about a diagnosis or medical plan of care.
   b) If they question the reasonableness or necessity of recommended procedures.
   c) If the clinical indications are not clear or are complex and confusing.
   d) If the treatment plan in progress is not improving the medical condition within an appropriate period of time.
Advanced Directives

UUHP members have the right to make decisions about their health care, including a written Advance Directive. Under Utah law, there are four types of written advance directives:

1. **Special Power of Attorney for Health Care**: a person chooses someone else to make health care decisions if that person can’t make decisions for himself/herself.

2. **Living Will**: a written statement of the health care a person wants if he or she can’t make independent decisions.

3. **Directive for Medical Services after Injury or Illness**: a directive made between a person (or the individual who has Special Power of Attorney for the person) and a doctor for care when the person has a serious illness or disease, or if he or she is about to have an operation that could result in further illness, injury, or death.

4. **Emergency Medical Services/Do Not Resuscitate**: a directive alerting emergency workers that the person does not want CPR or life saving techniques. A doctor must determine that the person is suffering from a life-threatening illness before this directive can be made.

UUHP encourages members to tell their family members, the person who has Special Power of Attorney for them, and their providers about their wishes, and give them a copy of their advance directive.

Health care providers and health care facilities shall cooperate with a patient’s advance directive. In instances where an individual provider, or facility, or their overall institution objects to complying with a patient’s advance directive, whether based on policies, conscious objection, or other reasons as permitted under Utah state law (SB 75 2a-1114), providers shall meet all resulting requirements outlined in SB 75 2a-114.

If your patients need information about advance directives, they may call UUHP at 888-271-5870, option 1, or visit the Utah End of Life Partnership web site at http://www.carefordying.org/.

Additional information for patients and providers, including a provider specific manual, can be found at the University of Utah Center on Aging at http://aging.utah.edu/utah_coa/directives/.

Medicaid members may also contact Utah Legal Services at (801) 328-8891. If a Medicaid member feels a provider did not carry out the advance directive, he or she may call the Medicaid Bureau of Program Certification at 801-538-6158 or 1-800-662-4157.

Domestic Abuse, Neglect and/or Exploitation

To ensure the health and safety of children and adults, UUHP is committed to educating contracted providers about mandatory reporting requirements, reporting procedures, and opportunities for provider and patient education. Therefore, University of Utah Health Plans providers **MUST** report abuse, neglect, and/or exploitation of children, adults, and families.

Under Utah Law (26-23a-2), any health care provider who treats or cares for a person who suffers from any wound or other injury inflicted by the person's own act or by the act of another must immediately report it to a law enforcement agency. In addition, any person who has reason to believe that an elder or disabled adult is being abused, neglected or exploited must by law (62A-3-305 and 76-5-111.1) immediately report the situation to Adult Protective Services (a...
division of Aging and Adult Services) or the nearest law enforcement office. Under these laws, all reporters are immune from civil and criminal liability related to the report.

In addition to reporting to law enforcement agencies, providers may wish to notify the following divisions at the Utah Department of Health, specifically established for reporting purposes:

<table>
<thead>
<tr>
<th>Child &amp; Family Services</th>
<th>Adult &amp; Aging Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>120 North 200 West</td>
<td>Adult Protective Services</td>
</tr>
<tr>
<td>Room 225</td>
<td>120 North 200 West</td>
</tr>
<tr>
<td>Salt Lake City, Utah 84103</td>
<td>Room 325</td>
</tr>
<tr>
<td>Phone: (801) 538-4100</td>
<td>Phone: (801) 538-3910</td>
</tr>
<tr>
<td>Fax: (801) 538-3993</td>
<td>Fax: (801) 538-4395</td>
</tr>
<tr>
<td>24-Hour Child Abuse Reporting</td>
<td>To Report Adult Abuse, Neglect or Exploitation</td>
</tr>
<tr>
<td>(801) 281-5151</td>
<td>call our 24-Hour Adult Protective Reporting</td>
</tr>
<tr>
<td>24-Hour Adult Protective Reporting</td>
<td>(800) 371-7897 or (801) 264-7669</td>
</tr>
<tr>
<td>Domestic Violence Information Line</td>
<td>1-800-897-5465</td>
</tr>
</tbody>
</table>

Providers who are employed by the University of Utah Hospitals and Clinics should also familiarize themselves with the University of Utah policy on prevention, detection, and reporting requirements in the Abuse, Neglect and/or Exploitation Policy: [https://intercomm.utah.edu/policies/Lists/Policies/DispForm.aspx?ID=1962](https://intercomm.utah.edu/policies/Lists/Policies/DispForm.aspx?ID=1962)

UUHP encourages providers to educate themselves and their staff about the prevention and detection of abuse, neglect, and/or exploitation, and resources available for victims. Providers may contact the agencies above for additional prevention, detection, and resource information. Providers may also wish to direct patients to the agencies above for additional education. Providers may also refer patients who are victims of domestic abuse to the Domestic Violence Information Line at 1-800-897-5465 (LINK) for available resources.

**Medicaid Fraud Abuse Prevention and Detection**

To ensure that health care dollars are used as intended, UUHP is committed to preventing and detecting fraudulent and/or abusive behavior by providers, members, and other individuals or organizations associated with the operations of UUHP.

**Fraud Detection & Prevention:**

UUHP will prevent and detect fraudulent/abusive behavior and comply with state and federal fraud and abuse requirements by:

- Utilizing controls to prevent and detect fraudulent/abusive behaviors.
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- Claims system pre-processing checks
- Claims system edit reports
- Member and provider complaints/fraud and abuse reports
- Utilization management reviews - prospective, concurrent, and retrospective.
- Credentialing and re-credentialing reviews to identify patterns of suspected incidents, and detect confirmed incidents in the form of Medicare or Medicaid exclusions.

In accordance with federal regulation 42CFR 438.214 (d), University of Utah Health Plans will not include any individual in the provider network who:

- Has been debarred, suspended, or otherwise excluded from participation in Medicaid or Medicare programs;
- Has an affiliation with an individual who has been debarred, suspended or otherwise excluded from participation in Medicaid or Medicaid programs;
- Owns 5% or more in the University of Utah Health Plan's equity and is ineligible for participation in Medicare and Medicaid, or is affiliated with an individual who is ineligible, due to debarment, suspension, or exclusion from these programs.

UUHP encourages providers to institute a compliance plan to prevent and detect fraud and abuse. The Office of Inspector General (OIG) has published guidance for physician practices to assist in the development of a compliance plan: Final Compliance Program Guidance for Individual and Small Group Physician Practices PDF (65 FR 59434; October 5, 2000).

For further information about fraud and abuse detection and prevention, please visit the OIG’s web site at http://www.oig.hhs.gov/fraud/report-fraud/index.asp, or the National Health Care Anti-Fraud Association web site at http://www.nhcaa.org/.

Reporting Fraud and Abuse:

If you suspect fraud and abuse, you may report it to the University of Utah Health Plan Compliance Officer at 888-271-5870, Option 1.

If the University of Utah Health Plan suspects fraud and abuse, suspected incidents will be reported to the following Medicaid agencies after a preliminary internal audit: Health Care Financing, Bureau of Managed Care and the Medicaid Fraud Control Unit.

Newborn and Mothers’ Health Protection Act

UUHP honors the Newborn’s and Mothers’ Health Protection Act of 1996. The Newborns’ Act regulates that all health plans and insurance issuers do not restrict a mothers’ or newborns’ benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery and 96 hours following a cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

If the delivery is in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If the delivery is outside the hospital and then later admitted to the hospital in connection with childbirth, the period begins at the time of admission.

Follow-up care is required for women and infants discharged early following vaginal and cesarean section births. Women and infants discharged less than 48 hours following a vaginal birth or 96 hours following a cesarean section delivery should receive post-delivery follow-up care within 24-72 hours following the discharge.
Healthy U is a managed care health plan exclusively for Medicaid patients. The information provided in this section is designed to assist Healthy U providers in recognizing Medicaid patients and the services that must be accessible to Medicaid patients.

**Service Area**

Healthy U is available to eligible Medicaid enrollees throughout the state of Utah.

**Use of Primary Care Providers**

All Healthy U enrollees are encouraged to choose a Primary Care Provider (PCP) to manage and coordinate all of their care. A PCP is defined as a generalist in any of the following areas:

- Family Practice
- General Practice
- General Internal Medicine
- Obstetrics/Gynecology
- Pediatrics

A PCP can be a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner, Resident or Physician Assistant. The enrollee may also select a Clinic to act as their PCP.

**Receiving Care**

**Referrals** – Healthy U members may consult a specialist without obtaining a referral from their primary care provider.

**Use of Provider Network** – Except in the case of an emergency, enrollees must obtain covered services in the following manner:

a) Members must receive ALL services from a Healthy U PARTICIPATING provider in order to receive coverage. Services rendered by a NON-PARTICIPATING provider will be DENIED with no payment.

b) Facility services from a PARTICIPATING facility only. Services rendered by a NON_PARTICIPATING facility will be DENIED with no payment.

- Urgent Care Centers. Provider shall be reimbursed at 100% of the prevailing Medicaid Rate.

University of Utah Health Plans provides Healthy U Provider Directories to all its members upon enrollment in the plan. The most current provider directory may be viewed online at [http://uhealthplan.utah.edu/healthyU](http://uhealthplan.utah.edu/healthyU).

Directories are also made available to State Medicaid Health Program Representatives, and to participating providers upon request. Since information in the directory is subject to change,
Healthy U encourages members to check provider’s participating status prior to obtaining services.

**Care Management**

Patients are identified at the earliest possible point for care management intervention. The mechanism for identification may be through enrollment, claims, utilization trending, medical history, survey tool or notification by provider and/or State Medicaid Representative (HPR). HIGH RISK patients may be identified through primary care referral, specific diagnosis ICD-9 clustering, emergency room logs, referral requests, payer personnel and specialty provider contracts.

Each patient identified may be assigned a care manager from the CM Department, and followed by their case manager across the continuum of care; both in inpatient and ambulatory settings. Services may also be coordinated among social and community services, family, or specialty and primary care providers. Coordination is achieved via phone, e-mail, and fax or through case conferences.

All complex case management patients, pending open and closed cases are reported to the Healthy U UM Committee on a quarterly basis.

Care Coordination will be provided through our Case Management Department for the following:

- Healthy U-Restricted patients – Please notify Healthy U if services are not provided by the Primary Care Provider (PCP)
- Obstetrical Patients - Contact U Baby Care at 801-587-6480 and notify the plan when admitted for delivery.
- Out of area non-emergent care.
- Patients identified, by referral, from physician, patient or utilization patterns where Case Management assistance is needed.
- Patients with complex needs related to physical health and/or psychosocial issues.

**General Policies Regarding Covered Services**

All covered services must be medically necessary and all Healthy U plan utilization management requirements must be met for services to be reimbursed. All services must be obtained from a participating provider to be covered, except in the case of “emergency services” or when a referral has been obtained from the plan. If you have a question about whether a service or supply is covered, please contact Healthy U. You may also refer to the Utah Medicaid Provider Manual for more detailed information on covered services, including applicable definitions, regulations and limitations.

*Please note: Please reference our website for current plan information.*

**Non-Covered Services**

This list is not inclusive of all Medicaid non-covered services and supplies, but rather is intended to provide basic guidelines for determining non-covered services. Please refer to the Utah Medicaid Provider Manual for detailed information on non-covered services or contact a Healthy U Representative.

General Exclusions:

- Services rendered during a period the client was ineligible with the Healthy U Medicaid Plan.
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- Services not medically necessary or appropriate for the treatment of a patient’s diagnosis or condition.
- Services which fail to meet the existing standards of professional practice are investigational or experimental.
- Services obtained out-of-network that are not emergency services, urgent care services, or where a referral was not obtained from Healthy U.
- Covered services for illnesses and injuries sustained directly from a catastrophic occurrence or disaster, including but not limited to, earthquakes or acts of war. The effective date of excluding such covered services will be the date specified by the Federal Government or the State of Utah that a Federal or State emergency exists or disaster has occurred.
- Elective services requested or provided solely due to patient’s personal preference. Provider must notify patient in writing that service(s) is not covered and that financial responsibility will be the patient’s if the elective services are performed.
- Services for which a third party payer is primarily responsible. Healthy U will make a partial payment up to the plan’s allowable amount if the limit has not been reached by the third party.
- Services that are fraudulently claimed.
- Services that represent abuse or overuse.
- Services rejected or disallowed by Medicare for any of the reasons listed above.
- When a procedure or service is not covered for the above listed reasons or is disallowed by Healthy U, all related services and supplies, including institutional costs will be excluded for the standard post-operative recovery period.
- Cosmetic, reconstructive or plastic surgery procedures, including all services, supplies and institutional costs related to services which are elective or desired for primarily personal, psychological reasons or as a result of the aging process.
- Removal of tattoos.
- Hair transplants.
- Breast augmentation or reduction mammoplasty.
- Panniculectomy and body sculpturing procedures.
- Rhinoplasty unless there is evidence of recent accidental injury resulting in significant obstruction of breathing.
- Procedures related to trans-sexualism.
- Surgical procedures to implant prosthetic testicles or provide penile implants.
- Family planning services which are not covered include:
- Surgical procedures for the reversal of previous elective sterilization, both male and female
- Infertility studies
- In-vitro fertilization
- Artificial insemination
- Surrogate motherhood, including all services, tests and related charges.
Abortion, except when the life of the mother would be endangered or when the pregnancy is the result of rape or incest.

Certain services are excluded from coverage because medical necessity, appropriate utilization and cost-effectiveness of the service cannot be assured. No specific therapy or treatment is identified except for those that border on behavior modification, experimental or unproven practices. These services include:

- Sleep apnea, sleep studies, or both
- Pain management and pain clinic services
- Eating disorders.
- An inpatient admission for 24 hours or more solely for observation or diagnostic evaluation is not a covered Medicaid service.
- Miscellaneous supplies, dressings, durable medical equipment and drugs to be used as take-home supplies from an inpatient stay or outpatient service are not separately covered services.
- Surgical procedures, unproven or experimental procedures, medications for appetite suppression, or educational, nutritional support programs for the treatment of obesity or weight control are non-covered Medicaid services.

**Verification of Eligibility**

It is important for all Healthy U patients to show their Medicaid Identification Card BEFORE receiving any type of service. Providers must verify that the patient is eligible for Medicaid on the date of service and whether the patient is enrolled in an HMO, in a Prepaid Mental Health Plan, in the Restriction Program, or has a Primary Care Provider. This information is printed on the Medicaid Identification Card, and the information is also available through UUHP Member Services.

Since eligibility of a Medicaid member can change frequently, the provider’s office should request a copy of the member’s Medicaid Identification Card upon each visit and prior to rendering services.

Provider’s offices may contact UUHP member services to verify eligibility information:

Salt Lake County: 801-587-6480
Toll Free: 888-271-5870

Or providers may utilize the Medicaid Hotline:

Salt Lake County: 801-538-6155
Toll Free: 800-662-9651

‘Lock-in’ or Medicaid Restriction Program

When a Medicaid recipient uses their Medicaid services unwisely, they are placed on the ‘lock-in’ or Restriction Program. An example of misuse includes seeing a provider or seeing several physicians in an attempt to have pain medications prescribed. Once placed in the Restriction Program, the member is required to choose a PCP, hospital and pharmacy and is restricted to using only these providers. Healthy U conducts an in person orientation with the Restricted Medicaid member to ensure the member understands the limitations and requirements.
The Member’s Medicaid Identification Card will identify if the member is in the Restriction Program as well as list the primary care provider, hospital and pharmacy they are restricted to use. Questions regarding this program should be directed to University of Utah Health Plans Utilization Management at 801-587-6480, option 2.

For the duration of the “Lock-in” they are required to contact the State Department of Health Restriction Program to have their primary care provider, hospital or pharmacy changed. Restricted members are required to obtain medical services from their PCP. If, as determined by their PCP, the member is to receive services from another provider, the member must obtain and present a referral from their PCP provider. All services rendered outside the members PCP without a referral will be denied for payment.

Direct Billing of Services

Generally, health providers who agree to treat Medicaid patients are prohibited by Federal law from billing Medicaid patients directly for covered services. As such, the Provider is prohibited from billing and/or collecting from the member, except for State mandated patient responsibilities (such as co-payments & coinsurance) and/or non-covered services (see below for instructions on billing for non-covered services), any amount due to Provider by UUHP (Refer to Provider Agreement for further details), and Provider must accept Healthy U’s payment as payment in full. Failure to abide by State billing rules and regulations, and/or the Policies and Procedures of Healthy U may result in the claim(s) being denied for payment. In such cases, the Provider is prohibited from billing the member.

Healthy U members are responsible for presenting proof of Medicaid eligibility and enrollment in Healthy U at the time of service. Patients who fail to advise the provider of their Medicaid eligibility may be liable for services rendered on that date. Please refer to the Medicaid Provider Manual for additional rules and regulations.

Non Covered Services: A provider may be reimbursed for the provision of Non-covered services if one of the two conditions are met:

1. A benefit exception is obtained from Healthy U. To obtain a benefit exception, please contact the Healthy U Care Management Department. Where benefit exceptions are granted, the Provider is bound by the billing policies established above.

2. The Provider has informed (in writing) the Healthy U Member that the services to be rendered are not covered under their Medicaid benefits, informs them of the total charges for which they would be liable for, and obtains the members authorization signature prior to the services being rendered. (Note – This must be done each time a non-covered service is to be rendered. A single, onetime statement covering all future services is not acceptable.)

Medically Necessary

“Medically Necessary” means any medical services or supplies that are necessary and appropriate for the treatment of an Enrollee’s illness or injury and for the preventive care of the Enrollee according to accepted standards of medical practice in the community in which the provider practices and consistent with practice guidelines developed and approved by Healthy U. Covered services must meet the definition of medically necessary to be covered by the plan. Please contact the Healthy U Case Management Department for questions on medical necessity.
Emergency Services

“Emergency Services” means those services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in:

Placing the health of the individual (or with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy.

Emergency providers are expected to use prudent judgment in determining whether the member requires treatment in the emergency room. Members with non-emergent conditions should be referred to their primary care physician for treatment and follow-up care.

The initial screening examination to make a clinical determination whether an actual medical emergency exits will be covered by the plan with a triage fee. All services required to stabilize the enrollee with an emergency medical condition will be covered by the plan. The Healthy U care management department should be notified within 24 to 48 hours (same day or next working day for weekends and holidays) of emergency services being rendered.

If the initial screening examination determines that the enrollee’s condition is not an emergency nor of an urgent nature, the patient should be referred to his or her Primary Care Physician for further treatment. Healthy U will reimburse a triage fee to the emergency department and attending physician for this initial assessment. If the emergency room provider provides treatment for the patient even after determining the condition is not for a medical emergency, only a triage fee for the initial screening examination will be covered by the plan.

Out-of-network

“Out-of-network” shall mean services rendered by any provider that is not a participating, contracted provider in the Healthy U Medicaid plan. Out-of-network services will only be reimbursed by the plan when they are:

- Medical necessary services that were unavailable through the Healthy U network of participating providers and are approved by the plan through the referral process.
- Services that meet the definition of “emergency services” or urgent care services.
- Court ordered services that are Medicaid covered services and have been coordinated with Healthy U.

Translation Services

For a list of translations services, please call UUHP Customer Service at (801) 587-6480, option 1.

Women’s Services

Healthy U has special programs in place to ensure that women receive the highest quality healthcare.

“U Baby Care”

Healthy U requires provider notification on all pregnant members.

The “U Baby Care” program is provided for all pregnant members upon notification of pregnancy. A case manager (RN) is on staff to take calls from members who have questions or
concerns regarding their pregnancy and to provide case management services. Every member who completes the “U Baby Care” program receives a gift.

When Healthy U is notified (state report, provider notification, member notification, hospital admit) of a pregnant member, a welcome letter, risk survey, and education materials are mailed to the member. When the member returns the risk survey, and has indicated a pregnancy risk, the “U Baby Care” coordinator forwards the information to the case manager (RN). The case manager contacts the member and completes a risk assessment, scoring the member low, medium, or high risk. Medium and high risk members qualify for case management.

Healthy U offers Enhanced Services for pregnant members, including perinatal care coordination, prenatal and postnatal home visits, group prenatal and postnatal education such as Lamaze classes, nutritional assessment and counseling, and prenatal and postnatal psychosocial counseling. Providers may refer members for any of these services. Please call Healthy U’s Utilization Management Department for questions concerning enhanced services.

Information about HIV and sexually transmitted infections are provided to members of the “U Baby Care” program.

Healthy U requires providers to conduct a risk assessment on every pregnant member. Providers are encouraged to contact the “U Baby Care” case manager (RN) with any information that is pertinent to the member for coordination of care.

Healthy U honors the Newborn’s and Mother’s Health Protection Act. Mother and baby have the right to stay inpatient for 48 hours after a vaginal delivery and 96 hours after a C-Section.

For additional information please visit the University of Utah website at
http://www.dol.gov/ebsa/newsroom/fsnmhafs.html

Mammography

Mammography reminder letters and follow up calls go out to members meeting the mammogram criteria that have not had a mammogram within two years.

Mammogram screenings are covered for Healthy U members.

Cervical Cancer Screening

Healthy U recommends and covers Cervical Cancer Screening (pap test) for all female members on a yearly basis. Chlamydia Screening is also recommended and covered by Healthy U.

Family Planning Services

Family planning services are Medicaid covered services and must be made available to Healthy U patients free of charge. This includes disseminating information, counseling, and treatment related to family planning services. Healthy U members may go to any Medicaid provider for family planning even if he or she is not a Healthy U provider.

Birth control services include information and instructions related to: birth control pills, including emergency contraceptive pills; Depo Provera; IUDs; the birth control patch, the ring (Nuvaring), spermicides, barrier methods including diaphragms, male and female condoms; and cervical caps; vasectomy or tubal ligations. Office calls, examinations and counseling related to
contraceptive devices are also covered and must be made available to Healthy U patients. The removal of Norplant is also a covered benefit.

Please note that elective tubal ligations and vasectomies must have the Medicaid sterilization consent form signed 30 days prior to the procedure. The form expires 180 days after consent form is signed.

Providers are expected to be familiar with the Utah “Minor’s Consent to Treatment” Law. Providing family planning services and certain other treatments for minors without parents’ consent is legal and expected of Healthy U providers. The “Minor’s Consent to Treatment” Law outlines when a provider may treat a minor without getting the consent of the minor’s parents.

The complete text of the “Minor’s Consent to Treatment” Law and forms are included in the appendix of this handbook for your convenience.

Note: Any provider participating with Healthy U who does not wish to offer family planning services because of religious or personal reasons should contact Healthy U Provider Relations at 801-587-6602, or 801-587-6480 so patients can be directed to an alternate provider.

Foster Children

A special population served by the Healthy U Health Plan is children in the custody of the State of Utah Department of Human Services. This group includes both children who have been removed from their homes by the Division of Child and Family Services (DCFS) due to suspected abuse or neglect as well as children under the direction of the Division of Youth Corrections (DYC).

A Medicaid case is routinely opened for children in these groups and they are enrolled in one of the available Medicaid health plans. Healthy U contracts with providers who have experience and training in abuse and neglect to insure quality care for these children and is responsible to coordinate appointments with DCFS or DYC.

If a child in State custody has an established relationship with a provider contracted with Healthy U every effort will be made to insure that child continues his or her care with that provider.

There are specific guidelines that must be adhered to when scheduling provider visits for children in State custody because of suspected abuse or neglect. In cases where the DCFS child protective caseworker suspects physical and/or sexual abuse it is the responsibility of Healthy U providers to ensure that the child have an appropriate examination within 24 hours of notification of removal from the home.

In all other cases an initial health screening by a provider must take place within five calendar days of notification of removal from the home. This exam serves to identify any medical problems or conditions that require immediate attention or that might determine the selection of a suitable placement for the child. There are occasions when a child is placed with the State and must be examined and have medical treatment before a Medicaid case is opened for the child.

Child Health Evaluation and Care (CHEC)

CHEC is the Utah Medicaid version of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) with three main components: Outreach and Education, Expanded Services, and Screening and Prevention. This section of the provider manual includes information on each component, other CHEC services, and reimbursement.
Outreach and Education

Families of Medicaid eligible children are encouraged to seek early and repeated well-child health care visits beginning ideally at birth, and continuing through the child’s 20th birthday. The Utah Department of Health and Healthy U provide outreach services to families to ensure they are informed of the importance of well-child care and that a visit is due. Healthy U also conducts education sessions for primary care physician’s offices to keep them up-to-date with the CHEC Medicaid program. For more information about outreach education, please call Case Management at (801) 587-6480 or 800-271-5870, option 2.

Expanded Services for Medically Necessary Health Care

Section 1905 (a) of the Social Security Act provides expanded coverage for CHEC enrollees when services are medically necessary to prevent, or ameliorate defects, and/or improve physical and mental conditions identified during CHEC screening - even when the service is not covered on the Medicaid fee schedule. Coverage is based upon a medical necessity review. Please contact the University of Utah Healthy U Case Management at (801) 587-6480 or 800-271-5870, option 2, with any coverage questions, or for a medical necessity review.

Screening and Prevention Services

1) Comprehensive Health History:

Health history includes an assessment of both physical and mental development obtained from the parent, guardian, or other responsible adult who is familiar with the child’s history. The Health history should include:

i) Developmental History: following developmental screening tools are recommended for children up to 6 years of age:
   - Infant Development Inventory (IDI) - http://www.childdevrev.com/.

ii) Nutritional History: Use to identify nutritional deficiencies or unusual eating/feeding habits.

iii) Dental History

2) Comprehensive Physical Examination:

A comprehensive physical examination includes:

i) Physical Examination: A standardized physical examination with an assessment of all body systems and a complete oral inspection of the mouth, teeth and gums during each CHEC screening.

ii) Measurement of Length, Height, and Weight: Measure and lot these items (and the occipital frontal head circumference of each child two years of age and younger) on the 2000 CDC growth charts (available at http://www.cdc.gov/growthcharts/).

3) Vision Screening
Services include diagnosis and treatment for defects in vision, including eyeglasses. When needed, refer the child to the appropriate specialist. Further evaluation and proper follow-up is recommended for the following vision problems:

- Infants and children who show evidence of enlarged or cloudy cornea, cross eyes, amblyopia, cataract, excessive blinking or other eye normality.
- A child who scored abnormally on the fixation test, pupillary light reflex test, alternate cover test, or corneal light reflex in either eye.
- A child with unequal distant visual acuity (a two-line discrepancy or greater).
- A child under age five years of age with distant visual acuity of 20/50 or worse, or a child five years of age or older with distant visual acuity of 20/40 or worse.

Note: A table with the recommended vision screening protocols and intervals is available in the Utah Medicaid Provider Manual (Section 2 – CHEC Services) at http://health.utah.gov/medicaid/pdfs/chec.pdf.

4) Hearing Services

Services include diagnosis and treatment for defects in hearing, including hearing aids. Screening should be supervised by a state licensed audiologist.

If a newborn was not screened in the birthing facility before discharge, a screening test should be conducted as soon as possible after birth. Conduct screening exams on all children during the first CHEC exam and perform at each periodic visit if indicated by historical findings or the presence of risk factors. When indicated, Infants require screening every six months until three years of age. When needed, refer the child to an appropriate specialist.

Age appropriate hearing screening intervals, protocols, and procedures, and screening indicators are available in the Medicaid Provider Manual (Section 2 – CHEC Services) at http://health.utah.gov/medicaid/pdfs/chec.pdf.

5) Speech and Language Development

Screen for appropriate development and to identify developmental delays. The CHEC program recommends using the following landmarks for screening:

- At six months a child babbles and initiates social approach through vocalization.
- At one year a child says 'mama' and 'dada' specifically and engages in vocal play.
- At two years a child begins connecting words for a purpose, such as 'me go' and 'want cookie'.
- At three years a child holds up her fingers to show her age and has a vocabulary of 500-1,000 words. She will use an average of three to four words per utterance.
- At four years a child's speech should be 90% intelligible. They may make some articulation errors with letters s, r, l, and v. They should use a minimum of four to five words in a sentence.

Refer the child for a speech and hearing evaluation if you observe one or more of the following:

- Child is not talking at all by age 18 months.
- You suspect a hearing impairment.
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- Child is embarrassed or disturbed by his own speech.
- Child's voice is monotone, extremely loud, largely inaudible, or of poor quality.
- A noticeable hyper nasality or lack of nasal resonance.
- Child fails the screening tests.
- Recurrent otitis media.
- Speech is not understandable at age four years, especially in cases of suspected hearing impairment or severe hyper nasality.

6) Blood Pressure Measurements

Measure at each exam and compare against age specific percentiles for all children three years and older.

7) Age appropriate Immunizations

Assess whether the child’s immunizations are up-to-date. Provide all appropriate immunizations according to the schedule in Appendix B of the Medicaid Provider Manual at http://www.immunize-utah.org/ or on the CDC web site at http://www.cdc.gov/vaccines/. You may also refer the child to the local health department.

8) Laboratory Testing

Determine the applicability of specific tests for each child. Perform the following laboratory tests at the time of the CHEC screening using the recommendations of the American Academy of Pediatrics to determine the specific periodicity of each of the following tests:

- Newborn Metabolic Disease Screening.
- Hematocrit or Hemoglobin Screening.
- Tuberculin Screening with annual testing for the following high risk groups:
  - American Indian and Alaskan native children.
  - Children living in neighborhoods where the case rate is higher than the national average.
  - Children from Asia, Africa, the Middle East, Latin America or the Caribbean (or children whose parents have emigrated from these locations).
  - Children in households with one or more cases of tuberculosis.

Cholesterol Screening

Conduct at your discretion based on the risk of the child.

Lead Toxicity Screening

The Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend a lead risk assessment and a blood lead level test for all Medicaid eligible children between the ages of 6 and 72 months. All children in this age group are considered at risk and must be screened. This component of the CHEC screening is mandated by federal rules.

Verbal Lead Risk Assessment:

Complete a verbal risk assessment for all Medicaid-eligible children ages 6 to 72 months at each CHEC screening. Beginning at 6 months of age, a verbal risk assessment must be
performed at every CHEC visit. At a minimum, the following questions must be asked to determine the child’s risk for lead exposure:

- Does the child live in or regularly visit a house built before 1978? Was his/her child care center or preschool/babysitter’s home built before 1978? Does the house have peeling or chipping paint?
- Does the child live in a house built before 1978 with recent, ongoing or planned renovation or remodeling?
- Do any of the child’s siblings or playmates have lead poisoning?
- Does the child frequently come in contact with an adult who works with lead? (Examples are construction, welding, pottery, or other trades practiced in your community.)
- Does the child live near a lead smelter, battery recycling plant, or other industry likely to release lead? (Give examples in your community.)
- Do you or anyone give the child home or folk remedies that may contain lead?
- Does the child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
- Does the home the child live in have lead pipes or copper with lead solder joints?

Scoring the Verbal Risk Assessment:

- Low Risk for Lead Exposure: If the answers to all questions are negative, a child is considered low risk and must receive a blood lead test at 12 and 24 months.
- High Risk for Lead Exposure: If the answer to any question is positive, a child is considered high risk and a blood lead level test must be obtained regardless of the child’s age. Subsequent verbal risk assessments can change a child’s risk category. If a previously low risk child is re-categorized as high risk, that child must be given a blood lead level test.

Complete a blood lead level testing at required intervals:

- At 12 and 24 months: Complete for all children regardless of verbal assessment score.
- Between 24 and 72 months: Complete a blood lead level test if the child has not had it at 12 and 24 months regardless of the verbal assessment score. In addition, complete a test anytime the verbal assessment indicates the child is at high risk for lead poisoning.

Reportable blood lead levels:

Blood lead level samples may be capillary or venipuncture. However, a blood lead test result equal to or greater than 10 ug/dL obtained by capillary specimen must be confirmed using a venous blood sample. In accordance with the Utah Injury Reporting Rule (R386-703), all confirmed blood lead levels greater than 15 ug/dL must be reported to the Utah Department of Health, Bureau of Epidemiology which maintains a blood lead registry. Reports of children with blood lead levels of 20 ug/dL or greater will be shared with the Utah Department of Health, Bureau of Environmental Services.

Other Tests

Please consider other tests based on the appropriateness of the test. Take into account the child’s age, sex, health history, clinical symptoms and exposure to disease.
9) Health Education:

This is a CHEC requirement that includes anticipatory guidance. It should be provided to parents/guardians and children, and include information regarding developmental expectations, techniques to enhance development, benefits of healthy lifestyles, accident, injury, and disease prevention, and nutrition counseling.

Note: A table with the recommended screening and prevention components and administration intervals is available in Appendix C of Utah Medicaid Provider Manual at http://health.utah.gov/medicaid/pdfs/chec2_0104.pdf.

10) Mental Health:

Services that support young children’s healthy mental development can reduce the prevalence of developmental and behavioral disorders which have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems.

Broadly defined, screening is the process by which a large number of asymptomatic individuals are tested for the presence of a particular trait. Screening tools offer a systematic approach to this process. Ideally, tools that screen for the mental development of young children should:

- help to identify those children with or at risk of behavioral developmental problems,
- be quick and inexpensive to administer,
- be of demonstrated value to the patient and provide information that can lead to action,
- differentiate between those in need of follow-up and those for whom follow-up is not necessary, and
- be accurate enough to avoid mislabeling many children.

Screen the child for possible mental health needs. You may use a standardized behavior checklist to do this screen. We recommend the following social emotional screening tools for screening infants 0-12 months:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire: Social Emotional (ASQ:SE)
- Parent’s Evaluation of Developmental Status (PEDS)
- Temperament and Atypical Behavior Scale (TABS)

Screening accompanied by referral and intervention protocols can play an important role in linking children with and at-risk for developmental problems with appropriate interventions.

Please refer children with suspected mental health needs for mental health assessment.

Healthy U does not cover mental health services. Services are covered by the Prepaid Mental Health Program. For information, please call the General Medicaid Program at (801) 538-6155 or 800-662-9651. Healthy U and Medicaid encourage providers to refer children with suspected mental health needs to the mental health provider listed on the Medicaid Identification card. If no provider is listed on the Medicaid card, refer the child to a Medicaid Mental Health Provider in the child’s home area. Mental Health Services, at a minimum, include diagnosis and treatment for mental health conditions. Refer to the Utah Medicaid Provider Manual for Mental Health Services, Section 2, for policy on services.
11) Dental Services

Dental services are not covered by Healthy U. Services are covered by the General Medicaid Program at (801) 538-6155 or 800-662-9651. The state Medicaid program covers dental services for children including dental examinations, prophylaxis, fluoride treatment, sealants, relief of pain and infections, restoration of teeth, and maintenance of oral health. Orthodontic Treatment is provided in cases of severe malocclusions and requires prior authorization. Refer the child to a dentist as follows:

- Make the initial referral for most children beginning at age one year and yearly thereafter.
- Make a referral to a pediatric dentist at 6 months if warranted by an oral risk assessment.
- Make the referral if the child is at least four years and has not had a complete dental examination by a dentist in the past 12 months.
- Make the referral at any age if the oral inspection reveals cavities, infection, or significant abnormality.

12) Reimbursement for CHEC Services

The CHEC fee includes payment for all components of the CHEC exam. Services such as administration of immunizations, laboratory tests, and other diagnostic and treatment services may be billed in addition to the CHEC screening.

Please use the Preventive Medicine codes listed in the table below each time you complete a CHEC exam. Use these codes even if the child presents with a chronic illness and/or other health problem. Please avoid billing CHEC exams using Evaluation and Management codes. If you do use an Evaluation and Management code, it should be accompanied by the appropriate ICD-9 V code in the table below to identify it as a CHEC exam.

<table>
<thead>
<tr>
<th>Codes for Preventative Medicine Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Patient</strong></td>
</tr>
<tr>
<td>99381 Infant – less than 1 year of age.</td>
</tr>
<tr>
<td>99382 Early childhood – age 1 through 4 years.</td>
</tr>
<tr>
<td>99383 Late childhood – age 5 through 11 years.</td>
</tr>
<tr>
<td>99384 Adolescent – age 12 through 17 years.</td>
</tr>
<tr>
<td>99385 Young adult – age 18 through 20 years.</td>
</tr>
<tr>
<td><strong>Established Patient</strong></td>
</tr>
<tr>
<td>99391 Infant – less than 1 year of age.</td>
</tr>
<tr>
<td>99392 Early childhood – age 1 through 4 years.</td>
</tr>
<tr>
<td>99393 Late childhood – age 5 through 11 years.</td>
</tr>
<tr>
<td>99394 Adolescent – age 12 through 17 years.</td>
</tr>
<tr>
<td>99395 Young adult – age 18 through 20 years.</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>99431 History and examination for new born infant</td>
</tr>
<tr>
<td>99432 Normal newborn care in other than hospital or birthing room setting.</td>
</tr>
</tbody>
</table>

To bill for a CHEC screening electronically, enter the procedure code in loop 2400 - service line. The element is SV101-2 - Product/Service ID. In element SV111, enter a Y to indicate EPSDT/CHEC. On a paper claim, enter the procedure code in box 24-D and enter a Y in box 24-H EPSDT/CHEC.

For additional information regarding the latest in Pediatric Health, please visit the University of Utah Website at [http://healthcare.utah.edu/womenshealth/](http://healthcare.utah.edu/womenshealth/) or [www.ped.med.utah.edu](http://www.ped.med.utah.edu).
Utilization Management

Prior Authorizations

Healthy U does NOT require Prior Authorizations. Selected services will be reviewed prior to payment for medical necessity. Although Healthy U does not require prior authorization, Providers still may call to review medical necessity prior to the services being rendered.

Services will be paid according to Medicaid benefits and medical necessity. The following services will be reviewed for medical necessity prior to paying claims:

<table>
<thead>
<tr>
<th>Services Reviewed for Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion Services</td>
</tr>
<tr>
<td>Orthotics &amp; Prosthetics</td>
</tr>
<tr>
<td>Cosmetic Procedures</td>
</tr>
<tr>
<td>Orthopedic &amp; Prosthetics</td>
</tr>
<tr>
<td>Durable Medical Equipment over $5,000 in Billed charges</td>
</tr>
<tr>
<td>Outpatient Speech Therapy</td>
</tr>
<tr>
<td>Skilled Nursing Facility (Notification required upon admission)</td>
</tr>
<tr>
<td>Home Health Care Services</td>
</tr>
<tr>
<td>Synagis Immunizations</td>
</tr>
<tr>
<td>Hysterectomies and sterilization procedures inclusive of abdominal, vaginal or laparoscopic.</td>
</tr>
<tr>
<td>Transplant Services: Lung, Heart, Kidney, Bone Marrow, Cornea, etc.</td>
</tr>
<tr>
<td>Implants</td>
</tr>
<tr>
<td>Any service where Medicaid criteria is available.</td>
</tr>
<tr>
<td>Inpatient Services (Plan must be notified upon admission)</td>
</tr>
</tbody>
</table>

Services provided that are not medically necessary may result in the provider writing off the charges.

Services deemed ‘medically necessary’ do not guarantee payment if coverage terminates, benefits change, or benefit limits are exhausted.

Notification does not guarantee payment if coverage terminates, benefits change, or services provided are not medically necessary.

Utilization review means a review and confirmation program that determines medical necessity of any care service or treatment. In general all covered benefits are based on medical necessity and utilization review is not limited to the above list.

The UM department will actively review cases such as organ transplants, special health care needs patients, major catastrophic illnesses, highly complex case management cases, high cost cases (i.e., neonate), any referrals out of the provider network and cases involving risk management issues.
Requests are forwarded to the UM department for review. If approved, as medically necessary, the UM Department will assign a reference number. Reference notification will be sent to the provider, facility and enrollee.

If the request is denied, the UM department will send written notice via mail or fax to the requesting provider or facility and enrollee. If the requesting provider or enrollee finds the reasons given for denial insufficient, they may file an appeal to Healthy U for review (Please refer to Appeal Policy).

Medical necessity review requests can be sent to UUHP UM department via fax or mail. Internal University of Utah provider offices may send requests via EPIC.

Submit Medical Necessity Review Requests to:
University of Utah Health Plans
Attn: UM Department
P.O. Box 45180
Salt Lake City, Utah 84145

Turn-around time frames for Medical Necessity review are:
- Urgent request - Same day, (weekends, holidays and off-hours will be processed the next working day)
- Routine - 3-4 business days

Medical Appeals Process
The Healthy U policy and process is as follows:
- Clinical Appeals (i.e., appeals for pre-service denials) must be received within 90 calendar days from the date on the Notice of Action letter.
- For Clinical Appeals, you must obtain the member's consent to appeal.

For Appeals (or State Fair Hearing requests) related to a termination, suspension, or reduction of a previously authorized Medicaid-covered service (if the previous authorization is not expired):

a. Healthy U will mail a notice of action at least 10 days before the proposed date of the action, including the date the action will occur.
b. If the member/provider would like the service to continue during the appeal process, the appeal needs to be filed within 10 days of the proposed termination, suspension or reduction in the service.
c. If the member decides to continue the service, and the appeal decision is not in the member's favor, the member may have to pay for the service.

If the member's immediate health or life is in danger, you may request an Expedited appeal. If Healthy U determines that the members immediate health or life is in danger, we will review the request within 3 working days. If additional information is needed, we may request a 14 day extension, to complete the review. If the member's immediate health or life is not in danger, Healthy U will transfer the Expedited appeal request, to a routine appeal request. We will call you and send a letter, if we decide the request is not urgent.

- Non-clinical appeals (e.g., timely filing) must be received within 90 calendar days from the date notice of action.
Oral Appeals must be followed by a written appeal within 5 business days, or the appeal will be closed. The appeal rights will continue for the full 90 days from the date on the Notice of Action letter.

An appeal is a request for review of an **Action**. **Action** means:

- The denial or limited authorization of a requested service, including the type or level of service, including Restricted status;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state;
- The failure of Healthy U (ACO) to act within the timeframes provided in §438.408(b)

All appeals will be reviewed within 30 calendar days. Once we have made a decision, we will mail you an Appeal Resolution Letter, and call you if you requested an expedited appeal. If we need more time to review an appeal, we will request a 14 day extension to make our decision.

Medicaid appeals may be submitted by phone by calling Customer Service at (801) 587-6480, option 1.

We will accept appeals by mail, fax, or orally. An Appeal Request Form is available on our website at: [uhealthplan.utah.edu](http://uhealthplan.utah.edu)

**State Fair Hearing Process**

When a Healthy U Medicaid member, provider, or other authorized party is dissatisfied with an action taken by Healthy U Medicaid, they may file a request for a State Fair Hearing with the Office of Administrative Hearings. The “Request for Hearing/Agency Action” form must be filed within 30 calendar days of the “Notice of Appeal Resolution” letter, from Healthy U Medicaid.

When a provider wishes to appeal a payment reflected by an Explanation of Benefits (EOB), or other remittance document issued by Healthy U Medicaid, and they have completed the appeal process with Healthy U Medicaid, they may file a request for a State Fair Hearing with the Office of Administrative Hearings.

The “Request for Hearing/Agency Action” form must be filed within 30 calendar days of the “Notice of Appeal Resolution” letter, from Healthy U Medicaid. (Speaking to a customer service representative or other Healthy U Medicaid employee, exchanging e-mails, or having any other contact with Healthy U Medicaid about the claim or issue cannot extend or fulfill the 30 calendar day requirement).

Of note, Healthy U Medicaid “Notice of Appeal Resolution” Letters are sent by mail or fax and contain information about filing a State Fair Hearing, including the time within which a hearing must be filed, and a State Fair Hearing Form.

State Fair Hearing Forms may also be obtained on the Utah Medicaid website at: [https://medicaid.utah.gov/Documents/pdfs/Forms/HearingRequest2015.pdf](https://medicaid.utah.gov/Documents/pdfs/Forms/HearingRequest2015.pdf)
The form must be filled out and mailed or faxed to:

**Mailing Address:**
Office of Administrative Hearings  
DIVISION OF MEDICAID AND HEALTH  
FINANCING  
DIRECTOR'S OFFICE/FORMAL  
HEARINGS  
BOX 143105  
SALT LAKE CITY, UT 84114-3105

**Street Address:**
Office of Administrative Hearings  
DIVISION OF MEDICAID AND HEALTH  
FINANCING  
DIRECTOR'S OFFICE/FORMAL  
HEARINGS  
288 NORTH 1460 WEST  
SALT LAKE CITY, UT 84114-3105  
Fax: (801) 536-0143

If the member is currently receiving a service that has been reduced or denied, they may continue to receive the service, if they file a hearing request within 10 days from the date on the “Notice of Appeal” Resolution” letter. If the member decides to continue to get the service and the decision about their service/s is not in the member's favor, the member may have to pay for the service.

The member has a right to have an attorney or other person, familiar with their case, at the hearing.
Healthy Advantage is a federally licensed and approved Medicare Advantage Special Needs Plan. Healthy Advantage is available to all individuals who are entitled to Medicare Part A, are enrolled in Medicare Part B and are enrolled in one of the Utah Medicaid plans.

As a Medicare Advantage plan, all of the Centers for Medicare & Medicaid Services (CMS) rules, regulations, policies and procedures pertaining to Medicare Advantage plans apply to Healthy Advantage.

Information in this section is applicable to services prior to January 1, 2017. Effective January 1, 2017, Healthy Advantage will be administered by Molina Healthcare.

Please reference the following table for claims, appeals, Member Services, and Provider Relations contact information:

<table>
<thead>
<tr>
<th>Dates of service on or before December 31, 2016</th>
<th>Dates of service on or after January 1, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims</strong></td>
<td></td>
</tr>
<tr>
<td>University of Utah Health Plans</td>
<td>Molina Healthcare</td>
</tr>
<tr>
<td>ATTN: Claims</td>
<td>ATTN: Claims</td>
</tr>
<tr>
<td>P.O. Box 45180</td>
<td>P.O. Box 22811</td>
</tr>
<tr>
<td>Salt Lake City, UT 84145-0180</td>
<td>Long Beach, CA 90801</td>
</tr>
<tr>
<td>Phone: (801) 587-6480, option 5</td>
<td>Phone: 1-888-665-1328</td>
</tr>
<tr>
<td><strong>Appeals and Grievances</strong></td>
<td></td>
</tr>
<tr>
<td>University of Utah Health Plans</td>
<td>Molina Healthcare</td>
</tr>
<tr>
<td>ATTN: Appeals Committee Chairperson</td>
<td>ATTN: Appeals &amp; Grievances</td>
</tr>
<tr>
<td>6053 South Fashion Square Dr., Suite 110</td>
<td>P.O. Box 22816</td>
</tr>
<tr>
<td>Murray, UT 84107</td>
<td>Long Beach, CA 90801</td>
</tr>
<tr>
<td>Phone: 1-888-271-5870, option 1</td>
<td>Phone: 1-888-665-1328</td>
</tr>
<tr>
<td><strong>Member Services</strong></td>
<td></td>
</tr>
<tr>
<td>University of Utah Health Plans</td>
<td>Molina Healthcare of Utah</td>
</tr>
<tr>
<td>ATTN: Member Services</td>
<td>ATTN: Member Services</td>
</tr>
<tr>
<td>6053 South Fashion Square Dr., Suite 110</td>
<td>7050 Union Park Avenue, Suite 200</td>
</tr>
<tr>
<td>Murray, UT 84107</td>
<td>Midvale, UT 84047</td>
</tr>
<tr>
<td>Phone: (801) 587-6480, option 1</td>
<td>Phone: 1-888-665-1328</td>
</tr>
<tr>
<td><strong>Provider Relations</strong></td>
<td></td>
</tr>
<tr>
<td>University of Utah Health Plans</td>
<td>Molina Healthcare of Utah</td>
</tr>
<tr>
<td>ATTN: Provider Relations</td>
<td>ATTN: Provider Relations</td>
</tr>
<tr>
<td>6053 South Fashion Square Dr., Suite 110</td>
<td>7050 Union Park Avenue, Suite 200</td>
</tr>
<tr>
<td>Murray, UT 84107</td>
<td>Midvale, UT 84047</td>
</tr>
<tr>
<td>Phone: (801) 587-2838</td>
<td>Phone: 1-855-322-4081</td>
</tr>
</tbody>
</table>
Advantages of Participating with Healthy Advantage & Healthy U
Coordinating enrollment in Healthy Advantage with enrollment in Healthy U Medicaid offers providers the following advantages:

- Single claim submission for Medicare and Medicaid. Participation in both networks eliminates the need to send separate claims to the Medicare Advantage plan and Healthy U. This will reduce the overall cost of billing as only one claim needs to be sent.
- Faster Medicaid payments. Due to a single claim submission, the time incurred by submitting a second claim is eliminated, thus reducing the time in which your office receives the Medicaid remittance advice.
- Streamlined patient care. Coordinating care between two different insurance companies will no longer be needed. This will reduce administrative expense, and improve the overall delivery of care for the member.

Service Area
Healthy Advantage is available to dual eligible patients who live in the following counties:

- Davis
- Salt Lake
- Utah
- Weber

General Plan Information

Primary Care Providers
Healthy Advantage members are required to select and use a primary care provider. The following specialty types are considered PCPs: Family Practice, Pediatrics, General Internal Medicine, OB/GYN

Accessing Specialty Care
Healthy Advantage members must obtain a referral from their PCP to access services from a specialty provider.

In / Out of Network Services
In-network providers are providers who have signed an agreement with Healthy Advantage to care and treat Healthy Advantage members. Healthy Advantage members must receive their care from in-network providers.

Eligibility & Enrollment

“Beneficiary Eligibility”
Members who wish to enroll in Healthy Advantage, a Medicare Advantage SNP, must meet the following criteria:

- Be enrolled in both Medicare Part A and Part B;
- Not be medically determined to have End-Stage Renal Disease (ESRD) prior to completing the enrollment form;
University of Utah Health Plans
Provider Manual

- Permanently reside in the Healthy Advantage service area (Davis, Salt Lake, Weber and/or Utah Counties);
- Beneficiary or beneficiary’s legal representative completes an enrollment election form completely and accurately;
- Beneficiary is fully informed and agrees to abide by the rules of Healthy Advantage; and
- Is entitled to elect Healthy Advantage according to the election rules that apply to the beneficiary.

Healthy Advantage will not deny enrollment to a beneficiary who has elected the hospice benefit if the individual meets the other criteria for enrollment.

Healthy Advantage will accept all Members that meet the above criteria and elect Healthy Advantage during appropriate enrollment periods without reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation or family status.

Beneficiary Enrollment/Disenrollment Information for Healthy Advantage

All Members of Healthy Advantage are dual eligible (i.e. they receive both Medicare and Medicaid); therefore, Centers for Medicare & Medicaid Services (CMS) rules state that these Members may enroll or disenroll from Healthy Advantage on a monthly basis.

Persons who are dually eligible have special enrollment options. Additional information regarding enrollment and disenrollment are available on the following CMS Websites:

https://www.cms.gov/apps/firststep/content/medicare_dualelig.html
http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp

Prospective Members may call the Healthy Advantage Potential Member Customer Services Department – 866-403-8293 or TTY toll free at (800) 346-4128.

The effective date of coverage for Healthy Advantage Members will be the first (1st) day of the month following the acceptance of a completed application form by the Member or the Member’s authorized representative.

An enrollment cannot be effective prior to the date the beneficiary or their legal representative signed the enrollment form or completed the enrollment election.

During the applicable enrollment periods, if Healthy Advantage receives a completed enrollment form on the last day of the month, Healthy Advantage ensures that the effective date is the first (1st) day of the following month.

Disenrollment

Staff Members of UUHP may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare Member to disenroll except when the Member has:

- Moved outside the geographic service area;
- Committed fraud;
- Abused their membership card;
- Displayed disruptive behavior;
- Lost Medicare Part A or B;
Died; or
- Other justifiable causes as outlined in Paragraph V in this section.

The Healthy Advantage Membership Accounting Department is responsible for the involuntary disenrollment of any such Member, as it pertains to all other types of non-compliant behavior.

When Members permanently move out of the service area, or leave the service area for over six (6) consecutive months, they must dis-enroll from Healthy Advantage. There are a number of ways that the Membership Accounting Department may be informed that the Member has relocated. The majority of time, out-of-area notification will be received from The CMS on the monthly Membership report.

On occasion, the Member will call to advise Healthy Advantage that they have relocated. Other means of notification can be made through the Claims Department, if out-of-area claims are received with a residential address other that the one on file.

Healthy Advantage does not offer a visitor/traveler program to Members.

**Requested Disenrollment**

Healthy Advantage will request disenrollment of Members from the health plan only as allowed by CMS regulations.

Healthy Advantage will request that a Member be disenrolled from the Health Plan under the following circumstances:

- The Member requests disenrollment;
- The Member provided fraudulent information on the election form; or
- The Member has engaged in disruptive behavior;

Disruptive behavior is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan Members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Healthy Advantage will attempt to resolve the issues surrounding the disruptive behavior including providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. In addition, Healthy Advantage will inform the individual of the right to use the organization's grievance procedures. The beneficiary has a right to submit any information or explanation to Healthy Advantage before requesting disenrollment from CMS; and

Healthy Advantage will document and provide CMS with the documentation of the enrollee's behavior and efforts to resolve any problems, and any extenuating circumstances. Healthy Advantage will request from CMS the desire to decline future enrollment by the individual.

If CMS agrees with Healthy Advantage’s assessment of the situation and agrees to the disenrollment, the individual’s disenrollment will be processed within twenty (20) days. The disenrollment will be effective the first (1st) day of the calendar month after the month in which Healthy Advantage gives the individual notice of the disenrollment.

**Other reasons for the disenrollment may be one of the following**

- The Member abuses the enrollment card by allowing others to use it to obtain fraudulent services;
The Member leaves the service area and directly notifies Healthy Advantage of the permanent change of residence;

If the Member has not permanently moved but has been out of the service area for six (6) months or more, Healthy Advantage will request that the Member be disenrolled;

The Member loses entitlement to Medicare Part A or Part B benefits;

The Member dies;

The Member loses Medicaid eligibility;

Members enrolled in the SNP for Institutionalized beneficiaries lose their eligibility for the plan if they no longer qualify for institutionalized services;

Healthy Advantage loses or terminates its contract with CMS;

In the event of plan termination by CMS, Healthy Advantage will send CMS approved notices and a description of alternatives for obtaining benefits under the Healthy Advantage Program. The notice will be sent timely, before the termination of the plan; or

Healthy Advantage discontinues offering services in specific service areas where the Member resides.

In all circumstances except death, Healthy Advantage will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

**Eligibility Card**

**HEALTHY ADVANTAGE**

Member: DOE, BOB L
Member # 000780003062
Date of Birth: 12/05/1979
Effective Date: 03/02/2007

Primary Care Provider: SMILES, JON GRAFF
Primary Care Provider Phone: (801)540-2000
Medical Group: JON G SMILES MD PC

RxGroup: 
RxCopay: $0 Generic/$0 Brand
RxBIN: 112189  RxPCN: 3045

User ID: 84073  Issued Date: 06/09/2008  H5428-006
**Member Rights & Responsibilities**

In addition to the Member Rights listed in Section III, Healthy Advantage members also have the right to:

- Choose a PCP from the Healthy Advantage Network.
- Have someone represent them during a grievance.
- Ask for an external independent review of experimental or investigational therapies.
- Ask for an independent medical review.
- Right to be informed of their right to make health care decisions and execute advance directives.
- Medicare Law gives the member the right to file a complaint with Healthy Advantage, or the state survey and certification agency if the member is dissatisfied with the handling of advance directives by Healthy Advantage and/or the Provider.

**Advance Directives**

Providers must inform patients of their right to make health care decisions and execute advance directives. During routine Medical Record review audits, Healthy Advantage auditors will look for documented evidence of discussion between the provider and the member. Auditors will also look for copies of the advance directive form.

**Billing of Members**

Practitioners/providers who participate in Medicare/Medicaid agree to accept the amount paid as payment in full (see 42 CRF 447.15) with the exception of co-payment amounts required in certain categories. Co-payments are outlined in this section.

Aside from co-payments, a practitioner/provider may not bill a Healthy Advantage Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- Failure to follow managed care policies: A Member must be aware of the practitioners/providers, pharmacies, facilities and hospitals, who are contracted with Healthy Advantage;
- Denied emergency room claims: A Member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided. The Member may only be billed for the emergency room charges, but cannot be billed for the ancillary charges (e.g., laboratory & radiology services); and
- Other Member responsibilities: 1) The Member has been advised by the practitioner/provider that the service is not a covered benefit; 2) The Member has been advised by the practitioner/provider that he/she is not contracted with Healthy Advantage; and 3) The Member agrees in writing to have the service provided with full knowledge that he/she is financially responsible for payment.

**Benefits Summary**

A current summary of the Healthy Advantage benefits can be found at [http://www.molinamedicare.com](http://www.molinamedicare.com). If there are questions as to whether a service is covered or
requires prior authorization, contact Customer Services. (See “Who to Contact” for information on how to contact Customer Services)

All benefits will be modified as changes to national and local services occur. Benefits will be distinguished as Medicare or Medicaid Benefits with Medicaid being the payer of last resort. Medicaid offers additional benefits that complement the member’s Medicare benefit.

Medicaid Coverage for Healthy Advantage Members

There are certain benefits that will not be covered by Healthy Advantage but may be covered by Medicaid. In this case, the practitioner/provider should bill the Medicaid carrier with a copy of the Healthy Advantage remittance advice and Medicaid will pay the provider the lesser of:

- The practitioner/provider’s billed charge for the deductible, coinsurance, and/or co-pays;
- The difference between the Medicare plan’s payment to the practitioner/provider (of a service or services identified) and the maximum allowable payment rate under the Medicaid State Plan (for the same identified service or services); or
- The Medicaid liability if the service had been rendered under Medicare Part A or Part B.

Note – If the patient is a member of both Healthy Advantage and Healthy U, only the original claim needs to be filed with Healthy Advantage. The claims will automatically be processed under Healthy U once adjudication has been completed under Healthy Advantage.

Healthy Advantage Medical Pre-Authorization / Utilization Management

Prior authorization is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health Care, DME and out of area / out of network professional services. Prior authorization must ensure the following:

- Member Eligibility
- Covered Benefits
- Medical Necessity
- Services are within the providers scope of practice
- Services can be provided in a timely manner
- The appropriate information necessary for treatment is transferred
- Care will be provided in the most appropriate setting with the most appropriate provider
- Continuity and coordination of care are maintained
- Services are not experimental or investigational

Prior authorization instructions and form can be downloaded from the Healthy Advantage web site at http://www.molinamedicare.com.

Medical Appeals Process

On behalf of a member

Healthy Advantage members or their authorized representatives may file an appeal up to 60 calendar days after the date of a denial by fax, mail, or through the web site. Only expedited appeals will be taken over the phone (situations where any delay would adversely affect the
health of the enrollee). For expedited phone appeals, please call (866) 644-0344. Healthy Advantage will acknowledge the receipt of all appeals within 5 working days review and respond to appeals no later than 30 calendar days after the appeal is received.

**Appeal of Claim Denial**

Contracted Providers have 120 days to submit a claim appeal from the date on the EOB. Non-Contracted Providers have 60 days to submit a claim appeal from the date on the EOB.

Providers may appeal any denied claim. The appeal may be faxed, mailed, or submitted through the web site. The appeals process may take up to 60 calendar days for full review of the claim. A receipt letter and a letter of final decision (Appeal resolution letter) will be sent out to the provider. Non-contracted provider appeals must be resolved within 60 days and provider disputes must be resolved within 30 days. All determinations with contracted provider appeals are the final determination.

Please mail all appeals to:

Appeals Coordinator  
PO Box 45180  
Salt Lake City, UT 84145-0180  
OR fax it to (801) 281-6121.

If you have any questions about the processes above, please contact the Appeals Committee Chairperson at (801)-587-6480.

**Pharmacy Benefits**

As a Medicare Advantage plan, Healthy Advantage requires the use of a prescription drug formulary.

A formulary is a list of medications selected by Healthy Advantage in consultation with a team of healthcare practitioners/providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Healthy Advantage will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Healthy Advantage network pharmacy, and other plan rules are followed. Healthy Advantage is contracted with the Rx America network to provide drugs to our Members.

Formularies may change over time. Current formularies may be downloaded from the Healthy Advantage website at [http://www.molinamedicare.com](http://www.molinamedicare.com).

**Member Co-pays**

The amount a Member pays depends on which drug tier the drug is in and whether the member fills the prescription at a preferred network pharmacy. See the benefits grid for the co-payment amount for each type of drug for Healthy Advantage.

*Please note: At CMS’ discretion, co-pays and/or benefit design may change at the beginning of the Next contract year, and each year thereafter.*

**Non Covered Healthy Advantage (Medicare Part D) Drugs**

The following drugs are non-covered Medicare Part D drugs:
Agents when used for anorexia, weight loss, or weight gain (no mention of medical necessity);

Agents used to promote fertility;

Agents used for cosmetic purposes or hair growth;

Agents used for symptomatic relief of cough or colds;

Prescription vitamins and minerals, except prenatal and fluoride preparations;

Non-prescription drugs, except those OTCs used as part of an official step therapy program;

Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;

Barbiturates (e.g., Phenobarbital); and

Benzodiazepines (e.g., Valium, Restoril).

Some of the Medicare-excluded drugs default to the State for Medicaid benefit coverage.

**Restrictions on Healthy Advantage drug coverage**

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization**: Healthy Advantage requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary without prior approval, Healthy Advantage may not cover the drug;

- **Quantity Limits**: For certain drugs, Healthy Advantage limits the amount of the drug that is covered. For example, Healthy Advantage provides six (6) tablets every thirty (30) days per prescription for Zomig. This may be in addition to a standard thirty (30)-day supply;

- **Step Therapy**: In some cases, Healthy Advantage requires patients to first try certain drugs to treat a medical condition before Healthy Advantage will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Healthy Advantage may not cover drug B unless drug A is tried first; and

- **Part B Medications**: Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration.

The formulary contains information on prior authorization, quantity limits, step-therapy, and Part B medications.

**Part D Prescription Drug Exception Policy**

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan’s tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).
Healthy Advantage is committed to providing access to medically necessary prescription drugs to members of Healthy Advantage. If a drug is prescribed that is not on Healthy Advantage’s formulary, the Member or Member’s representative may file for an exception. Please contact the Pharmacy Department for an exception. Members or the Member’s representatives (who can include practitioners/physicians and pharmacists) may call or fax Healthy Advantage’s Pharmacy Department to request an exception. Procedures and forms to apply for an exception may be obtained from this department. This form is also in the back of this manual.

Part D Exceptions and Appeals

Appeals can be made by calling toll free (877) 644-0344, or through fax at toll free (866) 290-1309.

Initiating a Part D Exception (Prior Authorization) Request

Healthy Advantage will accept requests from practitioners or a pharmacy on behalf of the Member either by a written or verbal request. The request may be communicated through the use of the standardized Healthy Advantage Medication Prior Authorization Request Form. The form is then faxed to the Pharmacy Department. All requests will be determined and communicated to the (enrollee) and the enrollee’s prescribing physician with an approval or denial decision within seventy-two (72) hours (three [3] calendar days) after Healthy Advantage receives the “completed request.” Healthy Advantage will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by a: 1) Healthy Advantage Pharmacy Technician under the supervision of a Pharmacist; 2) Healthy Advantage Pharmacist; or 3) Healthy Advantage Medical Director. Review criteria will be made available at the request of the enrollee or his/her prescribing practitioner. Healthy Advantage will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

- A prescription drug is a Part D drug only if it is for a “medically accepted” indication as defined in the Medicare regulations. A medically accepted indication is one which is “supported by one or more citations included or approved for inclusion with the following compendia;
- American Hospital Formulary Service Drug Information;
- United States Pharmacopeia-Drug Information;
- DRUGDEX Information System; or
- American Medical Association Drug Evaluations.

Requests for off-label use of medications will need to be accompanied with excerpts from one of the four CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.

Depending upon the prescribed medication, Healthy Advantage may request the prescribing practitioner to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes and medical summaries.

Expediting Part D Determinations

If a coverage determination is expedited, Healthy Advantage will notify the Member of the coverage determination decision within the twenty-four (24)-hour timeframe by telephone.
If Healthy Advantage does not notify the Member within the specified timeframe, Healthy Advantage will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

**Part D Denials**

Denial decisions are only made by a Healthy Advantage Pharmacist or a Healthy Advantage Medical Director. The written denial notice is sent to the Member (and the prescribing practitioner) within seventy-two (72) hours and includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a Member’s right to, and conditions for, obtaining an expedited an appeals process.

If no written notice is given to the enrollee within the specified timeframe, Healthy Advantage will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

**How to File a Part D Appeal**

If Healthy Advantage’s initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within sixty (60) calendar days from the date of the notice of the coverage determination. In a standard appeal, Healthy Advantage has up to seven (7) days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven (7) calendar days from the date the request for re-determination is received.

**Expedited Part D Appeal**

Members or a Member’s prescribing practitioner may request Healthy Advantage to expedite a re-determination if the standard appeal timeframe of seven (7) days may seriously jeopardize the Member’s life, health, or ability to regain maximum function. Healthy Advantage has up to seventy-two (72) hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within seventy-two (72) hours after receiving the request for re-determination.

If additional information is needed for Healthy Advantage to make a re-determination, Healthy Advantage will request the necessary information within twenty-four (24) hours of the initial request for an expedited re-determination. Healthy Advantage will inform the Member and prescribing practitioner of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

If the request does not meet the expedited criteria, Healthy Advantage will render a coverage decision within the standard re-determination time frame of seven (7) calendar days.

To submit a verbal request, please call **toll free (877) 644-0344**. Written Part D appeals must be mailed to:

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Healthy Advantage
7050 S. Union Park Center, Suite 200
Midvale, Utah  84047
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or faxed to

**toll free (866) 290-1309**

_The Part D Qualified Independent Contractor (IRE)_
If the re-determination is unfavorable, a Member may request reconsideration by the Qualified Independent Contractor (IRE). The Part D IRE is currently MAXIMUS Federal, a CMS contractor that provides second level appeals.

- Standard Appeal: The IRE has up to seven (7) days to make a decision
- Expedited Appeal: The IRE has up to seventy-two (72) hours to make a decision

Appeals of IRE Decision:

NOTE – Regulatory timeframe does not apply at these levels of appeal.

- 1st Level – A member may request a hearing with an Administrative Law Judge (ALJ), if the amount in controversy requirement is satisfied.
- 2nd Level – If the ALJ ruling is unfavorable, the member may appeal to the Medicare Appeals Committee (MAC), an entity within the Department of Health and Human Services.
- 3rd Level – If the MAC decision is unfavorable, the Member may appeal to a Federal District Court, if the amount in controversy requirement is satisfied.

Mental Health Benefits

Access for Behavioral Health Services

Healthy Advantage is responsible for developing and maintaining a system that ensures access to behavioral health care services. Healthy Advantage is required to comply with access standards as defined by state and federal regulations.

Member with the following conditions must be seen within the following timeframes:

- Life-threatening – immediately;
- Emergent non-life threatening – no greater than six hours from request to appointment;
- Urgent – no greater than twenty-four (24) hours from request to appointment;
- Non-Urgent (Routine) – no greater than ten (10) business days from request to appointment;
- Specialty outpatient referral and/or consultation appointments - consistent with the clinical urgency, but no greater than twenty-one (21) days, unless the Member requests a later time;
- Scheduled follow-up outpatient visit – consistent with the Member's clinical need;
- Ongoing scheduled appointments - consistent with the Member's clinical need; and
- Outpatient scheduled appointments – not more than thirty (30) minutes after the scheduled time, unless the Member is late or the practitioner was delayed due to an unforeseen emergency.

The role of the PCP is to refer the Member to the appropriate level of behavioral health care. A referral is not needed for a Healthy Advantage Member to access behavioral health care. The PCP should assist the Member in accessing needed behavioral health services.

The following is a list of risk factors and indicators for PCP referral for behavioral health services:

- Suicidal/homicidal ideation or attempts;
- Suspected or confirmed alcohol and/or drug abuse;
- Stressful life events such as divorce, bereavement, loss of job;
- Victims or perpetrators of neglect or abuse;
- Symptoms of depression, anxiety, posttraumatic stress, or other psychological disorder;
- Living with a chronic condition or terminal illness;
- Family history of mental illness;
- Lack of social support;
- Child or adolescent with symptoms of a behavioral or learning disorder
- Severe mental and/or functional impairment; and
- Previous major depressive episode.

The PCP can assist Members by:
- Encouraging the Member to see a behavioral health care practitioner / provider when necessary;
- Providing the Member with Healthy Advantage’s Member Services number (866) 644-0344
- Locating an appropriate behavioral health specialist in the Healthy Advantage Provider Directory;

Coordination of Care for Behavioral Health Services

When a Healthy Advantage member is seen, the behavioral health practitioner/provider must provide appropriate follow-up information to the PCP. With the Member’s documented permission, request appropriate medical records within seven (7) days of the initial screening and evaluation.

If a behavioral health practitioner/provider meets with a Member who has not seen his/her PCP within the past year, the behavioral health practitioner/provider should refer the Member to his/her PCP for an appropriate consultation or checkup.

The following should be communicated between the Member’s PCP and the behavioral health practitioner/provider:
- Drug therapy and medical consultation, including all medications, his/her doses, duration prescribed, why prescribed, and changes in the drug regimen;
- Laboratory and radiology results;
- Transition or changes in level of care, such as discharge from inpatient treatment;
- Sentinel events such as hospitalization, emergencies, incarceration, suicide attempts;
- Treatment or care plans, including goals and treatment modalities; and
- Member compliance with follow-up appointments, medication, and treatment plans.

Information should continue to be communicated between practitioners/providers throughout the duration of the patient's behavioral health care.

Healthy Advantage continuously evaluates the coordination of care our Members receive through medical record reviews, site audits, and by conducting Member and provider surveys.
Behavioral Health Utilization Management

Utilization Management (UM) Standards mandate that Healthy Advantage:

- Clearly define the structure and processes within its UM program and assign responsibility to appropriate individuals;
- Use written criteria based on sound clinical evidence and specify the procedures for appropriately applying the criteria for UM decisions;
- Provide access to staff for Members and practitioners seeking information about the UM process and authorization of care;
- Use qualified health professionals to assess the clinical information used to support UM decisions;
- Make utilization decisions in a timely manner to accommodate the clinical urgency of the situation;
- Obtain relevant clinical information and consult with the treating practitioner when making a determination of coverage based on medical necessity;
- Clearly document and communicate the reasons for each denial;
- Maintain written policies and procedures for thorough, appropriate and timely resolution of Member appeals;
- Adjudicate Member appeals in a thorough, appropriate and timely manner;
- Evaluate the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral health procedures, pharmaceuticals and devices;
- Evaluate Member and practitioner satisfaction with the UM process;
- Provide, arrange for or otherwise facilitate all needed emergency services including appropriate coverage of costs;
- Ensure that its procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals;
- Facilitate the delivery of appropriate care and monitor the impacts of the UM program to detect and correct potential under and over-utilization of services; and
- Provide oversight of UM delegates per Human Services Department/National Committee for Quality Assurance requirements. Protocols for UM provide guidelines for the provision of appropriate, cost-effective services that promote recovery or stabilization at the Member’s highest level of functioning.

Who Makes our UM Decisions for Behavioral Health Services?

Licensed master level mental health professionals perform pre-service, concurrent and post-service reviews. A board certified psychiatrist has substantial involvement in the development and implementation of the UM program. Case Managers cannot deny care. Only psychiatrists, doctoral level clinical psychologists or certified addiction medicine specialists can deny care for behavioral health services.

How are UM Decisions Made for Behavioral Health Services?

UM decisions are rendered in a fair, impartial and consistent manner that serves the best interest of the Member.
UM staff review and assess the clinical information submitted by the practitioner/provider to support the UM decision. Healthy Advantage has objective, measurable criteria that are used for making UM decisions. Healthy Advantage has a mechanism for assessing the consistency with which care managers and practitioners apply UM criteria.

**How are Clinical Criteria Developed and Applied for Behavioral Health Services?**

For behavioral health, Healthy Advantage involves appropriate, actively practicing practitioners in the development or adoption of criteria and in the development and review of procedures for applying the criteria. The criteria are reviewed at specified intervals and are updated as necessary, but at least annually. The clinical criteria for determining medical necessity are clearly documented and include procedures for applying the criteria based on the needs of the individual Member and characteristics of the local delivery system. Healthy Advantage considers at least the following factors when applying criteria to a given Member’s care:

- Age;
- Co-morbidities;
- Complications;
- Progress of treatment;
- Psychosocial situation;
- Home environment, when applicable; and
- Characteristics of the local delivery system that is available for the Member.

At least annually, Healthy Advantage evaluates the consistency with which the behavioral health care professionals involved in utilization review apply the criteria in decision-making. This is termed “inter-rater reliability.” In the following manner, Healthy Advantage will make available to practitioners and Members upon request the clinical criteria we use to make utilization decisions.

- The clinical criteria used to make UM decisions is available for your review by calling Healthy Advantage toll free at (866) 472-9479.

**Utilization Review Process for Behavioral Health Services**

All utilization review forms necessary to request prior authorization for behavioral health services may be found at the end of the Behavioral Health Section of this manual. Prior authorization does not guarantee payment. Payment is subject to benefit coverage and eligibility at the time the service is rendered.

Please ensure that you verify the Member’s eligibility and benefits before rendering services. A claim will not be paid for a service rendered to an ineligible Member, to a Member who does not have the benefit, or to a Member who has reached his/her benefit limit.

**Emergency Services for Behavioral Health Services**

Facilities will be reimbursed for emergency services provided to Healthy Advantage Members. A medical emergency is defined as a condition in which a patient manifests acute symptoms and/or signs which represent a condition of severity such that the absence of immediate medical attention could reasonably be expected by a reasonably prudent layperson to result in death, serious impairment of bodily function or major organ, and/or serious jeopardy to the overall health of the patient.

**Pre-Service Authorization for Behavioral Health Services**
All Behavioral Health services require pre-service authorization with the exception of the first seven (7) outpatient psychiatric services requiring only claims submission. Practitioners/providers may obtain pre-service authorization for services by completing the Behavioral Health Clinical Review Form (Form 002-S) and faxing it toll free at (866) 472-9481. Inpatient psychiatric reviews, however, are performed telephonically. Sufficient clinical information to support the level of care and amount of care being requested must be submitted. If Healthy Advantage does not receive sufficient information to support a decision, Healthy Advantage reserves the right to request additional information such as medical records, progress reports or other pertinent data necessary to make a utilization management decision.

Concurrent Reviews for Behavioral Health Services

Practitioners/providers requesting concurrent review authorizations for ongoing care may do so by completing the Behavioral Health Clinical Review Form. Concurrent review forms must contain sufficient clinical information to support the level and amount of care requested. A sample form and instructions are included at the end of this section. Practitioners/providers may fax the document toll free to (866) 472-9481.

Post-Service Reviews for Behavioral Health Services

Post-service reviews are conducted by UM staff based on established decision-making guidelines. The process includes reviewing medical and behavioral health treatments after the service has been rendered and a claim has been submitted. The most common opportunities for conducting post service reviews include:

- Medical Review;
- Claims Review;
- Focused Review;
- Pattern Review; and
- Peer Review.

All of these reviews can be performed for the following reasons:

- To establish medical necessity of care when a pre service authorization was not obtained due to an emergency or failure of the practitioner/provider to obtain a pre-service authorization;
- To establish that charges are appropriate and necessary and reflect the actual care delivered to the Member;
- To provide information to a practitioner and/or doctoral level clinical psychologist that may clarify issues in an appeal of a denial;
- To provide information regarding treatment patterns and trends, and over or under utilization;
- To provide information regarding quality issues;
- To review complaint and appeal (CARs); and
- To review utilization statistics for the purposes of education and quality.

Emergency room (ER) claims will only be reviewed for purposes of identifying over and under-utilization patterns by practitioners/providers and Members.

Denial Procedures
For behavioral health, Healthy Advantage employs appropriately licensed behavioral health professionals to supervise all review decisions. Board certified licensed psychiatrists or doctoral level clinical psychologists render all denials of care based on medical necessity.

When a denial is rendered, Healthy Advantage provides written notification of the denial to the Member and practitioner/provider. The written notification contains the following:

- The specific reason for the denial in easily understandable language;
- A reference to the benefits provision, guideline, protocol or other similar criterion on which the denial decision was based;
- Notification that the Member and practitioner/provider can obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial decision was based, upon request;
- Includes information about appeal and fair hearing rights and processes;
- Information on how to contact the Medical Director
- The circumstances under which expedited resolution of an appeal is available and how to request it; and
- The Member’s right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.

Coordination of Medical and Behavioral Health Services

**Statement:** Research indicates that coordination of medical and behavioral health care services results in improved treatment outcomes for patients. When coordination of care does not take place, there is an increased risk for missed or delayed diagnosis and treatments, repeated or unnecessary testing, adverse drug reactions, and a host of other problems, including litigation. The literature also suggests that patients strongly desire a system in which health care professionals work together effectively, follow a coherent plan of care, and demonstrate familiarity with his/her unique needs and circumstances. Furthermore, various aspects of continuity and coordination of care have been identified by patients as important to them and have been shown to be independent predictors of satisfaction.

**Purpose:** To assist practitioners/providers in the sharing of appropriate and timely information, in order to improve patient satisfaction and treatment outcomes, and to promote and support an integrated health care delivery system for all Healthy Advantage Members.

**Recommendations:** Coordination of medical and behavioral health care is necessary, and it is the responsibility of the PCP and behavioral health specialist to ensure that effective coordination of care takes place. Coordination is required for those patients who have recently initiated behavioral health care and those who are receiving behavioral health services on an ongoing basis.

**Confidentiality and the Right to Refusal for Behavioral Health Services**

It is the practitioner/provider’s responsibility to help the Member understand the importance of coordinating care and to ensure that a consent form authorizing the release of medical information is signed by the patient prior to the sharing of information between practitioners/providers. In addition, all practitioners/providers must adhere to state and federal regulations regarding confidentiality of medical records. Members have the right to refuse coordination of medical records, although Healthy Advantage anticipates that the majority of
patients will allow coordination to take place. Should a Member refuse to consent to the release of medical information, this must be documented in the Member's medical record.

**Continuity & Coordination of Care for Behavioral Health Services**

Healthy Advantage ensures the continuity and coordination of care that Members receive. Please reference Section H of the 2007 Provider Manual for details regarding Healthy Advantage's continuity and coordination of care efforts. Healthy Advantage monitors a behavioral health practitioner/provider's compliance with continuity and coordination of care standards through medical record audits. Well documented care facilitates coordination and continuity of care and promotes the efficiency and effectiveness of care.

Healthy Advantage has established standards for the organization and documentation of medical records. On an annual basis, Healthy Advantage assesses practitioners against these standards. The results of these reviews are used as a Healthy Advantage statewide quality of care indicator, and are considered as a factor in the re-credentialing of individual practitioners. Behavioral health practitioners' medical records are audited for compliance with medical record documentation standards as outlined in Medical Assistance Division (MAD) regulation 8.306.8.9 and 8.305.8.17. In addition to the requirements established in Section F of the 2007 Provider Manual, behavioral health practitioners/providers are responsible for coordination of services between physical and behavioral health practitioners/providers, and between waiver programs, and the Children, Youth & Families Department when appropriate as outlined in MAD regulation 8.305.9.10.

**Healthy Advantage Provider Responsibilities**

In addition to the responsibilities listed under Section II of this manual, Providers shall also:

- **Report of Suspected Abuse of an Adult.** Healthy Advantage reports suspected or potential abuse of vulnerable adults as required by state and federal law.

  A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental or emotional condition.

  A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

  Mandatory reports include: Healthy Advantage employees who have knowledge of the abuse; law enforcement officer; social worker; professional school personnel; individual practitioner/provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care or hospice agency; county coroner or medical examiner; Christian Science provider or health care practitioner/provider.

  A permissive reporter may report to the department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur on an ad hoc basis.

  The following are the types of abuse which are required to be reported:

  - Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints;
Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing;

Mental mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress;

Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health;

Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition;

Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person’s profit or gain; and

Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter, or health care.

In the event that an employee of Healthy Advantage or one of its contracted practitioners/providers encounters potential or suspected abuse of a vulnerable adult, a call must be made to the appropriate agency telephone number to report the incident, including the:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Source of information;
- Names and telephone numbers of other people who can provide information about the situation; and
- Any safety concerns.

Healthy Advantage’s Care Coordination Team will work with practitioners/providers who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the practitioners/providers or other clinical personnel.

A person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding is immune from liability resulting from the report or testimony.

Healthy Advantage will follow up with Members that are reported to have been abused to ensure appropriate measures were taken, and follow up on safety issues. Healthy Advantage will track, analyze, and report aggregate information regarding abuse reporting to the Utilization Management Committee and the proper state/federal agency.

**Healthy Advantage Payments**

All payments received by Provider for services rendered to Healthy Advantage members are paid with Federal Funds.
Healthy Advantage Plus HMO is a federally licensed and approved Medicare Advantage plan for all eligible Medicare Beneficiaries in Salt Lake, Davis, Weber and Utah counties. Healthy Advantage Plus is available to all individuals who are entitled to Medicare Part A and are enrolled in Medicare Part B.

As a Medicare Advantage plan, all of the Centers for Medicare & Medicaid Services (CMS) rules, regulations, policies and procedures pertaining to Medicare Advantage plans apply to Healthy Advantage Plus.

Information in this section is applicable to services prior to January 1, 2017. Effective January 1, 2017, Healthy Advantage Plus will be administered by Molina Healthcare.

Please reference the following table for claims, appeals, Member Services, and Provider Relations contact information:

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<th>Dates of service on or before December 31, 2016</th>
<th>Dates of service on or after January 1, 2017</th>
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<td>Molina Healthcare</td>
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<td>ATTN: Claims</td>
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<tr>
<td>P.O. Box 45180</td>
<td>P.O. Box 22811</td>
</tr>
<tr>
<td>Salt Lake City, UT 84145-0180</td>
<td>Long Beach, CA 90801</td>
</tr>
<tr>
<td>Phone: (801) 587-6480, option 5</td>
<td>Phone: 1-888-665-1328</td>
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<tr>
<td><strong>Appeals and Grievances</strong></td>
<td></td>
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<tr>
<td>University of Utah Health Plans</td>
<td>Molina Healthcare</td>
</tr>
<tr>
<td>ATTN: Appeals Committee Chairperson</td>
<td>ATTN: Appeals &amp; Grievances</td>
</tr>
<tr>
<td>6053 South Fashion Square Dr., Suite 110</td>
<td>P.O. Box 22816</td>
</tr>
<tr>
<td>Murray, UT 84107</td>
<td>Long Beach, CA 90801</td>
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<tr>
<td>Phone: 1-888-271-5870, option 1</td>
<td>Phone: 1-888-665-1328</td>
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<td><strong>Member Services</strong></td>
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<tr>
<td>6053 South Fashion Square Dr., Suite 110</td>
<td>7050 Union Park Avenue, Suite 200</td>
</tr>
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<td>Murray, UT 84107</td>
<td>Midvale, UT 84047</td>
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<tr>
<td>Phone: (801) 587-6480, option 1</td>
<td>Phone: 1-888-665-1328</td>
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<td>6053 South Fashion Square Dr., Suite 110</td>
<td>7050 Union Park Avenue, Suite 200</td>
</tr>
<tr>
<td>Murray, UT 84107</td>
<td>Midvale, UT 84047</td>
</tr>
<tr>
<td>Phone: (801) 587-2838</td>
<td>Phone: 1-855-322-4081</td>
</tr>
</tbody>
</table>
Service Area
Healthy Advantage Plus is available to dual eligible patients who live in the following counties:
- Davis
- Salt Lake
- Utah
- Weber

General Plan Information
Primary Care Providers
Healthy Advantage Plus members are required to select and use a primary care provider. The following specialty types are considered PCPs: Family Practice, Pediatrics, General Internal Medicine, OB/GYN

In / Out of Network Services
In-network providers are providers who have signed an agreement with Healthy Advantage Plus to care and treat Healthy Advantage Plus members. Healthy Advantage Plus members must receive their care from in-network providers.

Eligibility & Enrollment
“Beneficiary Eligibility”
Members who wish to enroll in Healthy Advantage Plus, a Medicare Advantage HMO, must meet the following criteria:
- Be enrolled in both Medicare Part A and Part B;
- Not be medically determined to have End-Stage Renal Disease (ESRD) prior to completing the enrollment form;
- Permanently reside in the Healthy Advantage Plus service area (Davis, Salt Lake, Weber and/or Utah Counties);
- Beneficiary or beneficiary’s legal representative completes an enrollment election form completely and accurately;
- Beneficiary is fully informed and agrees to abide by the rules of Healthy Advantage Plus; and
- Is entitled to elect Healthy Advantage Plus according to the election rules that apply to the beneficiary.

Healthy Advantage Plus will not deny enrollment to a beneficiary who has elected the hospice benefit if the individual meets the other criteria for enrollment.

Healthy Advantage Plus will accept all Members that meet the above criteria and elect Healthy Advantage Plus during appropriate enrollment periods without reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation or family status.
Beneficiary Enrollment/Disenrollment Information for Healthy Advantage Plus

Prospective Members may call the Healthy Advantage Plus Potential Member Customer Services Department – (866) 939-5741, TTY/TDD 711, 7 days a week, 8:00 a.m. – 8:00 p.m.


Medicare beneficiaries may also enroll in the Healthy Advantage Plus plan through the CMS Medicare Online Enrollment Center located at www.medicare.gov

The effective date of coverage for Healthy Advantage Plus Members will be the first (1st) day of the month following the acceptance of a completed application form by the Member or the Member’s authorized representative.

An enrollment cannot be effective prior to the date the beneficiary or their legal representative signed the enrollment form or completed the enrollment election.

During the applicable enrollment periods, if Healthy Advantage Plus receives a completed enrollment form on the last day of the month, Healthy Advantage Plus ensures that the effective date is the first (1st) day of the following month.

Disenrollment

Staff Members of UUHP may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare Member to disenroll except when the Member has:

- Moved outside the geographic service area;
- Committed fraud;
- Abused their membership card;
- Displayed disruptive behavior;
- Lost Medicare Part A or B;
- Died; or
- Other justifiable causes as outlined in Paragraph V in this section.

The Healthy Advantage Plus Membership Accounting Department is responsible for the involuntary disenrollment of any such Member, as it pertains to all other types of non-compliant behavior.

When Members permanently move out of the service area, or leave the service area for over six (6) consecutive months, they must dis-enroll from Healthy Advantage Plus. There are a number of ways that the Membership Accounting Department may be informed that the Member has relocated. The majority of time, out-of-area notification will be received from The CMS on the monthly Membership report.

On occasion, the Member will call to advise Healthy Advantage Plus that they have relocated. Other means of notification can be made through the Claims Department, if out-of-area claims are received with a residential address other that the one on file.

Healthy Advantage Plus does not offer a visitor/traveler program to Members.
Requested Disenrollment

Healthy Advantage Plus will request disenrollment of Members from the health plan only as allowed by CMS regulations.

Healthy Advantage Plus will request that a Member be disenrolled from the Health Plan under the following circumstances:

- The Member requests disenrollment;
- The Member provided fraudulent information on the election form; or
- The Member has engaged in disruptive behavior;

Disruptive behavior is defined as behavior that substantially impairs the plan’s ability to arrange for or provide services to the individual or other plan Members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Healthy Advantage Plus will attempt to resolve the issues surrounding the disruptive behavior including providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. In addition, Healthy Advantage Plus will inform the individual of the right to use the organization's grievance procedures. The beneficiary has a right to submit any information or explanation to Healthy Advantage Plus before requesting disenrollment from CMS; and

Healthy Advantage Plus will document and provide CMS with the documentation of the enrollee's behavior and efforts to resolve any problems, and any extenuating circumstances. Healthy Advantage Plus will request from CMS the desire to decline future enrollment by the individual.

If CMS agrees with Healthy Advantage Plus’s assessment of the situation and agrees to the disenrollment, the individual’s disenrollment will be processed within twenty (20) days. The disenrollment will be effective the first (1st) day of the calendar month after the month in which Healthy Advantage Plus gives the individual notice of the disenrollment.

Other reasons for the disenrollment may be one of the following

- The Member abuses the enrollment card by allowing others to use it to obtain fraudulent services;
- The Member leaves the service area and directly notifies Healthy Advantage Plus of the permanent change of residence;
- If the Member has not permanently moved but has been out of the service area for six (6) months or more, Healthy Advantage Plus will request that the Member be disenrolled;
- The Member loses entitlement to Medicare Part A or Part B benefits;
- The Member dies;
- Healthy Advantage Plus loses or terminates its contract with CMS;
- In the event of plan termination by CMS, Healthy Advantage Plus will send CMS approved notices and a description of alternatives for obtaining benefits under the Healthy Advantage Plus Program. The notice will be sent timely, before the termination of the plan; or
- Healthy Advantage Plus discontinues offering services in specific service areas where the Member resides.
In all circumstances except death, Healthy Advantage Plus will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

Eligibility Card

Member Rights & Responsibilities

In addition to the Member Rights listed in Section III, Healthy Advantage Plus members also have the right to:

- Choose a PCP from the Healthy Advantage Plus Network.
- Have someone represent them during a grievance.
- Ask for an external independent review of experimental or investigational therapies.
- Ask for an independent medical review.
- Right to be informed of their right to make health care decisions and execute advance directives.
- Medicare Law gives the member the right to file a complaint with Healthy Advantage Plus, or the state survey and certification agency if the member is dissatisfied with the handling of advance directives by Healthy Advantage Plus and/or the Provider.

Advance Directives

Providers must inform patients of their right to make health care decisions and execute advance directives. During routine Medical Record review audits, Healthy Advantage Plus auditors will look for documented evidence of discussion between the provider and the member. Auditors will also look for copies of the advance directive form.

Billing of Members

Practitioners/providers who participate in Medicare agree to accept the amount paid as payment in full (see 42 CRF 447.15) with the exception of co-payment amounts required in certain categories. Co-payments are outlined in this section.

Aside from co-payments, a practitioner/provider may not bill a Healthy Advantage Plus Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:

- Failure to follow managed care policies: A Member must be aware of the practitioners/providers, pharmacies, facilities and hospitals, who are contracted with Healthy Advantage Plus;
Denied emergency room claims: A Member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided. The Member may only be billed for the emergency room charges, but cannot be billed for the ancillary charges (e.g., laboratory & radiology services); and

Other Member responsibilities: 1) The Member has been advised by the practitioner/provider that the service is not a covered benefit; 2) The Member has been advised by the practitioner/provider that he/she is not contracted with Healthy Advantage Plus; and 3) The Member agrees in writing to have the service provided with full knowledge that he/she is financially responsible for payment.

Benefits Summary

Healthy Advantage Plus Medical Pre-Authorization / Utilization Management
Prior authorization is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health Care, DME and out of area / out of network professional services. Prior authorization must ensure the following:

- Member Eligibility
- Covered Benefits
- Medical Necessity
- Services are within the providers scope of practice
- Services can be provided in a timely manner
- The appropriate information necessary for treatment is transferred
- Care will be provided in the most appropriate setting with the most appropriate provider
- Continuity and coordination of care are maintained
- Services are not experimental or investigational


Medical Appeals Process
On behalf of a member
Healthy Advantage Plus members or their authorized representatives may file an appeal up to 60 calendar days after the date of a denial by fax, mail, or through the web site. Only expedited appeals will be taken over the phone (situations where any delay would adversely affect the health of the enrollee). For expedited phone appeals, please call (866) 644-0344. Healthy Advantage Plus will acknowledge the receipt of all appeals within 5 working days review and respond to appeals no later than 30 calendar days after the appeal is received.

Appeal of Claim Denial
Contracted Providers have 120 days to submit a claim appeal from the date on the EOB. Non-Contracted Providers have 60 days to submit a claim appeal from the date on the EOB.
Providers may appeal any denied claim. The appeal may be faxed, mailed, or submitted through the web site. The appeals process may take up to 60 calendar days for full review of the claim. A receipt letter and a letter of final decision (Appeal resolution letter) will be sent out to the provider. Non-contracted provider appeals must be resolved within 60 days and provider disputes must be resolved within 30 days. All determinations with contracted provider appeals are the final determination.

Please mail all appeals to:

Appeals Coordinator
PO Box 45180
Salt Lake City, UT 84145-0180
OR fax it to (801) 281-6121.

If you have any questions about the processes above, please contact the Appeals Committee Chairperson at (801)-587-6480.

Pharmacy Benefits

As a Medicare Advantage plan, Healthy Advantage Plus requires the use of a prescription drug formulary. A formulary is a list of medications selected by Healthy Advantage Plus in consultation with a team of healthcare practitioners/providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Healthy Advantage Plus will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Healthy Advantage Plus network pharmacy, and other plan rules are followed. Healthy Advantage Plus is contracted with the Rx America network to provide drugs to our Members.


Member Co-pays

The amount a Member pays depends on which drug tier the drug is in and whether the member fills the prescription at a preferred network pharmacy. See the benefits grid for the co-payment amount for each type of drug for Healthy Advantage Plus.

*Please note: At CMS’ discretion, co-pays and/or benefit design may change at the beginning of the Next contract year, and each year thereafter.

Non Covered Healthy Advantage Plus (Medicare Part D) Drugs

The following drugs are non-covered Medicare Part D drugs:

- Agents when used for anorexia, weight loss, or weight gain (no mention of medical necessity);
- Agents used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for symptomatic relief of cough or colds;
- Prescription vitamins and minerals, except prenatal and fluoride preparations;

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- Non-prescription drugs, except those OTCs used as part of an official step therapy program;
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;
- Barbiturates (e.g., Phenobarbital); and
- Benzodiazepines (e.g., Valium, Restoril).

Some of the Medicare-excluded drugs default to the State for Medicaid benefit coverage.

Restrictions on Healthy Advantage Plus drug coverage

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization**: Healthy Advantage Plus requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary without prior approval, Healthy Advantage Plus may not cover the drug;
- **Quantity Limits**: For certain drugs, Healthy Advantage Plus limits the amount of the drug that is covered. For example, Healthy Advantage Plus provides six (6) tablets every thirty (30) days per prescription for Zomig. This may be in addition to a standard thirty (30)-day supply;
- **Step Therapy**: In some cases, Healthy Advantage Plus requires patients to first try certain drugs to treat a medical condition before Healthy Advantage Plus will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Healthy Advantage Plus may not cover drug B unless drug A is tried first; and
- **Part B Medications**: Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration.

The formulary contains information on prior authorization, quantity limits, step-therapy, and Part B medications.

**Part D Prescription Drug Exception Policy**

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan’s tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

Healthy Advantage Plus is committed to providing access to medically necessary prescription drugs to members of Healthy Advantage Plus. If a drug is prescribed that is not on Healthy Advantage Plus’s formulary, the Member or Member’s representative may file for an exception. Please contact the Pharmacy Department for an exception. Members or the Member’s representatives (who can include practitioners/physicians and pharmacists) may call or fax Healthy Advantage Plus’s Pharmacy Department to request an exception. Procedures and forms to apply for an exception may be obtained from this department.

**Part D Exceptions and Appeals**
Appeals can be made by calling toll free (877) 644-0344, or through fax at toll free (866) 290-1309.

**Initiating a Part D Exception (Prior Authorization) Request**

Healthy Advantage Plus will accept requests from practitioners or a pharmacy on behalf of the Member either by a written or verbal request. The request may be communicated through the use of the standardized Healthy Advantage Plus Medication Prior Authorization Request Form. The form is then faxed to the Pharmacy Department. All requests will be determined and communicated to the (enrollee) and the enrollee’s prescribing physician with an approval or denial decision within seventy-two (72) hours (three [3] calendar days) after Healthy Advantage Plus receives the “completed request.” Healthy Advantage Plus will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by a: 1) Healthy Advantage Plus Pharmacy Technician under the supervision of a Pharmacist; 2) Healthy Advantage Plus Pharmacist; or 3) Healthy Advantage Plus Medical Director. Review criteria will be made available at the request of the enrollee or his/her prescribing practitioner. Healthy Advantage Plus will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

- A prescription drug is a Part D drug only if it is for a “medically accepted” indication as defined in the Medicare regulations. A medically accepted indication is one which is “supported by one or more citations included or approved for inclusion with the following compendia;
- American Hospital Formulary Service Drug Information;
- United States Pharmacopeia-Drug Information;
- DRUGDEX Information System; or
- American Medical Association Drug Evaluations.

Requests for off-label use of medications will need to be accompanied with excerpts from one of the four CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.

Depending upon the prescribed medication, Healthy Advantage Plus may request the prescribing practitioner to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes and medical summaries.

**Expedited Part D Determinations**

If a coverage determination is expedited, Healthy Advantage Plus will notify the Member of the coverage determination decision within the twenty-four (24)-hour timeframe by telephone.

If Healthy Advantage Plus does not notify the Member within the specified timeframe, Healthy Advantage Plus will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

**Part D Denials**

Denial decisions are only made by a Healthy Advantage Plus Pharmacist or a Healthy Advantage Plus Medical Director. The written denial notice is sent to the Member (and the prescribing practitioner) within seventy-two (72) hours and includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a Member’s right to, and conditions for, obtaining an expedited an appeals process.
If no written notice is given to the enrollee within the specified timeframe, Healthy Advantage Plus will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

**How to File a Part D Appeal**

If Healthy Advantage Plus’s initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within sixty (60) calendar days from the date of the notice of the coverage determination. In a standard appeal, Healthy Advantage Plus has up to seven (7) days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven (7) calendar days from the date the request for re-determination is received.

**Expedited Part D Appeal**

Members or a Member’s prescribing practitioner may request Healthy Advantage Plus to expedite a re-determination if the standard appeal timeframe of seven (7) days may seriously jeopardize the Member’s life, health, or ability to regain maximum function. Healthy Advantage Plus has up to seventy-two (72) hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within seventy-two (72) hours after receiving the request for re-determination.

If additional information is needed for Healthy Advantage Plus to make a re-determination, Healthy Advantage Plus will request the necessary information within twenty-four (24) hours of the initial request for an expedited re-determination. Healthy Advantage Plus will inform the Member and prescribing practitioner of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

If the request does not meet the expedited criteria, Healthy Advantage Plus will render a coverage decision within the standard re-determination time frame of seven (7) calendar days.

To submit a verbal request, please call **toll free (877) 644-0344**. Written Part D appeals must be mailed to:

Healthy Advantage Plus  
7050 S. Union Park Center, Suite 200  
Midvale, Utah 84047  

or faxed to  

toll free (866) 290-1309

**The Part D Qualified Independent Contractor (IRE)**

If the re-determination is unfavorable, a Member may request reconsideration by the Qualified Independent Contractor (IRE). The Part D IRE is currently MAXIMUS Federal, a CMS contractor that provides second level appeals.

- **Standard Appeal:** The IRE has up to seven (7) days to make a decision
- **Expedited Appeal:** The IRE has up to seventy-two (72) hours to make a decision

**Appeals of IRE Decision:**

NOTE – Regulatory timeframe does not apply at these levels of appeal.
1\textsuperscript{st} Level – A member may request a hearing with an Administrative Law Judge (ALJ), if the amount in controversy requirement is satisfied.

2\textsuperscript{nd} Level – If the ALJ ruling is unfavorable, the member may appeal to the Medicare Appeals Committee (MAC), an entity within the Department of Health and Human Services.

3\textsuperscript{rd} Level – If the MAC decision is unfavorable, the Member may appeal to a Federal District Court, if the amount in controversy requirement is satisfied.

\textbf{Mental Health Benefits}

\textbf{Access for Behavioral Health Services}

Healthy Advantage Plus is responsible for developing and maintaining a system that ensures access to behavioral health care services. Healthy Advantage Plus is required to comply with access standards as defined by state and federal regulations.

Member with the following conditions must be seen within the following timeframes:

- Life-threatening – immediately;
- Emergent non-life threatening – no greater than six hours from request to appointment;
- Urgent – no greater than twenty-four (24) hours from request to appointment;
- Non-Urgent (Routine) – no greater than ten (10) business days from request to appointment;
- Specialty outpatient referral and/or consultation appointments - consistent with the clinical urgency, but no greater than twenty-one (21) days, unless the Member requests a later time;
- Scheduled follow-up outpatient visit – consistent with the Member’s clinical need;
- Ongoing scheduled appointments - consistent with the Member's clinical need; and
- Outpatient scheduled appointments – not more than thirty (30) minutes after the scheduled time, unless the Member is late or the practitioner was delayed due to an unforeseen emergency.

The role of the PCP is to refer the Member to the appropriate level of behavioral health care. A referral is not needed for a Healthy Advantage Plus Member to access behavioral health care. The PCP should assist the Member in accessing needed behavioral health services.

The following is a list of risk factors and indicators for PCP referral for behavioral health services:

- Suicidal/homicidal ideation or attempts;
- Suspected or confirmed alcohol and/or drug abuse;
- Stressful life events such as divorce, bereavement, loss of job;
- Victims or perpetrators of neglect or abuse;
- Symptoms of depression, anxiety, posttraumatic stress, or other psychological disorder;
- Living with a chronic condition or terminal illness;
- Family history of mental illness;
- Lack of social support;
Child or adolescent with symptoms of a behavioral or learning disorder
Severe mental and/or functional impairment; and
Previous major depressive episode.

The PCP can assist Members by:
Encouraging the Member to see a behavioral health care practitioner / provider when necessary;
Providing the Member with Healthy Advantage Plus’s Member Services number (866) 644-0344
Locating an appropriate behavioral health specialist in the Healthy Advantage Plus Provider Directory;

Coordination of Care for Behavioral Health Services
When a Healthy Advantage Plus member is seen, the behavioral health practitioner/provider must provide appropriate follow-up information to the PCP. With the Member’s documented permission, request appropriate medical records within seven (7) days of the initial screening and evaluation.
If a behavioral health practitioner/provider meets with a Member who has not seen his/her PCP within the past year, the behavioral health practitioner/provider should refer the Member to his/her PCP for an appropriate consultation or checkup.
The following should be communicated between the Member’s PCP and the behavioral health practitioner/provider:
Drug therapy and medical consultation, including all medications, his/her doses, duration prescribed, why prescribed, and changes in the drug regimen;
Laboratory and radiology results;
Transition or changes in level of care, such as discharge from inpatient treatment;
Sentinel events such as hospitalization, emergencies, incarceration, suicide attempts;
Treatment or care plans, including goals and treatment modalities; and
Member compliance with follow-up appointments, medication, and treatment plans.
Information should continue to be communicated between practitioners/providers throughout the duration of the patient’s behavioral health care.

Healthy Advantage Plus continuously evaluates the coordination of care our Members receive through medical record reviews, site audits, and by conducting Member and provider surveys.

Behavioral Health Utilization Management
Utilization Management (UM) Standards mandate that Healthy Advantage Plus:
Clearly define the structure and processes within its UM program and assign responsibility to appropriate individuals;
Use written criteria based on sound clinical evidence and specify the procedures for appropriately applying the criteria for UM decisions;
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- Provide access to staff for Members and practitioners seeking information about the UM process and authorization of care;
- Use qualified health professionals to assess the clinical information used to support UM decisions;
- Make utilization decisions in a timely manner to accommodate the clinical urgency of the situation;
- Obtain relevant clinical information and consult with the treating practitioner when making a determination of coverage based on medical necessity;
- Clearly document and communicate the reasons for each denial;
- Maintain written policies and procedures for thorough, appropriate and timely resolution of Member appeals;
- Adjudicate Member appeals in a thorough, appropriate and timely manner;
- Evaluate the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral health procedures, pharmaceuticals and devices;
- Evaluate Member and practitioner satisfaction with the UM process;
- Provide, arrange for or otherwise facilitate all needed emergency services including appropriate coverage of costs;
- Ensure that its procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals;
- Facilitate the delivery of appropriate care and monitor the impacts of the UM program to detect and correct potential under and over-utilization of services; and
- Provide oversight of UM delegates per Human Services Department/National Committee for Quality Assurance requirements. Protocols for UM provide guidelines for the provision of appropriate, cost-effective services that promote recovery or stabilization at the Member's highest level of functioning.

Doctors are not Rewarded for Denying Care

Healthy Advantage Plus reminds our practitioners/providers that decisions about utilization management (effective use of services) are based only on whether care is appropriate and whether a Member has coverage. Healthy Advantage Plus does not reward doctors or others for denying coverage or care. UM decisions are based only on appropriateness of care and service and existence of coverage. Healthy Advantage Plus does not reward practitioners/providers or other individuals for issuing denials of coverage or service care; and UM decision-makers do not receive financial incentives.

Who Makes our UM Decisions for Behavioral Health Services?

Licensed master level mental health professionals perform pre-service, concurrent and post-service reviews. A board certified psychiatrist has substantial involvement in the development and implementation of the UM program. Case Managers cannot deny care. Only psychiatrists, doctoral level clinical psychologists or certified addiction medicine specialists can deny care for behavioral health services.

How are UM Decisions Made for Behavioral Health Services?
UM decisions are rendered in a fair, impartial and consistent manner that serves the best interest of the Member.

UM staff review and assess the clinical information submitted by the practitioner/provider to support the UM decision. Healthy Advantage Plus has objective, measurable criteria that are used for making UM decisions. Healthy Advantage Plus has a mechanism for assessing the consistency with which care managers and practitioners apply UM criteria.

**How are Clinical Criteria Developed and Applied for Behavioral Health Services?**

For behavioral health, Healthy Advantage Plus involves appropriate, actively practicing practitioners in the development or adoption of criteria and in the development and review of procedures for applying the criteria. The criteria are reviewed at specified intervals and are updated as necessary, but at least annually. The clinical criteria for determining medical necessity are clearly documented and include procedures for applying the criteria based on the needs of the individual Member and characteristics of the local delivery system. Healthy Advantage Plus considers at least the following factors when applying criteria to a given Member’s care:

- Age;
- Co-morbidities;
- Complications;
- Progress of treatment;
- Psychosocial situation;
- Home environment, when applicable; and
- Characteristics of the local delivery system that is available for the Member.

At least annually, Healthy Advantage Plus evaluates the consistency with which the behavioral health care professionals involved in utilization review apply the criteria in decision-making. This is termed “inter-rater reliability.” In the following manner, Healthy Advantage Plus will make available to practitioners and Members upon request the clinical criteria we use to make utilization decisions.

- The clinical criteria used to make UM decisions is available for your review by calling Healthy Advantage Plus **toll free at (866) 472-9479.**

**Utilization Review Process for Behavioral Health Services**

All utilization review forms necessary to request prior authorization for behavioral health services may be found at the end of the Behavioral Health Section of this manual. Prior authorization does not guarantee payment. Payment is subject to benefit coverage and eligibility at the time the service is rendered.

Please ensure that you verify the Member’s eligibility and benefits before rendering services. A claim will not be paid for a service rendered to an ineligible Member, to a Member who does not have the benefit, or to a Member who has reached his/her benefit limit.

**Emergency Services for Behavioral Health Services**

Facilities will be reimbursed for emergency services provided to Healthy Advantage Plus Members. A medical emergency is defined as a condition in which a patient manifests acute symptoms and/or signs which represent a condition of severity such that the absence of immediate medical attention could reasonably be expected by a reasonably prudent layperson
to result in death, serious impairment of bodily function or major organ, and/or serious jeopardy to the overall health of the patient.

Pre-Service Authorization for Behavioral Health Services

All Behavioral Health services require pre-service authorization with the exception of the first seven (7) outpatient psychiatric services requiring only claims submission. Practitioners/providers may obtain pre-service authorization for services by completing the Behavioral Health Clinical Review Form (Form 002-S) and faxing it toll free at (866) 472-9481. Inpatient psychiatric reviews, however, are performed telephonically. Sufficient clinical information to support the level of care and amount of care being requested must be submitted. If Healthy Advantage Plus does not receive sufficient information to support a decision, Healthy Advantage Plus reserves the right to request additional information such as medical records, progress reports or other pertinent data necessary to make a utilization management decision.

Concurrent Reviews for Behavioral Health Services

Practitioners/providers requesting concurrent review authorizations for ongoing care may do so by completing the Behavioral Health Clinical Review Form. Concurrent review forms must contain sufficient clinical information to support the level and amount of care requested. A sample form and instructions are included at the end of this section. Practitioners/providers may fax the document toll free to (866) 472-9481.

Post-Service Reviews for Behavioral Health Services

Post-service reviews are conducted by UM staff based on established decision-making guidelines. The process includes reviewing medical and behavioral health treatments after the service has been rendered and a claim has been submitted. The most common opportunities for conducting post service reviews include:

- Medical Review;
- Claims Review;
- Focused Review;
- Pattern Review; and
- Peer Review.

All of these reviews can be performed for the following reasons:

- To establish medical necessity of care when a pre service authorization was not obtained due to an emergency or failure of the practitioner/provider to obtain a pre-service authorization;
- To establish that charges are appropriate and necessary and reflect the actual care delivered to the Member;
- To provide information to a practitioner and/or doctoral level clinical psychologist that may clarify issues in an appeal of a denial;
- To provide information regarding treatment patterns and trends, and over or under utilization;
- To provide information regarding quality issues;
- To review complaint and appeal (CARs); and
- To review utilization statistics for the purposes of education and quality.
Emergency room (ER) claims will only be reviewed for purposes of identifying over and under-utilization patterns by practitioners/providers and Members.

Denial Procedures

For behavioral health, Healthy Advantage Plus employs appropriately licensed behavioral health professionals to supervise all review decisions. Board certified licensed psychiatrists or doctoral level clinical psychologists render all denials of care based on medical necessity.

When a denial is rendered, Healthy Advantage Plus provides written notification of the denial to the Member and practitioner/provider. The written notification contains the following:

- The specific reason for the denial in easily understandable language;
- A reference to the benefits provision, guideline, protocol or other similar criterion on which the denial decision was based;
- Notification that the Member and practitioner/provider can obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial decision was based, upon request;
- Includes information about appeal and fair hearing rights and processes;
- Information on how to contact the Medical Director
- The circumstances under which expedited resolution of an appeal is available and how to request it; and
- The Member's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.

Coordination of Medical and Behavioral Health Services

Statement: Research indicates that coordination of medical and behavioral health care services results in improved treatment outcomes for patients. When coordination of care does not take place, there is an increased risk for missed or delayed diagnosis and treatments, repeated or unnecessary testing, adverse drug reactions, and a host of other problems, including litigation. The literature also suggests that patients strongly desire a system in which health care professionals work together effectively, follow a coherent plan of care, and demonstrate familiarity with his/her unique needs and circumstances. Furthermore, various aspects of continuity and coordination of care have been identified by patients as important to them and have been shown to be independent predictors of satisfaction.

Purpose: To assist practitioners/providers in the sharing of appropriate and timely information, in order to improve patient satisfaction and treatment outcomes, and to promote and support an integrated health care delivery system for all Healthy Advantage Plus Members.

Recommendations: Coordination of medical and behavioral health care is necessary, and it is the responsibility of the PCP and behavioral health specialist to ensure that effective coordination of care takes place. Coordination is required for those patients who have recently initiated behavioral health care and those who are receiving behavioral health services on an ongoing basis.

Confidentiality and the Right to Refusal for Behavioral Health Services

It is the practitioner/provider’s responsibility to help the Member understand the importance of coordinating care and to ensure that a consent form authorizing the release of medical information is signed by the patient prior to the sharing of information between
practitioners/providers. In addition, all practitioners/providers must adhere to state and federal regulations regarding confidentiality of medical records. Members have the right to refuse coordination of medical records, although Healthy Advantage Plus anticipates that the majority of patients will allow coordination to take place. Should a Member refuse to consent to the release of medical information, this must be documented in the Member’s medical record.

**Continuity & Coordination of Care for Behavioral Health Services**

Healthy Advantage Plus ensures the continuity and coordination of care that Members receive. Please reference Section H of the 2007 Provider Manual for details regarding Healthy Advantage Plus’s continuity and coordination of care efforts. Healthy Advantage Plus monitors a behavioral health practitioner/provider’s compliance with continuity and coordination of care standards through medical record audits. Well documented care facilitates coordination and continuity of care and promotes the efficiency and effectiveness of care.

Healthy Advantage Plus has established standards for the organization and documentation of medical records. On an annual basis, Healthy Advantage Plus assesses practitioners against these standards. The results of these reviews are used as a Healthy Advantage Plus statewide quality of care indicator, and are considered as a factor in the re-credentialing of individual practitioners. Behavioral health practitioners’ medical records are audited for compliance with medical record documentation standards as outlined in Medical Assistance Division (MAD) regulation 8.306.8.9 and 8.305.8.17. In addition to the requirements established in Section F of the 2007 Provider Manual, behavioral health practitioners/providers are responsible for coordination of services between physical and behavioral health practitioners/providers, and between waiver programs, and the Children, Youth & Families Department when appropriate as outlined in MAD regulation 8.305.9.10.

**Healthy Advantage Plus Provider Responsibilities**

In addition to the responsibilities listed under Section II of this manual, Providers shall also:

- **Report of Suspected Abuse of an Adult.** Healthy Advantage Plus reports suspected or potential abuse of vulnerable adults as required by state and federal law.

  A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental or emotional condition.

  A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

  Mandatory reports include: Healthy Advantage Plus employees who have knowledge of the abuse; law enforcement officer; social worker; professional school personnel; individual practitioner/provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care or hospice agency; county coroner or medical examiner; Christian Science provider or health care practitioner/provider.

  A permissive reporter may report to the department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur on an ad hoc basis.

  The following are the types of abuse which are required to be reported:
Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints;

Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing;

Mental mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress;

Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health;

Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition;

Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain; and

Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter, or health care.

In the event that an employee of Healthy Advantage Plus or one of its contracted practitioners/providers encounters potential or suspected abuse of a vulnerable adult, a call must be made to the appropriate agency telephone number to report the incident, including the:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Source of information;
- Names and telephone numbers of other people who can provide information about the situation; and
- Any safety concerns.

Healthy Advantage Plus’s Care Coordination Team will work with practitioners/providers who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the practitioners/providers or other clinical personnel.

A person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding is immune from liability resulting from the report or testimony.

Healthy Advantage Plus will follow up with Members that are reported to have been abused to ensure appropriate measures were taken, and follow up on safety issues. Healthy Advantage Plus will track, analyze, and report aggregate information regarding abuse reporting to the Utilization Management Committee and the proper state/federal agency.

**Healthy Advantage Plus Payments**

All payments received by Provider for services rendered to Healthy Advantage Plus members are paid with Federal Funds.
Healthy Premier Individual Plan is offered to eligible members on or off the Health Insurance Exchange Marketplace. The information provided in this section is designed to assist Healthy Premier providers.

**Service Area**

Healthy Premier Individual is available to eligible enrollees who live in the following counties:

- Box Elder
- Cache
- Davis
- Duchesne
- Grand
- Iron
- Morgan
- Rich
- Salt Lake
- Summit
- Tooele
- Uintah
- Utah
- Wasatch
- Washington
- Weber

**Plan Categories and Benefits**

Our individual and family plans fall into four categories.

- Healthy Premier BRONZE – Salt Lake County only
- Healthy Premier BRONZE HSA
- Healthy Premier SILVER
- Healthy Premier GOLD

Plan documents and additional information can be found on our website at: [http://uhealthplan.utah.edu/individual/](http://uhealthplan.utah.edu/individual/)
Individual Plan Provider Appeals

Appeals must be received within 180 days from the date of the UUHP determination notification/Notice of Action (NOA) letter or Explanation of Benefit (EOB). UUHP will review and provide notification of decisions to the member for Appeals and Panel-level Expedited Appeals. See below for Voluntary External (Routine or Expedited) Appeal Information.

UUHP will respond to appeals: Pre-service Appeals within 30 calendar days of receipt of the request. Post-service Appeal within 45 calendar days of receipt of the request. Expedited Appeals within 72 hours of receipt of the request. Voluntary Expedited External Appeals within 72 hours of the receipt of your request.

UUHP may extend the timeframes for appeal resolutions, including expedited appeals, by up to 14 calendar days if the enrollee requests or agrees to extend the appeal timeframe or UUHP determines and documents that there is need for additional information and how the delay is in the enrollee’s interest. If UUHP extends the timeframes, a written notice of the reason for the delay will be given to the enrollee.

Appeals may be received via mail, in person delivery, fax, or orally. Oral appeals may be made by calling: (801) 587-6480 opt. 1 or (888) 271-5870 and must be followed with a written signed appeal from the entity submitting the appeal within 5 business days unless it is an expedited appeal. Written requests can be sent to: University of Utah Health Plan, 6053 South Fashion Square Dr., Suite 110, Murray, UT 84107; or Faxed to: (801) 281-6121. The appeal may be completed, using the online form, located on the University of Utah Health Plans website: uhealthplan.utah.edu.

A Provider or other authorized representative may appeal on behalf of the member, as long as the member or member’s legal guardian authorize, in writing, disclosure of personal information for the purposes of the appeal. A Consent to Appeal on Behalf of Member form is available on the website: uhealthplan.utah.edu.

Voluntary External (Routine or Expedited) Appeal: Available to members/Policy holders. The review and decision is made by an Independent Review Organization (IRO) at no cost to the member, for issues involving medical judgement, or determination that a treatment is investigational, after the member has exhausted the applicable non-voluntary levels of appeals, or if UUHP has failed to adhere to internal appeal requirements. The Voluntary External appeals must be requested within 180 days of the member receipt of the notice of the prior adverse decision. The IRO will make a decision within 45 days after receipt of the request.

Members should use the Independent Review Request form, available at www.insurance.utah.gov. Submit the request and documentation to the Utah Insurance Department by: mail: Suite 3110 State Office Building, Salt Lake City UT 84114; email: healthappeals.uid@utah.gov; or fax: 801-538-3829. If you are not able to access the request form by computer, call 801 538-3077 or toll-free 800 439-3905 to have the form mailed to you.
Coverage and Eligibility

When Coverage Begins
What is the Effective Date of Coverage?
1. The Policyowner is covered under this Policy upon Our receipt of the application and remittance of the required premium payment. The effective date of coverage is the same as the Policy Effective Date shown in the Application which is filed.
2. Eligible Dependents are covered under this Policy as follows:
   a. On the date the coverage is effective if they are included in the application for this Policy;
   b. On the date the Dependent is eligible for coverage, meaning: (1) birth; (2) adoption (3) placement for adoption; (4) a marriage that results in the spouse or Domestic Partner and stepchildren being added to coverage; and (5) minor dependents required to be covered by court order or administrative order.

When members may Enroll for Coverage
Members may enroll for coverage during the Enrollment Period set by CMS or the State, or during a special enrollment period, or outside of the open enrollment period because of a qualifying event as defined by the Health Insurance Portability and Accountability Act.

Coverage for Dependent Child Due to Court or Administrative Order
If a court or administrative order requires a Policyowner to provide coverage for a Dependent Child, and the child is enrolled for coverage under this Policy on or after the Policy Effective Date, the following provisions will apply to the child’s coverage.
We will not deny coverage for the child on the grounds that the child:
1. Was born out of wedlock and is entitled to coverage as a noncustodial parent;
2. Was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent’s policy;
3. Is not claimed as a dependent on the parent’s federal tax return; or
4. Does not reside with the parent within our service area.

How do You Enroll Dependents After the Policy Effective Date?
If after the Policy Effective Date, the Policyowner acquires a Dependent as a result of:
1. Marriage or the establishment of a Domestic Partnership;
2. Birth;
3. Placement for adoption; or
4. A court or administrative order;
The Dependent may be enrolled for coverage within the time period indicated below in the Adding a Dependent Due to Marriage/Domestic Partnership, Adding a Dependent Child, and Adding a Dependent Due to Court or Administrative Order provisions or by Exchange Rules if this Policy is purchased on the Exchange.

Adding a Dependent Due to Marriage/Domestic Partnership:
If a Policyowner has a new Dependent(s) due to marriage or the establishment of a Domestic Partnership, the effective date of coverage for the eligible Dependent(s) will be the first of the month following the event, provided we receive notification of the new Dependent(s) and approve the Dependent(s) for coverage under this Policy. The Policyowner must notify us within 60 days from the date of marriage or establishment of Domestic Partnership. If there is a change in premium, it will be included in the first billing date after the change, adjusted back to the effective month of the change.

Adding a Dependent Child Due to Birth or Placement for Adoption:
The Policyowner must notify us when they acquire a new Eligible Dependent Child due to:
1. Birth; or
2. Placement for adoption.
The effective date of coverage for the new Eligible Dependent will be:
1. The date of birth for a newborn natural child;
2. The date of birth for newborn adopted child if placement for adoption occurs within 60 days of birth; and
3. The date of Placement for an adopted child, if Placement for adoption occurs 60 days or more after the child’s birth.

We must receive notification and any required premium for the new Eligible Dependent Child within 60 days in order for coverage to be continued under this Policy. If such notification and any required premium are not received by us within the 60-day period, coverage under this Policy for the child only will be continued through the end of the month in which the notification is due.

With regard to an adopted child, coverage under this Policy will cease prior to end of the 60-day period if:
1. The Placement is disrupted prior to legal adoption; and
2. The child is removed from Placement.

“Placement for adoption” or “Placement” means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

Adding a Dependent Child Due to Court or Administrative Order:
If a court or administrative order requires a Policyowner to provide coverage for a Dependent Child, We must receive notification and any required premium for the child’s coverage under this Policy within 30 days (or 60 days if purchased on the exchange) of the court or administrative order. Refer to “Coverage for Dependent Child Due to Court or Administrative Order” for an additional coverage details.

How Long Is Coverage Effective Under This Policy?
A Policyowner may elect to continue this Policy or discontinue this Policy during an open enrollment period or due to a qualifying event. Coverage under this Policy will be continued if the Policyowner elects to continue this Policy. If the Policyowner elects to discontinue this Policy, provide a written notice 30 days in advance of the requested termination date.

When Policyowner is no longer eligible for coverage: This Policy will terminate on the first of the month following the date:
1. They enter active duty in the military service. However, if the Policyowner retains coverage for the Covered Dependents, this Policy will remain in force to insure the Covered Dependents provided the required premiums continue to be paid;
2. Of Policyowner death;
3. This Policy terminates for any other reason.

When Covered Dependents are no longer eligible for coverage under this Policy: The coverage for Covered Dependents will continue in force through the last day of the month in which he or she ceases to be a Covered Dependent. A Covered Dependent will cease to be a Covered Dependent upon the occurrence of any of the following events:
1. The Covered Dependent no longer meets the eligibility requirements specified in this Policy;
2. The spouse is no longer an eligible Dependent as a result of a divorce decree or legal separation;
3. Policyowner and Domestic Partner are no longer in a Domestic Partnership relationship;
4. Dependent Child reaches his or her 26th birthday, except as provided for Handicapped Children;
5. Your Dependent enters active duty in the military;
6. Your death
7. This Policy terminates.
No coverage will be available for a Covered Dependent upon attainment of the limiting age for a Covered Benefit specifying a limiting age for coverage under this Policy.

**Continued Coverage for Former Spouse**
If the coverage for a Covered Dependent spouse is terminated under this Policy due to divorce or Policyowner death, the spouse will be entitled to have issued to him or her an individual policy upon entry of the divorce decree or annulment or upon the date of death. The individual policy that will be issued will be the same as this Policy, with a carryover of the Deductible and Coinsurance.

When We receive the actual notice that the Covered Dependent spouse is to be terminated because of a divorce or annulment or policy owner death, We will promptly provide the spouse written notification of (1) the right to obtain an individual policy; (2) the premium amounts required; and (3) the manner, place, and time in which premiums may be paid. The spouse may include coverage for Covered Dependent Children insured under this Policy.

The premium for the individual policy will be determined in accordance with our table of premium rates applicable to: (1) the age of the spouse; and (2) the type and amount of coverage provided. If the spouse applies for the individual policy and submits the first monthly premium to us within 30 days after receiving the written notification regarding the individual policy, we will issue the spouse with the individual policy which will be effective immediately upon termination of his or her coverage under this Policy.

**When May We Rescind this Policy?**
If we find that Policyowner committed fraud or intentionally misrepresented material information on an application for this Policy within two (2) years from the Policy Effective Date, this Policy will be rescinded and will be considered as never having been in effect provided we give 30 days prior notice. Any premiums paid for coverage for the ineligible person will be refunded minus any claims paid for that person. We are entitled to recover the claim amounts that exceed the amount of premium paid.

**When Can We Terminate this Policy?**
We will terminate this Policy at 12:01 a.m. local time at Policyowner place of residence on the earliest of the following:
1. During any open enrollment period that the policy is not renewed;
2. If Policyowner fails to pay the required premium payment when due, subject to the Grace Period; or
3. If Policyowner obtained this Policy through fraudulent means;
4. For any other reason for termination of this Policy as specified in this Policy, provided we give Policyowner at least forty-five (45 days) prior written notice.

**What Is Our Responsibility for Payment of Claims if this Policy Terminates?**
We will only pay a claim for covered services which were received prior to the termination date of this Policy. We will not pay Covered Medical Expenses for Covered Benefits that are incurred after the date this Policy terminates for any reason.

**Premiums**
**When are Premiums Due?**
All premium, any charges or fees for this Policy (hereinafter referred to as “premium”) must be paid to us. The premium for this Policy is shown in the Application. If Policyowner does not pay premiums when due, this Policy will terminate subject to the Grace Period. The Premium Due Date is shown in the Application.
Grace Period

This Grace Period provision applies if Policyowner is NOT receiving any federal subsidies for this Policy.

After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next thirty (30) days. These thirty (30) days are called the Grace Period. Coverage under this Policy will remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, this Policy will automatically terminate at the end of the Grace Period.

This Grace Period provision applies if Policyowner is receiving any federal subsidies for this Policy.

After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next ninety (90) days. These ninety (90) days are called the Grace Period. Coverage under this Policy will remain in force during the Grace Period. During the first month of the grace period, we will continue to pay claims incurred for Covered Medical Expenses. During the second and third months of the grace period, we will suspend payment of any claims until we receive the past due premiums. If payment is not received for all outstanding premium by the end of the grace period, this Policy will be terminated effective at 12:01 a.m. on the first day of the second month of the three month grace period. Policyowner will be responsible for the cost of any health care services they receive after the last day of the first month of the grace period.

Can the Company Change the Premium Rates?

Subject to the rate requirements in the state of Utah, where this Policy is issued, we may change the rates for this Policy on any Policy Anniversary Date. Any rate change will be made only when we change rates for all policies in the same rate class on the same form as this Policy that are issued in Utah. We will give Policyowner at least 45 days advance written notice prior to the effective date of any rate change.

When is a Premium Refund Applicable?

In the event the Policy is canceled for a reason other than a material misrepresentation any unearned amount of collected premium will be refunded. In the event of material misrepresentation on the application collected premium minus claims paid will be refunded.

If this Policy is Terminated, Can It be Reinstated?

If any renewal premium is not paid within the time granted to Policyowner for payment, a subsequent acceptance of premium by University Health Plans or by any agent duly authorized by University Health Plans to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if University Health Plans or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from University Health Plans or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless University Health Plans has previously notified Policyowner in writing of our disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects Policyowner and University Health Plans have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in
connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Utilization Review Guidelines

Utilization Review Guidelines and limitations can be found on our website at:

http://uhealthplan.utah.edu/for-providers/pdf/um%20review%20guidelines%20healthy%20premier%20individual.pdf
At University of Utah Health Plans (UUHP) we offer a wide range of product options, including traditional HMO plans, PPO plans, and HSA compatible plans. We are flexible and effective in benefit design and provider network combinations. With an emphasis on population health management we focus on keeping employees healthy while managing utilization to lower costs.

Fully – Insured Products:
UUHP has an experienced actuarial team that develops solutions specifically for Utah employers. A variety of plans for employers with 51 or more employees makes it easy to obtain high satisfaction.

Third Party Administration (TPA):
UUHP has been providing TPA services for employers in Utah since 1998. Local and attentive staff are ready to manage custom plans effectively and efficiently.

Healthy Premier Group Plans
Healthy Premier Group plans are available to eligible Employer Groups across the state of Utah and surrounding states.
Additional information can be found on our website at: http://uhealthplan.utah.edu/employer-groups/

Healthy Preferred Group Plans
Healthy Preferred Group plans are available to eligible Employer Groups across the Wasatch Front.
Additional information can be found on our website at: http://uhealthplan.utah.edu/employer-groups/

Grand Valley Preferred Group Plans
Grand Valley Preferred Group plans are available to eligible Employer Groups in Colorado.
Additional information can be found on our website at: http://uhealthplan.utah.edu/employer-groups/

Healthy Premier, Healthy Preferred and Grand Valley Preferred Group Appeals
Appeals must be received within 180 days from the date of the UUHP determination notification/Notice of Action (NOA) letter or Explanation of Benefit (EOB). UUHP will review and provide notification of decisions to the member for first-level, second-level, and expedited appeals.

UUHP will respond to appeals: Pre-service Appeals within 30 calendar days of receipt of the request. Post-service Appeal within 45 calendar days of receipt of the request. Expedited
Appeals within 72 hours of receipt of the request. Voluntary External Appeals within 45 days of the receipt of request and Voluntary Expedited External Appeals within 72 hours of the receipt of your request.

UUHP may extend the timeframes for appeal resolutions, including expedited appeals, by up to 14 calendar days if the enrollee requests or agrees to extend the appeal timeframe or UUHP determines and documents that there is need for additional information and how the delay is in the enrollee’s interest. If UUHP extends the timeframes, a written notice of the reason for the delay will be given to the enrollee.

Appeals may be received via mail, in person delivery, fax, or orally. Oral appeals may be made by calling: (801) 587-6480 opt. 1 or (888) 271-6480 and must be followed with a written signed appeal from the entity submitting the appeal within 5 business days unless it is an expedited appeal. Written requests can be sent to: University of Utah Health Plan, 6053 South Fashion Square Dr., Suite 110, Murray, UT 84107; or Faxed to: (801) 281-6121. The appeal may be completed, using the online form, located on the University of Utah Health Plans website: uhealthplan.utah.edu.

A Provider or other authorized representative may appeal on behalf of the member, as long as the member or member’s legal guardian authorize, in writing, disclosure of personal information for the purposes of the appeal. A Consent form is available on the website: uhealthplan.utah.edu.

**Voluntary External (Routine or Expedited) Appeal:** Available to members/Policy holders. The review and decision is made by an Independent Review Organization (IRO) at no cost to the member, for issues involving medical judgement, or determination that a treatment is investigational, after the member has exhausted the applicable non-voluntary levels of appeals, or if UUHP has failed to adhere to internal appeal requirements. The Voluntary External appeals must be requested within 180 days of the member receipt of the notice of the prior adverse decision. The IRO will make a decision within 45 days after receipt of the request.

Members should use the Independent Review Request form, available at www.insurance.utah.gov. Submit the request and documentation to the Utah Insurance Department by: mail: Suite 3110 State Office Building, Salt Lake City UT 84114; email: healthappeals.uid@utah.gov; or fax: 801-538-3829. If you are not able to access the request form by computer, call 801 538-3077 or toll-free 800 439-3905 to have the form mailed to you.