# Unity Health Partners Introduction/Overview

Unity Health Partners (UHP) is a select group of physicians dedicated to delivering a superior healthcare experience by helping our patients successfully navigate the entire care journey. We do this through a unique, value-based partnership with both payers and health systems that supports data and metrics transparency, continuous outcomes improvement, and the belief that great healthcare begins long before a person becomes a patient. Learn more about the future of value-based care at www.unityhealthpartners.net

Unity Health Partners participate exclusively with the Memorial Hermann Medicare Advantage plan. UHP utilizes Apex Health Solutions in the management of their operations. To find more information about Apex Health Solutions please visit their website at www.Apex4health.com

This provider manual is designed to help participating providers understand UHP's policies, procedures, and protocols.

Providers are independent providers of health services and solely responsible to members for the delivery and quality of health services.

Providers have a duty at all times to exercise independent medical judgment to make independent healthcare treatment decisions regardless of whether a health service is determined to be a covered service. UHP has no right to intervene in a provider's medical decision making regarding a member and does not endorse or control the clinical judgment or treatment recommendations made by providers.

If you have any questions or concerns, please contact the Provider Relations department at (713) 357-6762 or providerrelations@apex4health.com Calls are answered from 8 a.m. to 5 p.m., Monday through Friday (CST).

Thank you for your participation.

# General Information

## HOW TO CONTACT UNITY HEALTH PARTNERS

| | | |
|---|---|---|
| **Mailing Address** | **---** | **10505 Town and Country Way #19909**<br>**Houston, TX 77024-9998** |
| **HCC Claims Address** | | **Unity Health Partners**<br>**PO Box 19909**<br>**Houston, TX 77224**<br>**(713)-324-7798** |
| **Provider Relations** | | **(713) 357-6762** |
| **Claims Management** | | **(713) 324-7798** |
| **Medical Management** | | **Please refer to Memorial Hermann Health Plan** |
| **Member Services** | | **Please refer to Memorial Hermann Health Plan** |
| **Behavioral Health** | | **Please refer to the Memorial Hermann Health Plan** |
| **Pharmacy** | | **Please refer to the Memorial Hermann Health Plan** |
| **TDD/TYY Services** | | |
| **Appeals and Grievances** | | **Memorial Hermann Health Plan:**<br>**(855) 645-8448** ***follow prompts***<br>**Fax (713) 704-0884**<br><br>**Health plan appeals/grievances: please see health plan provider manual** |

# Member-Related Information

## Member Rights and Responsibilities

Members have rights and responsibilities when seeking health care services.

## Members have the right to:

- Be treated respectfully and with due consideration for dignity and privacy.
- Have privacy during a visit with their doctor.
- Talk about their medical record with their provider, ask for a summary of that record and request to amend or correct the record as appropriate.
- Be properly educated about and helped to understand their illness and available health care options, including a candid discussion of appropriate clinically or medically necessary treatment options, including medication treatment options regardless of the cost or benefit coverage.
- Participate in decision-making about the health care services they receive.
- Refuse health care (to the extent of the law) and understand the consequences of their refusal.
- Be free from any form of restraint, seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Decide ahead of time regarding the kinds of care they want if they become sick, injured or seriously ill by making a living will.
- Expect their records (including medical and personal information) and communications will be treated confidentially.
- If under age 18 and married, pregnant or have a child, be able to make decisions about his or her own health care and/or his or her child's health care.
- Choose their PCP from the network of participating providers.
- Make a complaint and get a response within 30 days.
- Have information about their health coverage, services, practitioners, and providers and member rights and responsibilities.
- Receive information on the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).
- Get a current directory of health care providers
- Be referred to health care providers for ongoing treatment of chronic disabilities.
- Have access to their PCP or Specialist or a backup 24 hours a day, 365 days a year.
- Receive immediate care from any hospital when their medical condition meets the definition of an emergency.
- Receive post-stabilization services following an emergency condition in some situations.
- File a grievance or appeal if he/she is not happy with the results of a grievance and received acknowledgement within 30 days.
- Freely exercise the right to file a grievance or appeal such that exercising of these rights will not adversely affect the way the member is treated.
- Receive notification to present supporting documentation for their appeal.

- Examine files before, during and after their appeal.
- Request an administrative hearing when dissatisfied with the UHP's decision.

## Members have the responsibility to:

- Treat their providers, their providers' staff and UHP associates with respect and dignity.
- Not behave in a disruptive manner while in the provider's office.
- Respect the rights and property of all providers.
- Cooperate with people providing health care.
- Tell their provider about their symptoms and problems and ask questions.
- Get information and consider treatments before they are performed.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Discuss anticipated problems with following their provider's directions.
- Consider the outcome of refusing treatment recommended by a provider.
- Follow plans and instructions for care they have agreed on with their providers.
- Help their provider obtain medical records from the previous provider and help their provider complete new medical records as necessary.
- Supply information (to the extent possible) the organization and its practitioners and providers need to provide care.
- Respect the privacy of other people waiting in providers' offices.
- Call their health plan to change their PCP selection before seeing a new PCP.
- Make and keep appointments and arrive on time; members should always call if they need to cancel an appointment, change an appointment time or if they will be late.
- Discuss complaints, concerns and opinions in an appropriate and courteous way.
- Tell their provider how they want to receive their health information.
- Read the Member Handbook to understand how their health plan works.
- Be involved in their health care and cooperate with their provider(s) about recommended treatment.
- Learn the correct method by which his or her medications should be taken.
- Carry his or her health plan ID card at all times and quickly report any lost or stolen cards to the health plan; members should contact their health plan if information on the ID card is wrong or if there are changes to their name, address or marital status.
- Show their health plan and other applicable insurance ID cards to each provider.
- Tell their health plan about any providers they are currently seeing.
- Provide true and complete information about their circumstances.
- Report change(s) in their circumstances.
- Notify his or her PCP as soon as possible after they receive emergency services.
- Go to the emergency room only when they have an emergency.
- Report suspected fraud and abuse.

# Pharmacy Information

Please see the health plan provider manual

# Claim Appeals

A claim appeal is a formal request from a provider for reconsideration of a claim already processed by UHP. The provider must submit a written appeal for reconsideration of a claim within 180 days from the date on the Explanation of Payment ("EOP") for commercial and Medicare Advantage members, along with the Claim Appeal Form, a copy of the claim and any supporting documentation. The Claim Appeal form is available on the UHP website. www.unityhealthpartners.net

## Medicare Advantage Appeals-Reconsiderations

| Part C Medical Claim Appeals | |
|---|---|
| Participating providers have 180 days to file an appeal for post service (claims) related appeals.<br>Non-Par providers have 60 days to file an appeal for post service (claims) related appeal. | |
| Payment reconsideration | Pay or deny within 60 calendar days of Plan's receipt |

## Initiating An Appeal:

To file an Adverse Determination or a Claim appeal complete the Adverse Determination Appeal Request Form found on the website along with the information listed below and fax to (713)-324-7798 or mail to:

**Unity Health Partners**
**Attn: Appeals and Grievances Department**
**929 Gessner Road, Suite 1500**
**Houston, TX 77024**

The following information must accompany the request in order to be reconsidered:

1. A complete Adverse Determination Appeal Request form located online
2. The specific reason for the reconsideration request
3. Additional information or documentation to support the request
4. If applicable, also include the following:
   - Authorization/Referral number
   - Copy of the claim
   - Copy of the original EOP

- Copy of corrected claim

The appeals and grievances unit will notify the provider if additional information is required to complete the review of the appeal. The provider will receive notification of the appeal decision in writing within [# of days] days or the time frames specified below via an EOP, Remittance Advise or resolution letter.

| Appeal Notifications | |
|---|---|
| Claim appeal | Pay or deny within 60 calendar days of receipt of the appeal |

## Second Level Appeal

If a provider is not satisfied with the decision of the Appeals and Grievances Department, the provider may submit a second level appeal. Please indicate that the request is a second level appeal in the Additional Comments section of the Adverse Determination Appeal Form. The second level appeal should include any initial determination that confirms the reason for your appeal.

The Health Plan will provide a determination within 30 days of receipt of the appeal. Requests for a second level appeal must include the same information as presented for the initial appeal, as well as any additional information the provider would like to present to further support the appeal. Appeals must be submitted within 30 days from date on the notification to the provider regarding the initial determination of the Appeals and Grievances Department. Second level appeals will be reviewed according to the standard policy and process.

#### Second Level Appeal Medicare Advantage Specific Provisions

If a provider is not satisfied with the decision of the Appeals and Grievances Department regarding a Medicare Advantage member, the provider may request to have the appeal case is sent to the Independent Review Entity (IRE) within 60 calendar days of receipt of the initial appeal decision. If the IRE reverses the initial decision on a claim appeal, UHP shall reprocess the claim within 30 calendar days of receipt of the IRE notice of reversal.

## Untimely Appeal

If an appeal request is filed after the appeal time limit, UHP may extend the time limit if good cause is shown by the provider. UHP will resolve the issue of whether good cause exists before taking any other action on the appeal.

Good cause may be found when the record clearly shows, or the provider alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the appeal was furnished by UHP to the provider; or
- Unavoidable circumstances that prevented the provider from timely filing a request for appeal. Unavoidable circumstances encompass situations that are beyond the provider's control, such as major floods, fires, tornados, and other natural catastrophes.

**Note:** Failure of a billing company or other consultant that the provider has retained to timely submit appeals or other information is NOT grounds for finding good cause for late filing of an appeal. UHP does not find good cause where the provider, physician, or other supplier claims that lack of business office management skills or expertise caused the late filing.

# Grievances

A grievance is a complaint that does not involve a coverage decision. Members or their authorized representative may file a grievance if they are dissatisfied with the quality of care or services received from UHP or a provider.

An expedited grievance may include a complaint if UHP refused to expedite or invoked an extension time frame for an organization determination/coverage determination or reconsideration/redetermination. UHP will provide written notice explaining the reasons for such a decision and explaining the member's right to file an expedited grievance.

UHP maintains procedures for the timely hearing and resolution of a member concerns as shown below:

| **Grievances** | |
|---|---|
| Standard grievance review | Respond within 30 calendar days of receipt of the grievance |
| Expedited grievance review | Respond within 24 hours of receipt of the grievance |

# Claims

## Claims Filing Deadline

### Medicare Advantage Claims

Claims must be received no later than 95 calendar days from date of service or as designated in the provider agreement.

## Timeliness of Claims Submission

Providers forfeit payment for claims not filed within the specified deadline and claims filed after the specified deadline will be denied with no appeal rights. For claims that include or span several dates of service, filing timeliness is determined as follows:

- The "through date" on the UB claim form is used to determine the date of service for institutional claims
- The "from date" on the HCFA claim form is used to determine the date of service for professional claims

For claims involving coordination of benefits with other insurance carriers or government programs, filing timeliness is determined from the date of the other insurance carriers EOP or remittance advice from Medicare. A copy of the primary carrier's EOP or remittance advice must be submitted to UHP with the claim.

## Claims Address

Claims should be submitted electronically or mailed to:

**Electronic Claims**

| Clearinghouse | Payer ID |
|---|---|
| Availity/THIN | A1152 |
| WebMD/Emdeon | TN 92 |

**Paper Submission**

**Unity Health Partners**
**Attn: Claims Department**
**PO Box 19909**
**Houston, TX 77224**
**(713)-324-7798**

## Clean Claim Requirements

A clean claim includes all the data elements specified by the Texas Department of Insurance ("TDI") in prompt pay rules or applicable electronic standards. Each specified data element must be legible, accurate, and complete. A claim that does not comply with the applicable standard is a deficient claim. When UHP is unable to process a deficient claim, it will notify the provider of the deficiency and request the correct data element.

Electronic claims by professional or institutional providers must be submitted using the ASC X12N 837 format in order to be considered a clean claim. Providers must submit the claim in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements related to electronic health care claims, including applicable implementation guidelines, companion guides, and trading partner agreements.

"Clean claims", as defined by TDI regulations, will be processed within 30 days of receipt if submitted electronically and within 45 days of receipt if submitted on paper.

Healthcare providers must submit claims to the plan as outlined in the provider's Participation Agreement. Failure to comply with applicable requirements may result in denial of a claim for payment. In the event that a claim is denied, the member is to be held harmless and not billed for the services by the provider.

UHP's clearinghouse may not refuse to process an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. Batch submission means "a group of electronic claims submitted for processing at the same time within a Health Insurance Portability and Accountability Act (HIPPA) standard ACS X12N 837 Transaction Set and identified by a batch control number."

### National Provider Identifier (NPI)

The NPI is a 10-digit intelligence-free numeric identifier. All participating providers must have an NPI number and must include the NPI number on the claim.

## Coding and Bundling Guidelines

UHP uses standard claim guidelines that are current to the date the claim is processed. These guidelines have been developed in part using such references as including, but not limited to the AMA position statements from its official publication "CPT assistant," which is published monthly; other official AMA publications, such as "CPT changes" which is published annually; Medicare Guidelines, which are updated quarterly; and specialty guidelines from sources such as the American College of Surgery, the Orthopedic Society, the American College of Cardiology and the American College of OB/GYN. UHP also utilizes industry standard claim editing software in the evaluation of a claim.

Providers must implement mechanisms to ensure that: (a) billing forms, CPT codes, ICD-10 codes, modifiers, "medical necessity", etc. are supported by appropriate and timely medical record documentation; (b) all claim forms and patient statements are transmitted properly; (c) instances of "code gaming", "unbundling", "up-coding", and other improper activity designed to increase reimbursement, which may constitute fraud, waste or abuse, are avoided; (d) arrangements with other providers adhere to anti-kickback and self-referral statutes; and (e) all provider marketing efforts do not improperly induce patients to utilize services and are conducted with adherence to any and all applicable state and federal regulations.

Changes to the original claim  for any reason must be supported by documentation in the member's medical record. A provider's billing staff shall not routinely change CPT or diagnostic codes or attach modifiers to bypass claims processing edits without warranted justification; any code changes must be supported by documentation in the member's medical record. Providers are expected to cooperate with UHP Claims Department when questions arise.

Providers should ensure that compensation for billing department coders and billing consultants does not provide a financial incentive to up-code claims improperly. In addition, all compensation arrangements with physicians on the provider's staff must comply with "Stark II" regulations and applicable state laws.

### HCPCS and CPT Codes

Current HCPCS and CPT Codes must be used since many changes are made to these codes annually. Current HCPCS and CPT Code manuals may be purchased at any technical bookstore and various online bookstores or by contacting the American Medical Association at https://commerce.ama-assn.org/store/ or at (800) 621-8335.

UHP is in compliance with 5010 mandates. The following are UHP reminders related to 5010:

- The billing provider's address must be a physical address that equates to Box 33 on the CMS 1500 form. As an UHP provider and according to 5010 rules, your billing provider/pay to provider address can no longer be a P.O. Box or lock box. Therefore, if you have a P.O. Box or Lock Box, please confirm with your clearinghouse or billing software vendor that this is mapped correctly; i.e., to the appropriate loop designated as your "pay to provider" (which can be a P.O. Box or Lock Box). Otherwise, your claims will be rejected by UHP.
- Claims must have valid 9 digit ZIP code (Zip Code+ 4). Claims submitted to UHP without a valid ZIP code+ 4 will be rejected and returned to the provider. Go to http://ZIP4.usps.com/ZIP4/welcome.jsp to obtain your valid ZIP code.
- Anesthesia claims must be reported in minutes, not units, unless the procedure code has minutes in its description. All time should be in minutes, i.e., 1 hour 15 minutes equals 75 minutes on the bill. A new quantity (QTY) segment called "Obstetric Unit Anesthesia Count" is used to report additional complexities beyond those reported in the procedure and anesthesia segments for service line information.

**Claim Filing**

Electronic claims filing is preferred but if provider must file a non-electronic claim, use of the current standard UB-04 or CMS-1500 (02/12) claim form is required.

Providers must submit a clean claim as specified in the Clean Claim Requirements section of this Provider Manual.

## Claim Requirements for Professional Services

- **Correct Coding** - Use the appropriate CPT, HCPCS and ICD codes including appropriate modifiers on all claims.

- **National Drug Code (NDC) Billing Guidelines for Professional Claims** - UHP requires National Drug Codes (NDCs) and related information when drugs are billed on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims.

- **CMS-1500 Claim Form** - UHP requires a CMS-1500 (02/12) Claim form as the only acceptable document for participating professional providers for filing claims.

- **Return of Claims with Missing NPI Number** - Claims that do not have the billing provider's NPI number listed correctly in the appropriate block on the claim form will be returned to the provider. To avoid delays, please list the billing provider's NPI number in block 33 on the standard CMS-1500 (02/12) claim form.

## Claim Requirements for Institutional Services

- **UB-04 Claim Form** - The electronic ANSIX12N 8371-Institutional or the Uniform Bill (UB-04) is the standardized billing form for institutional services. For information on the UB-04 billing form, or to obtain an Official UB-04 Data Specifications Manual, visit the National Uniform Billing Committee (NUBC) website at www.nubc.org. All claims must include all information necessary for adjudication of claims.

- **Failure to Submit Necessary Data Elements** - Failure to submit data elements that UHP has identified as potentially necessary for claim adjudication could result in payment delays as UHP may need to request the additional information from the provider in order to adjudicate the claim. All claims must include all information necessary for adjudication of claims.

- **NPI** - Some facilities may have several NPI numbers (i.e., substance abuse wings, partial psychiatric day treatment). It is important to bill with the correct NPI for the services provided or this could delay payment or even result in a denial of a claim.

- **Patient Status** - The appropriate patient status is required on an inpatient claim. An incorrect patient status could result in inaccurate payments or a denial.

**Occurrence Code/Date** - All institutional claims require the appropriate occurrence code and the date(s) of service.

## Reimbursement

This section provides information about claim pricing and reimbursement, including payment, recovery of excess payment, third-party liability and coordination of benefits.

### Certification, Payment Determination and Explanation of Payment (EOP)

The Claims System determines the member's eligibility, benefit coverage and if the services required a prior authorization.

If one or more service on the claim lacks a required prior authorization the claim will be reviewed retrospectively upon appeal for benefit approval based upon the terms in the member's Evidence of Coverage or Certificated of Coverage (collectively "EOC/COC"). Benefit verification of treatment or services or a determination of medical necessity based upon criteria in the applicable EOC/COC does not guarantee payment and is subject to review upon appeal.

Once a claim is determined to be payable, the maximum allowable amount is determined from the provider's Participation Agreement for participating providers or the maximum allowable amount as determined by UHP for non-participating providers. Payment is the lesser of the maximum allowable amount or the provider's billed charges, less any applicable member responsibility. An explanation of payment statement (EOP) is generated when a claim is finalized and includes: a summary

of the allowed amount and payment and the member's responsibility; and/or non-payment, reason for denial or additional information that may be required.

## Member Liability for Covered Services

The only charges for which the member may be liable for and for which provider may bill the member are:

- Deductibles, copayments, and coinsurance amounts as specified in the member's EOC/COC; or
- Medical services not covered by the member's EOC/COC where the member has specifically agreed in advance, in writing, to accept financial responsibility as further described on page 30 of this Provider Manual.

If the member's plan includes a deductible, the deductible must be met before additional benefits are payable. Some plans may also have benefit-specific deductibles. The member is financially responsible for the deductible amount(s). In addition, the member is responsible for paying any applicable copayments or coinsurance for services received after all required deductibles have been satisfied. Copayments and deductibles may be collected at the time the services are rendered or upon receipt of the EOP.

To determine the member's financial responsibility (i.e., the copayment amount or whether any required deductible has been satisfied), contact Health Plan Member Services at the toll-free number listed on the member's ID card. The information is valid only as of the time the information is provided and is subject to change as additional claims are processed.

If a provider receives an overpayment from a member, the provider must refund the amount of the overpayment to the member not later than the 30th day after the date provider determines that an overpayment has been made.

## Member Liability for Services that are Not Medically Necessary

Providers may not charge a member for medical services denied as not medically necessary under the member's EOC/COC unless the member has provided written agreement of financial responsibility in advance of receiving such services.

The member's written agreement of financial responsibility must be specific to the services rendered. If the amounts collected from the member exceed the member's responsibility, the provider must refund the amount of the overpayment to the member not later than the 30th day after the date provider determines that an overpayment has been made or receipt of the EOP.

## Coordination of Benefits

The Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing insurance coverage to the member. When a member has more than 1

health insurance, the primary and secondary are normally determined in accordance with the primary carrier rules or as required under the laws of the state where the member's EOC/COC was issued.

Primary carrier rules are often used by insurance carriers industry wide and have been incorporated into appropriate health plan EOC/COC's. These rules determine the payment responsibilities between the health plan and other applicable insurance carriers by establishing the primary carrier and the secondary insurance carrier.

**NOTE:** The payment will not exceed the maximum allowable amount as set forth in the provider's participation agreement, total charges or the member's responsibility for covered services, whichever is less, except as otherwise required by law.

The primary carrier rules normally do not apply to:

- Non-group policies (individual policies)
- Auto insurance policies
- Medicaid
- CHAMPUS/CHAMPVA

## Third-Party Liability

Third-Party Liability occurs when a person or entity other than the member is or may be liable or legally responsible for the member's illness, injury or other condition and is, therefore, responsible for the costs associated with the member's illness, injury or condition. UHP may be entitled to reimbursement from the member from any settlement he/she may receive from a third party in those situations.

## Unsolicited Refunds

Providers have the responsibility to report "unsolicited" overpayments or improper payments to UHP or the health plan. Providers must issue a refund within 60 days from the date of the "unsolicited" overpayments or as required in the provider's participation agreement

Providers have the option of requesting future off-sets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the EOP or remittance advice along with affected claims identified).

## Overpayment and Recovery Procedures

In the event of a determination that an overpayment has been made, UHP may seek recovery of all excess payments from the payee to whom the check was made payable including, but not limited to, recoupment or off-sets against future payments to payee.

If the payee disagrees with the over payment, the payee may contact UHP in writing at:

**Attn: Claims Department**
**PO Box 19909**
**Houston, TX 77224**
**(713)-324-7798**

Provider or payee should contact Provider Services with any questions concerning overpayment recovery. In the event the terms of the provider's Participation Agreement or state or federal laws or regulations differ from the process outlined above, the terms of the Participation Agreement or state or federal laws or regulations will prevail.

# Credentialing and Recredentialing

Prior to acceptance into the network, providers must undergo a formal credentialing process. This section describes the credentialing and recredentialing processes, the Credentialing Committee and the appeal process for providers whose UHP network participation has been terminated or suspended. Providers have the right to request the status of their application; and to correct any incomplete, inaccurate, or conflicting credentialing information.

## Credentialing Standard:

The credentialing standards are aligned with national standards for providers. Additionally, the State of Texas and CMS, requires UHP to follow state and federal laws and regulations:

- The Standardized Credentialing Application form is required for the credentialing and recredentialing of providers.

- UHP has a documented process for selection and retention of contracted providers and providers. The credentialing process complies with NCQA or American Accreditation HealthCare Commission, Inc., standards, to the extent that those standards do not conflict with the laws of the state of Texas. UHP has a documented process for expedited credentialing of providers, including a documented process for payment of claims during an expedited credentialing process, in compliance with Insurance Code Chapter 1452.

- Delegation of Credentialing. If UHP delegates the credentialing functions to other entities, the delegated entity's credentialing process must comply with the standards promulgated by the NCQA, to the extent that those standards do not conflict with other laws of the state of Texas.

## Criteria

UHP utilizes a selective criteria to ensure that providers who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Must have applicable, current, and unencumbered licensure in the state of practice as required by state and federal entities.

- Must have a current, valid, and unrestricted federal DEA Provable training in the requested practice specialty.
- Must maintain current malpractice coverage with limits commensurate with the community standard in which practitioner practices.
- Practitioners must be a participating provider in Medicare and have a Medicare number and/or a National Provider Identification number to participate in the Medicare Advantage network.
- Provider cannot be excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

## Application Process

Once a provider is approved by UHP for network participation the credentialing team will send a link to the credentialing application portal via electronic email for the provider to begin the credentialing process.

Providers must submit a complete online credentialing application. Provider's applications are reviewed by the Credentialing Committee, which meets at least quarterly. The Credentialing Committee will provide formal notification to the provider of the credentialing decision. All final decisions concerning credentialing of a provider are made by the Credentialing Committee.

### Practitioners

The verification of credentials and documentation, may include the following but not limited to:

- Work history
- State medical license or certification
- Education
- History of state and/or federal sanctions
- History of professional liability claims
- Assessment of board certification for applicable providers
- Proof of malpractice insurance

Practitioners must submit a complete online credentialing application.

### Ancillary Services/Facility

Collection of application and verification of credentials and documentation, including, but not limited to:

- Proof of license to operate
- CMS or State Department of Health survey report or an approval letter from the CMS or State Department of Health stating the facility's review date and inspection results
- Accreditation or most recent survey results from the State Department of Health, if not currently accredited

- Professional Liability and General Liability Insurance Certificate, which list amounts and coverage dates

## Recredentialing

In-Network providers must complete the recredentialing process at least once every 36 months. The credentialing team will send a link to the recredentialing application portal via electronic email for the provider to begin the recredentialing process at least 180 days prior to the expiration of the provider's current credentialing period or in a timeframe determined by UHP as necessary.

## Termination of Credentialing Status

A provider's credentialing status may be terminated at any time when information is obtained that indicates the provider does not continue to meet minimum credentialing standards. The UHP Credentialing Committee will decide ongoing credentialing status. Provider's UHP network participation will be terminated if the provider no longer meets the minimum credentialing standards.

Any participating provider who is denied participation, suspension or terminated for cause by UHP shall receive written notification within 30 business days of the decision, including the reasons for rejection, suspension or termination, by the UHP Chief Medical Officer.

## Credentialing Grievance and Appeal Process

UHP provides a fair opportunity and process for any participating provider to appeal unfavorable actions taken by the Credentialing Committee that relate to the provider's network participation status and for any action taken by the plan related to the provider's professional competency or conduct.

All grievances and appeals will be processed following the policies and procedures as approved by the Credentialing Committee.

In compliance with the Civil Rights Act of 1964, UHP will not discriminate against any provider on the basis of age, race, color, ethnicity, national origin, sex, or religion/creed.

Any participating provider who is denied participation, suspension or terminated for cause by UHP shall receive written notification within 30 business days of the decision, including the reasons for rejection, suspension or termination, by the UHP Chief Medical Officer. If a provider receives notice of an adverse action by the UHP Credentialing Committee upon recommendation by the UHP Executive Committee, the provider is entitled to:

- A review by a Grievance Panel
- A review that permits the participating provider to appear before the Credentialing Committee panel and present relevant information.

If dissatisfied with the decision of the Grievance Panel, the provider may submit a written request up to two appeals. The request must be in writing, addressed to the Chief Medical Officer and include a brief description of the reasons for grievance. If the request for grievance is not received within 30 days of notice, both parties shall be deemed to have accepted the decision of the Credentialing Committee and it shall become final and effective immediately.

Within 30 business days of receipt of a request for Grievance Panel review, the Chief Medical Officer shall schedule and arrange for a grievance panel review and send notice to the provider. The grievance panel, comprised of the Credentialing Committee and Executive Committee, will discuss the matter with the participating provider. Every attempt shall be made to conduct the review within 30 days from receipt of the request.

The review process is intended to offer the participating provider an opportunity to address any special circumstances that may apply and to respond to questions the grievance panel may have. The participating provider is deemed to have waived his/her appearance rights with the panel should he/she not appeal nor send written notification of the request to reschedule the grievance review date. The scheduled date cannot be more than 30 days from first scheduled grievance review date. If a clinical peer of the provider is not represented on the Credentialing Committee, an ad hoc appointment of a peer-matched provider who is not otherwise involved in network management will be made.

The notice of the Grievance Panel hearing shall be sent to the provider, at the address shown on the application, by certified mail, return receipt request, inclusive of the place, time and date of the hearing. Within 30 days after receipt of the Grievance Panel review recommendations, the UHP Credentialing Committee shall render its decision. The decision will be forwarded to the provider in writing by certified mail, return receipt requested. This notification will be approved and signed by the UHP Chief Medical Officer.

## Confidentiality

Information obtained during the credentialing or recredentialing process is confidential. All credentialing processes are privileged and confidential per federal law and state review laws.

# Provider Responsibilities and Standards

Participating providers agree to follow and adhere to the policies and procedures in this manual, billing guidelines, Medical Management guidelines and other policies and procedures established and revised from time to time.

## Checking Benefits and Eligibility

Each provider’s office should have a system in place for identifying patient’s primary and secondary health insurance coverage. UHP also recommends that providers have a system in place at the time of member check-in to verify if there have been any changes in health insurance coverage since the last time the member was seen.

Providers should check the member's benefits and eligibility before providing care.

Checking benefits and eligibility:

- Helps ensure that you submit the claim to the correct payer
- Allows you to collect copayments
- Determines if a referral, prior authorization or notification is required; and
- Reduces denials for non-coverage

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information.

There are two ways to verify a member's eligibility:

- Please visit the member's health plan website.
- Call Member Services at the number on the member's ID card.

Providers should contact Member Services at the number on the member's ID card to verify benefits.

Providers contacting Member Services for eligibility verification will receive the member's plan type, effective date and eligibility status at the time of the call. The information received is not a guarantee of coverage. If coverage terminates after eligibility is verified, UHP may not be responsible for services rendered after the date of termination.

Members should present their card when seeking medical services. Check the member's healthcare card at each visit and keep a copy of both sides of the card for your records.

## Provider Responsibility for Notification of Change

Providers must notify UHP of changes to the following information changes no less than 30 calendar days prior to the effective date of the change:

- TIN changes (include copy of W-9 Form)
- Address additions, changes, or deletions
- Phone number or fax number changes
- Hospital Affiliations
- Specialty
- State License Number
- NPI number
- Additions or departures of providers or location from a group practice or ancillary/facility group
- Office hour changes

Any changes to a provider's ownership, TIN/FEIN or W-9 will suspend provider's network participation status until approved in writing by UHP.

The network participation status of any new providers to a group practice or new locations for Ancillary/Facility providers will be effective upon approval from UHP and as of the date of successful completion of credentialing.

Failure to notify UHP of any of the above changes may result in payment denials.

## Provider Expectations

This section describes UHP's expectations for providers:

- Provide care to members in a culturally competent manner, being sensitive to language, culture and reading comprehension capabilities.
- Freely communicate with members regarding treatment regimens, including medication treatment options, regardless of benefit coverage limitations.
- Utilize UHP's participating providers and facilities.

## Provider responsibilities include but are not limited to:

- A provider must treat UHP members the same as all other patients in the provider's practice, regardless of the type or amount of reimbursement.
- A provider must not discriminate on the basis of race, age, religion, sex, national origin, marital status, source of payment, or disability of any member.
- A provider must agree to provide continuing care to participating members.
- A provider must utilize UHP's participating providers when services are available and can meet the patients' needs. Based on the members' plan benefits, prior approval may be required when referring members to providers who are outside the network of participating providers (out-of-network providers).
- A provider must abide by UHP's quality improvement, utilization management, credentialing, peer review, appeals, grievance and other policies and procedures established and revised by UHP from time to time. This includes participation in evidence-based patient safety programs.
- A provider may not balance bill a member for services that are covered by UHP. He/she may only bill members for applicable deductibles, co-payments and/or co-insurance amounts. A provider may not bill for charges that exceed contractually allowed reimbursement rates.
- A provider may bill a member for a service or procedure that is not a covered benefit in two instances:
    - If the member did not inform the provider that he/she was an UHP member prior to receiving services or within a reasonable time after receiving emergency services.
    - If the member was informed that the services were non-covered and he/she agreed in advance, in writing to pay for the services. An agreement to pay must be evidenced by written records that include: 1) provider notes written prior to receipt of the services demonstrating that the member was informed that the services were

non-covered and the member agreed to pay for them; and 2) a statement and/or letter signed by the member prior to receipt of the services acknowledging that the services were non-covered and the member agreed to pay for them.

- The provider agrees to prepare complete medical and other related records in a timely fashion for all members in his/her care and maintain contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment and the outcome at completion or discontinuation of treatment.
- Medical records for members must be maintained for minimum of 10 years from the last date in which service was provided.
- The provider agrees to abide by UHP rules and regulations and all other lawful standards, policies, rules, and regulations.
- The provider agrees to allow access to medical records for review by appropriate committees of UHP and, upon request, must provide the medical records to representatives of UHP, governmental entities and/or their contracted agencies.
- The provider agrees to inform UHP, in writing, within 24 hours of any revocation or suspension of his/her Drug Enforcement Agency (DEA) number, certification or other legal credential authorizing him/her to practice in the state of Texas or any other state. Failure to comply with the above could result in termination from the plan.
- The provider agrees to inform UHP immediately, in writing, of any changes in licensure status, tax identification numbers, phone numbers, addresses, status at participating hospitals, loss of liability insurance, change in eligibility for payment under Medicare and any other change that would affect his/her status with UHP.
- The provider agrees to provide or assist UHP in obtaining Coordination of Benefits/Third-party Liability information.

## Primary Care Providers Responsibilities include but are not limited to:

- Primary Care Providers (PCPs) must provide continuous 24 hour, 7 days a week access to care for UHP members. The PCP is responsible for arranging for a backup PCP when he/she is not or will not be available and for assuring that the covering physician will abide by plan policies and procedures.
- In the event the PCP is temporarily unavailable, or unable to provide patient care or referral services to UHP members, he/she must arrange for another physician (the “Covering Physician”) to provide such services. This coverage cannot be provided by an emergency room. The PCP shall provide UHP with the name of his/her covering physician so that claims will be processed correctly.
- Primary Care Physicians shall provide follow-up care to patients that have been in the hospital setting within seven (7) days of hospital discharge. Discharge follow-up should include documentation of medication reconciliation.
- All providers are required to actively promote and participate in all quality initiatives inclusive of any and all chart audits, patient preventive care, and patient satisfaction activities.
- Confirm member eligibility and benefits prior to rendering services.

## Specialists Responsibilities include but are not limited to:

- Specialists must provide specialty services upon referral from the Primary Care Physician and work closely with the referring physician regarding the treatment the patient is to receive. Specialists must also provide continuous 24 hour, 7 days a week access to care for patients.
- Specialist are required to obtain any required authorizations prior to rendering services. Specialists are required to coordinate referrals and authorizations with UHP for further care that they recommend. This responsibility does not revert back to the PCP while the care of the patient is under the care of the Specialist.
- Specialists agree to participate in peer review activities as they relate to the Quality Management/Utilization Review program.
- Confirm member eligibility and benefits prior to rendering services.
- Provide a consultation report to the PCP within 30 days of the consult.
- Provide lab or hospital-based providers with the prior authorization number and the member's ID number.

#### Accepting New Patients

To the extent that a provider is accepting new patients, the provider must also accept new patients who are UHP members. If the provider decides to no longer accept new patients, the provider must notify UHP in writing 45 days prior to closing his/her practice to new patients. In no event will an established patient of the provider be considered a new patient. If the provider's practice is closed to new patients, the provider is obligated to continue providing services to members receiving services at the time the practice is closed to new patients. Providers should send notification to Provider Relations at ProviderRelations@apex4health.com

## Dispute Resolution Process

UHP distinguishes disputes by the following categories:

- Administrative
- Issues concerning professional competence and conduct.

## Administrative Disputes

Administrative disputes may include, but are not limited to, a participating provider's written notice challenging, appealing or requesting reconsideration of a claim denial or payment, factual determinations by Utilization Management and/or contractual concerns. The dispute resolution process is available to any participating provider who wishes to initiate it. Participating providers have the right to have their administrative disputes reconsidered by an authorized representative of the plan who was not involved in the initial decision. Administrative disputes involving the categories below have specific resolution processes that can be found in the following sections of the manual:

- Claims disputes – **See "Claim Appeals"**
- Medical Management Determination Disputes – **See "Adverse Determination Appeals"**

Disputes involving contractual concerns or other administrative disputes not addressed in the above categories, can be initiated by the provider. The provider should submit written notification to the plan that includes the following:

- Provider's name and/or practice
- Contact's name and telephone number
- Clear explanation of the issue
- Provider's position on that issue
- Additional information or documentation that supports the provider's position.

The written notification should be forwarded to:

**Unity Health Partners**
**Attention Appeals - Administrative Disputes**
**929 Gessner Road, Suite 1500**
**Houston, TX 77024**

Unless otherwise specified in the Participation Agreement, UHP will use best efforts to provide written determination to the provider within 30 days of receipt. However, if the issue requires more than 30 days to resolve, the provider will be notified by UHP and given the projected time frame for resolution.

## Disputes Concerning Professional Competence or Conduct

Administrative disputes do not include actions that relate to a participating provider's status within participating provider network or any action related to a participating provider's professional competency or conduct. For disputes related to actions taken by the plan regarding a participating provider's network status and/or professional competency or conduct, please see "Appeals and Grievances" and "Credentialing Appeals and Grievances".

# Quality Improvement

## Goal of the Quality Program:

- Provide a continuous, comprehensive quality improvement program that addresses all dimensions of quality: clinical, service, and fiscal.
- Promote/incorporate quality into the health plan's organizational structure and processes.
    - Facilitate partnerships between members, providers, state agencies, and health plan staff for the continuous improvement of quality health care delivery
    - Clearly define roles, responsibilities, and accountability for the quality program
    - Continuously improve communication and education in support of these efforts
    - Promote objective, systematic, measurement, monitoring and evaluation of services, work processes, and implement quality improvement activities based upon the outcomes of those activities

- Provide effective monitoring and evaluation of patient care and services to ensure that care provided by the health delivery system meets standards of medical practice, meets the cultural and linguistic needs of membership, and is positively perceived by health plan member and professionals.
    - Evaluate and disseminate clinical and preventative practice guidelines
    - Monitor provider performance against established evidence-based medicine. Develop guidelines for quality improvement activities (access, availability, credentialing, peer review, etc.)
    - Analyze data (performance reports, trend analysis, score cards, etc.) and develop programs to improve satisfaction and preventative services
    - Collect and analyze data for population specific Quality Improvement projects
- Identify opportunities for improvement, including oversight of implementation, actions and follow-up.
- Identify and monitor quality indicators, problems, and concerns about health care services provided to members looking for opportunities for improvement.
- Implement and conduct a comprehensive Quality Improvement Program, tracking projects and metrics across the health plan.
- Monitor compliance with local, state, and federal regulatory requirements and accreditation standards.
- Tracks laws, rules and regulations as it relates to health plan clinical operations
- Monitor compliance with regulatory requirements for quality improvement and respond as needed
- Ensure reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies
- Act promptly to implement improvement activities based upon the measurement, monitoring, analysis, and evaluation of the quality activities
- Prioritize activities based upon:
    - Immediate impact to membership
    - Patient safety
    - Immediate impact to health plan
    - Long term impact to membership and/or health plan, to include;
        - Considerations of volume impact, problem prone nature of issue
        - Laws, rules, regulations, accreditation standards
        - Stakeholder impact.

## Quality Improvement Program Oversight Authority and Accountability

The Board of Directors is the governing body of the organization and has granted authority for quality management to the Quality Committee. The Board of Directors functions as they relate to the quality improvement program include:

- Annual review and approval of the Quality Improvement Program description
- Review of the annual QI Work Plan, and the annual QI Evaluation
- Provides feedback and recommendations to the Quality Committee no less than annually
- Support commitment to quality and to the Health Plan’s Quality Improvement Program

- Designation of the Chief Medical Officer as the Senior Clinical Staff person responsible for all aspects of Quality Management and associated programs

In order to fulfill the goals and objectives of the Quality Improvement Program, UHP has integrated quality improvement activities into all functional areas. These include, but are not limited to the following functional areas and departments:

- Medical and Behavioral Health Services, including Population Health, Utilization Management, Case Management, Care Coordination and Pharmacy
- Member Services
- Grievance and Appeals
- Network/Provider Management
- Credentialing
- Compliance
- Claims
- Quality Management and Improvement

Additionally, through the Quality Program, UHP will ensure:

- Methods to communicate these quality activities to the relevant members of the staff related to the results of consumer and client satisfaction surveys best practices for consideration and adoption.

UHP maintains a quality management and improvement program that promotes objective and systematic measurement, monitoring and evaluation of services and work processes and implements improvement activities based upon the outcomes and findings of its measurement, monitoring and evaluation. The Quality Program includes a quality program description, a quality work plan, quality policies and procedures, a Quality Department, a Quality Committee and subcommittees.

The Chief Medical Officer is responsible for all aspects of the Quality program. He or she provides oversight and direction to all quality activities. The Chief Medical Officer is an M.D. with a current, active, unrestricted license in the State of Texas and possesses additional training as evidenced through board certification.

## Quality Plan

The Quality Program Description is an overarching, comprehensive document that describes the quality program and that covers the areas that fall under its scope. The plan describes the scope, objectives, activities, and structure of the program, defines roles and responsibilities of the Quality Management Committee, and how the organization will measure, analyze and improve its performance through the use of data.

The program requires performance reporting including reporting from delegates. This information is reviewed by the Quality Committee as part of the oversight responsibilities for the delegation activities. The program is reviewed, updated, and approved by the Quality Committee at least annually.

As part of the Quality Management Program, the health plan provides written documentation of targeted quality improvement activities initiated in response to analysis of measured performance. This includes:

- Measurement of process, satisfaction or outcome trend information using valid and accurate measurement methods
- Analysis of process, satisfaction or outcome trend information that is directly related and relevant to the services realized by the member
- Implementation of action plans to improve or correct identified problems or to meet acceptable levels of performance on measures
- Mechanisms to communicate to relevant staff the results of such activities and the sharing and integration of best practices
- Mechanisms to communicate the results to the Quality Committee
- Once acceptable levels of performance are met, periodically re-measure levels of performance to ensure sustained improvement

Separate Business Continuity, Credentialing, Compliance, Communications and Marketing Plans are maintained.

## Quality Work Plan

The purpose of the Quality Work Plan is to describe the quality improvement initiatives of the health plan for the coming year. These initiatives are developed throughout the year as a result of ongoing data gathering and trend review, identification of areas for improvement, prioritization of those areas of identification based upon impact to the health plan and membership based upon:

- Risk
- Intensity
- Volume
- Ability to affect change or improvement.

The quality work plan consists of detailed goals for each department within the health plan which is developed and reviewed at least annually.

## Monitoring Activities

Monitoring activities include measurement of established goals and indicators to ensure that they are conforming to requirements or specifications. These are measured and reported at pre-established intervals. Annually the Quality Improvement Committee evaluates the status of such activities and makes a determination regarding the need for ongoing monitoring, process improvement or other activity.

## Improvement Activities

These types of activities are focused on improving current performance. UHP maintains an active Chronic Care Improvement Project in accordance with CMS regulation
42 CFR §422.152(c). Through monitoring and tracking of performance and quality metrics, UHP may also identify improvement opportunities and implement internal quality improvement projects.

The criteria for selection of Quality Improvement Projects, studies and other improvements initiatives include 1 or more of the following:

- Supports the overall quality management strategy as approved by clinical leadership
- Has potential for measurable impact, to include attainment of performance levels
- Potential to improve consumer health or internal work processes based upon various factors
- The project or study is relevant to the population served by the health plan
- Baseline data is available or can be obtained
- Community or practice standards suggest opportunity for improvement or further analysis
- Benchmarking to best practices suggests the project or study represents an opportunity for improvement
- The project/study/initiative represents an opportunity to reduce error or improve performance related to the services provided
- Promotes and supports organizational efforts to maintain and refine consumer and client/member services
- Promotes/supports strategic, operational, regulatory, accrediting or contractual requirements
- Is high volume, high risk or problem prone for key processes or outcomes

Projects are selected and prioritized based upon their potential to impact patient quality, ability to implement, and those that are at high risk, high volume and/or problem prone in nature.

## Confidentiality and Conflicts of Interest

The Quality Committee and its related committees and subcommittees follow the Health Care Quality Improvement Act of 1986, the Privacy Act of 1974, 45 CFRPart 160 and Subparts A and E of Part 164 (HIPAA Privacy Rule) and Act 68 of 1998 (Quality Health Care Accountability and Protection Act).

The Quality Committee will follow all policies and procedures regarding the confidentiality of member information. Committee records are only available to individuals who are authorized in accordance to local, state, federal, and other regulatory agencies. Compliance with mandatory releases does not compromise the claim to the privilege, protected and confidential nature of these proceedings and minutes. Members may not keep complimentary copies of any documents unless specifically declared by the chairperson as materials that would otherwise be generally available outside of committee.

Committee members will refrain from discussion of the committees' proceedings outside of committee. Release of any proceedings will flow from committee to committee. Providers will be required to sign a confidentiality agreement and a conflict of interest agreement.

Conflicts of interest may arise from time to time due to the nature of the committee and the involved parties. Individuals have a responsibility for identifying when their participation in a discussion or action may represent a conflict of interest, and to recuse themselves from participation in such situations. Committee members have a responsibility to identify conflicts of interest that may arise for other participants if not otherwise identified. Conflicts of interest raised in this way may be

subject to further discussion or inquiry. There shall be no retaliation for any concern raised in good faith.

## Ensuring Good Faith and Due Process

Quality improvement proceedings are to be founded in:

- Fact
- Freedom from malice
- Freedom from prejudice
- Avoidance of activities related to restraint of trade
- Assurance of due process for any party that may stand to be negatively affected as a result of a Quality Committee decision or sanction.

The Chief Medical Officer may request qualified personnel to screen a review or report for potential quality issues. The Director of Quality or designees may refer cases to the Chief Medical Officer for review and recommendations.
The Chief Medical Officer review may result in such determinations as:

- No quality issue exists
- Referral to Credentialing Sub-Committee for further exploration

The Chief Medical Officer will recommend action as appropriate to the event, in keeping with the Quality Plan, Policies and Procedures, contractual requirements, requirements under the terms of the Plan's contract with the clients and any relevant federal, state or local regulatory requirements. The Chief Medical Officer may refer all pertinent issues to the health plan quality department or CMO as appropriate.

## Special Procedures

**Procedure for Unusual Provider Practice Patterns:**

Whenever a concern regarding the clinical quality of care and services provided arises, all available records and related correspondence are screened by the Quality Improvement Department. The concerns are then forwarded to the Chief Medical Officer for review and determination of any potential quality issues.

Individual concerns that do not represent a pattern of behavior or do not seriously jeopardize patient care/welfare may be individually addressed by the Chief Medical Officer and summarized to the Quality Improvement Committee at its next regularly scheduled meeting.

The Quality Improvement Committee may accept the Chief Medical Officer's assessment and follow up actions, or it may recommend another course of action based upon the information presented.

When individual concerns represent a pattern of behavior, the Chief Medical Officer shall ensure that the matter is addressed through the Quality Improvement Committee.

**The Quality Improvement Committee Process is outlined below:**

When individual concerns or patterns of behavior represent a serious threat to member care or welfare, the Chief Medical Officer (Medical Director) shall immediately act upon the behalf of the Quality Improvement Committee. The Quality Improvement Committee will review the information available and render a decision on behalf of UHP regarding the provider within 7 business days,

In non-emergent situations, when the Quality Management Program determines that inappropriate or substandard services have been provided or services which should have been furnished have not been provided, the Chief Medical Officer and Credentialing Committee shall be notified.

The Quality Improvement Committee is responsible for assuring that corrective actions are implemented and follow-up monitoring occurs in non-emergent situations

A provider's practice pattern will be considered an exception to the norm or standard if:

- Data indicates that the pattern is greater than two standard deviations above or below the mean for the peer group (for those studies in which such measurement is available and relevant)
- More than 3 complaints or grievances in a single category which have been filed during the previous 6 months
- A pattern of documented failures to follow administrative procedures established by the Plan, after counseling by the Chief Medical Officer
- Any action or offense identified as reportable by state or federal law, or contract requirements.

# Quality Appeals and Grievances - Sanctioning and Fair Hearing

## The Sanctioning Process and Fair Hearing Procedure

### *Purpose*

To provide a clear and comprehensive mechanism for provider appeal/dispute in the event of any action or adverse determination related to any participating providers' participation status in matters of quality of care and/or services, to include matters of professional competency or conduct. To provide timeframes from initiation of the dispute resolution mechanism to notification of the outcome for the participating provider.

### *Definitions*

Fair Hearing: An appeals mechanism by which a provider of service may request review of a proposed adverse action.

## Policy

This policy shall be reviewed not less than annually with the involvement of participating providers minimally through the Quality Improvement Committee.

### Provisions

If the Credentialing Committee agrees that a deviation exists, the membership may request that the Chief Medical Officer counsel the provider. Such counseling should begin with written notification. The notification will include an opportunity for the provider to respond to the concerns identified.

The provider is given the option to respond either in writing or in person within 30 days of receipt of the letter.

Failure to respond to the letter within the designated timeframe may be interpreted by the Credentialing Committee as agreement by the practitioner with the concerns and recommendations contained in the Chief Medical Officer's letter.

Responses by the provider will be reviewed by the Credentialing Committee and used for evaluating the situation under review.

The committee may also direct that the Chief Medical Officer and provider develop a jointly agreed to plan of action. The Chief Medical Officer and provider will agree on a time frame for correcting the problem. After evaluating the plan and the time frames for correcting the problem, the Credentialing Committee will make both an interim and final recommendation to UHP regarding continued participation. After the time for correction has passed, the Credentialing Committee will review the provider's data again to determine if the practice pattern has been modified. Resolution of the matter which is acceptable to the  Committee will lead to a recommendation to UHP that continued participation be approved. Failure to resolve the matter (including disagreement by the affected provider as to the committee's assessment and position on the matter) may lead to a recommendation to UHP that continued participation is denied.

Such a decision is considered a sanction. In such cases an appeal process is available to the provider and is called a Fair Hearing.

## The Fair Hearing Process

When a situation occurs that is deemed to pose an immediate threat to the health and safety of consumers, the Chief Medical Officer may on behalf of UHP, the Quality Improvement Committee and the Credentials Committee, act to immediately revoke, limit or suspend the privileges of a participating provider. The affected provider will be immediately notified as will other affected parties (i.e.: Provider Relations, Utilization Management, Quality Management, and Plan Administration). In such an event, the Quality Improvement Committee will be assembled at the earliest possible time to hear the situation and support or override the Chief Medical Officer's (Medical Director's) decision. This shall be done on an expedited basis, usually within 7 business days of the suspension. As with all dispute resolution processes, any provider who is the subject of such actions may request access to the dispute resolution process for such an action.

## Provider Notification

Providers will be notified by letter, Certified Mail-Return Receipt Requested, of the decision of the Quality Improvement Committee. Providers may appeal decisions and actions of the Credentialing Committee by submitting a written request for an appeal or reconsideration and by providing additional information either in writing or in person. Please review Sanctioning and Fair Hearing / Section 8 for complete information.

Administrative matters shall be coordinated by Health Plan Administration and are described in Health Plan Administrative policies. There shall be a clear description of the dispute resolution process, including the methods for initiating the process, the right to present relevant information, and explicit time frames from initiation of the fair hearing mechanism, to notification of the outcome to the participating provider.

There shall be written notification of the fair hearing determination. All fair hearings are referred to a first level panel consisting of at least 3 qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute.

Providers may request consideration by a second level panel if the outcome of the first level panel is unfavorable to the provider who is the subject of the determination.

A second level panel shall consist of at least three qualified individuals, of which at least one must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute.

## The Sanctioning Process and Fair Hearing Procedure

The Sanctioning Process of UHP will follow the Health Care Quality Improvement Act of 1986. Due process will be conducted according to the procedures that follow.

## Notice of Proposed Action

The provider will be notified at the address included on the provider's application or the address maintained in the UHP system for provider payment or communication:

- A professional review action has been proposed
- Reasons for the proposed action
- The provider has the right to request a hearing on the proposed action within 30 days after receipt of the notice
- Summary of the hearing process.

## Procedure

**Notice of Hearing:** UHP shall provide for notice and a fair hearing to a provider in any case, except in cases of automatic suspension or limitation, in which action is proposed to be taken by UHP to

restrict, suspend or terminate the provider's ability to provide health care services, if same action is based on professional competence or professional conduct which affects or could adversely affect the health, safety or welfare of any patient and/or is reasonably likely to be detrimental to the delivery of quality patient care. If UHP takes an adverse action against a provider following the conduct of a fair hearing as provided in this Fair Hearing Procedure, UHP shall report such adverse action to the National Practitioner Data Bank pursuant to the Federal Health Care Quality Improvement Act and, as required by applicable state law, to the applicable state licensing/examining board.

**Final Proposed Adverse Action:** The procedures described in this Fair Hearing Procedure shall apply whenever an action is proposed to be taken by the UHP Chief Medical Officer on behalf of the Credentialing Committee to restrict, suspend or terminate a provider's ability to provide health care services to patients because of deficiencies in the providers quality of care, professional competence or professional conduct which affects or could adversely affect or is likely to be detrimental to the health, safety or welfare of any patient or to the delivery of quality patient care, the outcome of which if adverse would be required to be reported to the National Practitioner Data Bank under the federal Health Care Quality Improvement Act of 1986 or to the State Licensing Board/Agency under applicable state law. The process is available to any participating provider who is subject to suspension of their participation status.

**Role of Chief Medical Officer:** The Chief Medical Officer shall appoint a hearing panel on behalf of the Credentialing Committee in fulfilling its duties under Fair Hearing Procedure.

**Summary Action:** Nothing contained in this Fair Hearing Procedure shall limit or otherwise affect the authority of the Chief Medical Officer or Credentialing Committee to take action on behalf of UHP's Policy and Procedure for the restriction, suspension or termination of UHP's provider, including the duty to respond on an urgent basis to situations that pose an immediate threat to the health and safety of consumers. The terms of the summary action shall remain in effect pending the outcome of any hearing initiated by the provider pursuant to this Section of this Fair Hearing Procedure.

## Initiation of Hearing

**Grounds for Hearing:** Any 1 or more of the following actions, when taken or made based upon deficiencies in the quality of care, professional competence or professional conduct of a provider shall constitute "adverse actions" and grounds for a hearing:

- Termination of provider's ability to provide health care services to patients at any time
- Imposition or voluntary acceptance of restrictions on provider's ability to provide health care services to patients for 30 or more cumulative days in any 12-month period
- Imposition for a summary action which remains in effect for a period of more than 30 days.

**Notice of Adverse Action:** In all cases where an adverse action is proposed to be taken against a provider constituting grounds for a hearing, the Chief Medical Officer shall, within 10 days after making his or her decision to take adverse action, give practitioner written notice of the following:

- That an adverse action has been made or is proposed to be taken against the provider, which if adopted, shall be reported to the National Practitioner Data Bank pursuant to the

Federal Health Care Quality Improvement Act of 1986, as amended, and the applicable State licensing board or agency pursuant to applicable state law
- The reasons for the proposed adverse action (a specific statement of charges need not be included in the written notice)
- That the provider has a right to request a hearing on the proposed adverse action in accordance with this Fair Hearing Procedure within 30 days after receipt of the notice
- A summary of the provider's rights in connection with the hearing, as specified in this Fair Hearing Procedure.

**Request for Hearing:** A provider shall have 30 days following his or her receipt of notice of an adverse action to request a hearing on the proposed action. The request shall be given in writing to the Chief Medical Officer by personal delivery or by certified for registered mail and shall be deemed given upon receipt.

**Waiver:** Failure of the practitioner to request a hearing within the time and in the manner described above shall constitute a waiver of the hearing and of any review. In the case of such waiver, the provider shall be deemed to have accepted the Credentialing Committee's proposed action, and the proposed action shall become effective pending final action by the Board of Directors. The Credentialing Committee's proposed action shall be forwarded to the Board for review and final action of ratification.

## Hearing Prerequisites

**Notice and Time for Hearing:** Upon receiving notice, Chief Medical Officer shall set up hearing to occur within 45 days of receipt of the request for hearing. The Chief Medical Officer shall send written notice to the provider of the place, time, and date of the hearing at least 15 days prior to the established meeting date.

The notice to the provider shall contain:

- A list of the specific or representative patient records in question or other reasons or subject matter forming the basis for the adverse action
- A list of the witnesses, if any, expected to testify at the hearing. The notice shall specify that the provider may submit to the Chief Medical Officer within 10 days following receipt of the notice a list of witnesses expected to testify on behalf of the provider. The notice may state that the Chief Medical Officer reserves the right to amend the lists of documents, information, and witnesses. If so amended, notice shall be given to the provider.

**Request for Postponement:** A request for a postponement of a hearing and/or extension of time beyond the times stated in this plan shall be permitted only upon mutual agreement of the parties or by the hearing officer upon a showing of good cause.
**Failure to Appear or Proceed:** The personal presence of the provider who requested the hearing shall be required. Failure of the provider, without good cause, to appear and proceed at the hearing shall constitute a waiver of his or her right to a hearing and a voluntary acceptance of the adverse action, which shall become effective immediately. The matter shall be forwarded to UHP Board of Directors for review and final action or ratification.

**Hearing Panel and Officer:** If a hearing is requested on a timely basis (as per above) the hearing shall be held before a hearing panel of not less than 3 individuals appointed by UHP who did not participate in the prior decision. One member of the panel members should be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider who is the subject of the appeal and who is a clinical peer of the participating provider that filed the dispute.

A hearing officer shall be appointed by UHP, and shall maintain decorum and ensure that all participants have an opportunity to present relevant oral and documentary evidence. The hearing officer shall determine the order of procedure and make rulings on issues and matters.

A person shall be disqualified from serving as a hearing officer or on a hearing panel if he or she has participated in initiating the matter at issue (including participation in the original decision) or if he or she is in a personal or professional relationship with the provider. An individual serving as a hearing officer or as a member of a hearing panel need not be a physician or other health care provider. A confidentiality and conflict of interest statement will be obtained from this individual as well as panel members.

## Hearing Procedures

**Representation:** The provider who requested the hearing shall be entitled to be represented by an attorney or other person of his or her choice. The Credentialing Committee shall also be entitled to be represented by an attorney of choice and shall designate 1 or more persons to represent the facts in support of the adverse action and examine witnesses. The Chief Medical Officer shall appoint a representative of the Credentialing Committee to present the committee's proposed action and the facts in support of such action, to examine witnesses and to present evidence.

**Rights of Parties at Hearing:** Within reasonable limitations during the hearing, parties shall have the following rights: (a) to be provided with all of the information and evidence made available to the hearing officer; (b) to have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation thereof; (c) to call and examine witnesses on relevant matters; (d) to present and rebut any evidence in any format determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; (e) to introduce exhibits and documents relevant to the issues; and (f) to submit a written statement at the close of the hearing, provided, however, that these rights are exercised in an efficient and expeditious manner. If the provider does not testify on his or her own behalf, he or she may be called by the Credentialing Committee and examined as if under cross-examination.

Upon completion of the hearing, the provider shall have the following rights: (a) to receive the written recommendation of the hearing panel, including a statement of the basis for the recommendation(s); and (b) to receive a written decision of the UHP Board of Directors, including a statement of the basis for the decision.

**Admissibility of Evidence, Examination of Witnesses:** The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence and the

parties may present any evidence in any mutually acceptable format determined to be relevant by the hearing officer, regardless of its admissibility in a court of law. Any relevant evidence shall be admitted by the hearing officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of its admissibility in a court of law. The hearing officer may question the witnesses or call additional witnesses if it deems it appropriate. The hearing panel may request that oral evidence be taken only on oath or affirmation administered by a person entitled to notarize documents.

**Burdens of Presenting Evidence and Proof:** The burden of presenting evidence and the burden of proof during the hearing shall be as follows:

- The Credentialing Committee shall have the initial burden of presenting evidence, which supports the final proposed adverse action. The provider shall have the burden of presenting evidence in response
- The provider shall have the burden of proving, by clear and convincing evidence, that UHP adverse action lacks any substantial factual basis or that the conclusions drawn are arbitrary and capricious or unreasonable.

**Record:** A record or sufficiently accurate summary of the hearing shall be kept. The hearing officer may select the method to be used for making the record.

**Adjournment:** The hearing panel may recess, adjourn and reconvene the hearing without further notice for the convenience of the participants or to obtain additional evidence or consultation, with due consideration for reaching an expeditious conclusion to the hearing.

**Conclusion of Hearing:** At the conclusion of the presentation of evidence, the hearing shall be closed. The parties may, at the close of the hearing, submit a written statement. The hearing panel shall then, at a time convenient to itself, privately conduct its deliberation, reach a decision and adjourn the hearing.

## Decision of Hearing Panel

**Basis for Decision:** The decision of the hearing panel shall be based on the evidence produced at the hearing, including all logical and reasonable inferences drawn from the evidence and the testimony. This evidence may consist of the following: (a) oral testimony of witnesses; (b) briefs or written or oral arguments presented in connection with the hearing; (c) any material contained in the Credentialing Committee files regarding the practitioner who requested the hearing; and (d) any other evidence deemed admissible.

**Decision of Hearing Panel:** Within 15 days after adjournment of the hearing, the hearing panel shall prepare a written decision or report stating its findings of fact and recommendations, including a statement of the basis for the recommendations, and shall forward it to the Quality Improvement Committee who requested the hearing, and the UHP Board of Directors. If the provider is currently under suspension, however, the time for rendering the decision shall be 7 days. The notice shall contain information about the right to a second appeal and how to request such a hearing.

If the final proposed action adversely affects the ability of a provider to provide health care services to patients for a period longer than 30 days and is based on deficiencies in the providers quality of care, competence or professional conduct, then the recommendation shall state that the action, if adopted, will be reported to the National Practitioner Data Bank and the applicable State Licensing Board.

**Right of Second Appeal:** There shall be a second appeal of the decision of the hearing or panel upon request of the provider that was sanctioned by the UHP Credentialing Committee. The hearing panel and hearing officer shall consist of three qualified individuals who have not participated in prior decisions in this matter. At least one member of the panel shall be a participating provider who is not otherwise involved in network management and who is a clinical peer of the provider who is the subject of the appeal.

Time frames for request, notice and conduct of meeting shall be as per the first appeal (hearing). New relevant information may be presented by the appealing party as per guidelines.
Failure of the provider to request a second appeal within the specified timeframe 30 days will constitute an agreement with the decision rendered.

## NOTICE OF DECISION TO THE UHP QUALITY IMPROVEMENT COMMITTEE

**Review by the Quality Improvement Committee:** At its next regularly scheduled meeting, after receipt of the written recommendation of the hearing panel, the Credentialing Committee shall (a) review the report and recommendation of the hearing panel, the hearing record, any written statements and all other documentation relevant to the matter; and (b) consider whether to affirm or reject the recommendation of the hearing panel, or to refer the matter back to the hearing panel for further clarification.

**Final Decision by Credentialing Committee:** Upon completion of its review of the Hearing Panel's information and recommendations, the Credentialing Committee shall render a final decision concerning the restriction, suspension or termination of the provider's ability to provide health care services to patients, or any other corrective action.
The decision of the Credentialing Committee shall (a) be in writing, (b) specify the reasons for the action taken, (c) include the text of the report which shall be made to the National Practitioner Data Bank and the applicable state licensing board, if any, and (d) be delivered to the provider under review and the Chief Medical Officer at least 10 days prior to submission of a report to the National Practitioner Data Bank or the state licensing board.

Except where the matter is referred for further review and recommendations, the decision of the Credentialing Committee following completion of the procedures set forth in this Fair Hearing Procedure shall constitute the final action of UHP against the provider, shall be immediately effective and final and shall not be subject to further hearing or appellate review.

**Further Review:** If the matter is referred back to the Credentialing Committee or the hearing panel for further review, the Credentialing Committee or hearing panel shall promptly conduct its review and make its recommendation to the hearing panel and the UHP Board of Directors. This further review process and report back to the hearing panel and board shall in no event exceed 30 days in

duration except as the parties may otherwise stipulate. The board shall provide written final notice to the provider in this case within 10 days of a final determination.

**No Further Appeal Rights:** No provider shall be entitled as a matter of right to more than two appeals fair hearings on any single matter which shall have been the subject of an adverse action.

## Case Management

Case Managers on the Medical Management staff are available to discuss care and benefit options for catastrophic cases, as well as care that may require multidisciplinary or community services.

Health plan prior authorization requirements and prior authorization list can be found on the Member's health plan website.

Case Managers work with providers to coordinate care for complex catastrophic cases and are available to consult with providers about difficult or unusual situations. In the event that a member needs services not available through the network, the Case Management staff can work with the provider to locate an appropriate setting. Call the Case Management department at: (713)-579-7909

## Obligations of Recipients of Federal Funds

Providers participating in Medicare Advantage are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including, but not limited to:

- Title VI of the Civil Rights Act of 1964
- Rehabilitation Act of 1973
- Age Discrimination Act of 1975
- Americans with Disabilities Act of 1990.

UHP is prohibited from issuing payment to a provider or entity that appears on the "List of Excluded Individuals/Entities" as published by the Department of Health and Human Services Office of the Inspector General, on the CMS Preclusion list, or on the "List of Debarred Contractors" as published by the General Services Administration (with the possible exception of payment for emergency services under certification circumstances as defined by CMS).

The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities is at:

https://exclusions.oig.hhs.gov

The General Services Administration List of Debarred can be found at:

http://www.sam.gov/portal/SAM#1

Additional information about the program can be found at:

http://www.gsa.gov/portal/content/193147

## Medicare Advantage Star Ratings Performance Program

The Centers for Medicare and Medicaid Services (CMS) introduced the Star Ratings Quality Performance program in an effort to improve the quality of care and services for Medicare Advantage (MA) beneficiaries across all MA health plans, with an emphasis of quality of care outcomes and patient experience. CMS evaluates health and drug plans on quality and performance each year based on a 5 Star rating system. Ratings may change from one year to the next.

The health plan's STARS program is a comprehensive program dedicated to being a highly-rated plan, and is designed to foster provider and member engagement aimed to encourage wellness and preventive services that support continuous healthcare improvement. As a UHP provider, your commitment to providing quality care and services notably contributes to our achievement of high ratings.

CMS utilizes the following data sources to measure a plan's performance:

| Source | Measure Description |
|---|---|
| HEDIS™<br>(Healthcare Effectiveness Data and Information Set) | Claims data and medical record reviews used to validate those members are getting recommended medical services and that their chronic conditions. |
| CAHPS®<br>(Consumer Assessment of Healthcare Providers and Systems) | Annual CMS random patient experience survey results are utilized to measure member-perceived experiences and satisfaction with their healthcare providers and plan. |
| HOS<br>(Heath Outcomes Survey) | Patient-reported outcomes measure used in Medicare managed care utilizing a sampling of set survey results of members' health status over 2 years. Each spring a random sample of Medicare beneficiaries is drawn and surveyed from each participating Medicare Advantage Organization (MAO), with a minimum of 500 enrollees and resurveying 2 years later. |
| CMS Administrative Measures | These are measures that assess UHP's operations such as information from member complaints made directly to 1-800-MEDICARE, voluntary disenrollment, availability of foreign language interpreters and TTY, appeals timeliness, and appeals overturned by CMS' independent review entity (IRE). |

| | |
|---|---|
| Pharmacy Measures | Drug plans are compared to each other for outcomes and patient safety. Part D Star measures assess how often members with certain conditions get prescription drugs that are considered safer and clinically recommended for their condition. Also, how well the drug plan prices prescriptions and provides updated information on the Medicare plan finder website. |

## Star Rating Tips for Providers:

- Encourage patients to obtain preventive screenings when recommended by the U.S. Preventive Services Task Force (USPSTF).
- Implement processes to identify and intervene with noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Utilize CPT Category II codes to help ease the administrative burden of chart review for HEDIS™ performance measures.
- Understand how you impact each measure.
- Incorporate HOS questions into each visit. Sample surveys can be obtained from http://www.hosonline.org/en/survey-instrument/.
- Review the sample CAHPS® survey to identify opportunities for you or your office to have an impact: https://www.ahrq.gov/cahps/surveys-guidance/index.html.

## How can I use CPT 2 Codes to Close Gaps?

CPT Category II codes are a set of supplemental tracking codes that can be used for performance measurement. Submitting CPT Category II codes in addition to CPT or other codes used for billing will decrease the need for record abstraction and chart review, thereby minimizing your administrative burden for a number of quality-based initiatives including HEDIS®.
CPT Category II codes are billed in the procedure code field, just as CPT Category I codes are billed.
Please review the following CPT Category II codes. Although this is not a complete list, it includes the most common used for HEDIS®.

## HEDIS Reference Guide

| HEDIS Measure | Measure Description | CPT Category II Codes |
|---|---|---|
| Comprehensive Diabetes Care (CDC) | HgbA1c test & HgbA1c level | **3044F**-most recent HgbA1c <7%<br>**3045F**-most recent HgbA1c between 7-9%<br>**3046F**-most recent HbgA1c > 9% |
| | Eye exam | **2022F**-Documented and reviewed-dilated retinal eye exam with interpretation by an ophthalmologist or optometrist.<br>**2024F**-7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed. |

| | | |
|---|---|---|
| | | **2026F**-Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results documented and reviewed.<br>**2027F**- Low risk for retinopathy (no evidence of retinopathy in the prior year). |
| | Nephropathy screening | **3060F**-Positive microalbuminuria test result documented and reviewed.<br>**3061F**-Negative microalbuminuria test result documented and reviewed.<br>**3062F**-Positive macroalbuminuria test result documented and reviewed. |
| | Blood pressure readings | **3074F**-most recent systolic blood pressure <130 mm Hg.<br>**3075F**- most recent systolic blood pressure 130-139 mm Hg.<br>**3077F**- most recent systolic blood pressure > or = 140 mm Hg.<br>**3078F**-most recent diastolic blood pressure <80 mm Hg.<br>**3079F**- most recent diastolic blood pressure 80-89 mm Hg.<br>**3080F**-most recent diastolic blood pressure > or = 90 mm Hg. |

The following ICD-10

| HEDIS Measure | Measure Description | CPT Category II Codes |
|---|---|---|
| Controlling Blood Pressure (CBP) | Blood pressure readings | **3074F**-most recent systolic blood pressure <130 mm Hg.<br>**3075F**- most recent systolic blood pressure 130-139 mm Hg.<br>**3077F**- most recent systolic blood pressure > or = 140 mm Hg.<br>**3078F**-most recent diastolic blood pressure <80 mm Hg.<br>**3079F**- most recent diastolic blood pressure 80-89 mm Hg.<br>**3080F**-most recent diastolic blood pressure > or = 90 mm Hg. |
| Medication Reconciliation Post Discharge (MRP) | Medication reconciliation | **1111F**-Discharge medications reconciled with the current medication list in outpatient medical record. |

codes may be used in the same way CPT Category II codes are used for tracking adult BMI readings.

| Description | ICD-10 CM Code |
|---|---|
| BMI 20.0-20.9 | Z68.20 |
| BMI 21.0-21.9 | Z68.21 |
| BMI 22.0-22.9 | Z68.22 |
| BMI 23.0-23.9 | Z68.23 |
| BMI 24.0-24.9 | Z68.24 |

| | |
|---|---|
| BMI 25.0-25.9 | Z68.25 |
| BMI 26.0-26.9 | Z68.26 |
| BMI 27.0-27.9 | Z68.27 |
| BMI 28.0-28.9 | Z68.28 |
| BMI 29.0-29.9 | Z68.29 |
| BMI 30.0-30.9 | Z68.30 |
| BMI 31.0-31.9 | Z68.31 |
| BMI 32.0-32.9 | Z68.32 |
| BMI 33.0-33.9 | Z68.33 |
| BMI 34.0-34.9 | Z68.34 |
| BMI 35.0-35.9 | Z68.35 |
| **Description** | **ICD-10 CM Code** |
| BMI 36.0-36.9 | Z68.36 |
| BMI 37.0-37.9 | Z68.37 |
| BMI 38.0-38.9 | Z68.38 |
| BMI 39.0-39.9 | Z68.39 |
| BMI 40.0-44.9 | Z68.41 |
| BMI 45.0-49.9 | Z68.42 |
| BMI 50.0-59.9 | Z68.43 |
| BMI 60.0-69.9 | Z68.44 |
| BMI 70 or greater | Z68.45 |

References: American Medical Association
American Academy of Professional Coders
2019 HEDIS® Specs