
UnitedHealthcare Community Plan Kansas

MCO External Workgroup

August 2012

Claims Processing and Payment Systems

Prior Authorization

Provider Advocate staff are available in the State of KS to work with Providers and assist them with Claims payment issues as well as any prior authorization issues

Customer Call Center

Member Advocate staff will be located within the State of Kansas and will work closely with Member Services to assist members with any unresolved issues

State of KS Required Definitions

Clean Claim: A claim submitted in **accordance with 42 C.F.R. 447.45**, as amended from time to time, that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.

KS State Definitions, cont...

Medically Necessary or Medical Necessity: As defined in K.A.R. 30-5-58 (ooo)

- (1) A health intervention that is otherwise a Covered Service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:
 - (A) “Authority.” The health intervention is recommended by the treating physician and is determined to be necessary.
 - (B) “Purpose.” The health intervention has the purpose of treating a medical condition.
 - (C) “Scope.” The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
 - (D) “Evidence.” The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph three. For existing interventions, effectiveness shall be determined as provided in paragraph four.
 - (E) “Value.” The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. “Cost-effective” shall not necessarily be construed to mean the lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this definition of medical necessity. Interventions that do not meet this definition of medical necessity may be covered at the choice of United. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.
- (2) The following definitions shall apply to these terms only as they are used in this subsection;
 - (A) “Effective” means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
 - (B) “Health intervention” means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.
 - (C) “Health outcomes” means treatment results that affect health status as measured by the length or quality of a person’s life.

KS State Definitions, cont...

Prompt Payment. United will accept claims electronically by batch file upload or by direct data entry and shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract.

Timely Filing. Claims shall be received by United within the timeframe set forth in the Agreement but in no event shall United impose a timeframe such that United must receive claims from Provider less than 90 days from the date of service, or, in the event United is a secondary payer, in no event shall United impose a timeframe such that United must receive claims from Provider less than 90 days from the date Provider receives notice of adjudication from the primary payer. Provider may request an additional 30 days to submit a claim if good cause is shown and United shall not unreasonably deny Provider's request for an extension. Claims shall be submitted for Medicaid beneficiaries with retroactive eligibility in accordance with United's policy on retroactive eligibility as specified in the Provider Administrative Guide.

KS State Definitions, cont...

Prior Authorizations: All prior authorization reviews and communications will be conducted by United in compliance with all applicable state and federal laws, the State Contract and applicable attachments. United will establish a process that will allow Provider to submit and receive determination via a secure electronic transmission.

Compliance with State Contract: All tasks performed under the Agreement shall be performed in accordance with the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that United has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provision of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

Amendments: Any amendments or changes to United's Provider Manual and policies must be first approved by the State before promulgation. The State, also, requires United to communicate any approved amendments or changes in accordance with the relevant provisions of the State Contract. Amendments or changes will be communicated to Provider after State approval and in a manner consistent with the State Contract.

All of these definitions are required by the State of Kansas to insure standardization and are part of the Regulatory Appendix which is required to be included on all Provider contracts

Claims Processing and Payment Systems

Claims Payment

Objectives:

- 100% of all clean claims are processed within 20 days (90% of NF claims within 14 days)
- 99% of all non clean claims are processed within 45 days
- 100% of all claims are processed within 60 days

Providers may submit claims electronically or by paper

Claims payments will be issued twice a week, with additional payments being issued 5 days a week for categories such as HCBS and Nursing Facilities

Claims statuses may be reviewed via the same United Provider Portal that is currently in use by many Providers for our Commercial and Medicare products

Provider Advocates will be available throughout the State of KS to educate Providers and to assist them with escalation of claims payment issues

Claim Quality Program

Internal Quality Audits:

Statistical Review

- Weekly review of previous week's paid/denied claims
- Assess financial and procedural accuracy of claim processing
- Assess common cause and special cause variation

Claim Processor Review

- Examines sample of claim processors work on a daily basis to ensure on-going quality.
- Monthly random sample audit against claims processing instructions
- End to end sample audit against source of truth

Reporting

- Month-end reporting is distributed to front line and senior leadership for remediation and corrective action.

Prior Authorizations

Prior Authorization Submission

- UnitedHealthcare has limited prior authorization requirements in Kansas consistent with program guidelines and our standard practices
- Providers may submit authorization requests via the provider portal or the Prior Authorization call center which offers 24/7 coverage to members and providers.
- Prior Authorization intake coordinators enter authorization requests that are received by phone or fax.
- The services supported include initiating records of notifications and authorizations.
 - Auto approval if no medical review required
 - Update status and flag expedited reviews
 - Track pending notifications for authorizations needing medical review (communicate to providers)
- Care coordinators will also issue prior authorizations
 - Care coordinators will facilitate such requests on behalf of the providers



Prior Authorization Clinical Staff

- The clinical staff is available 24 hours per day, 7 days a week for service requests.
- Medical Director support:
 - There is a dedicated Medical Director resource to support Prior Authorizations with appropriate specialization to review cases. External review process is used as appropriate.
 - The requests that meet criteria may be approved by the Prior Authorization nursing staff. All adverse determinations are rendered by a Medical Director.
 - Peer to Peer discussion may occur when required by the state or requested by a physician.
 - Notice of outcome is communicated to the provider in accordance with the applicable Kansas state accreditation requirements. The notice of action letter is sent outlining the appeal rights if the service is not approved in part or in whole.



Customer Service

Member Services Overview

- Member toll-free number: 1-877-542-9238 (TTY: 711)
- Hours of operation: 8 a.m. and 8 p.m. Central Standard Time, Monday through Friday, excluding State declared holidays.
- Team of Customer Care Professionals (CCPs) will be located within the state of Kansas and trained on how to manage member calls effectively.
- Member Advocates will also be available within the State of KS and will work closely with Members and CCPs to insure all issues are resolved timely.
- Toll-free line will have an automated system available 24-hour a day, seven days a week
 - The option to talk directly to a nurse or other clinician (staffed 24x7)
 - Other member services options include speaking with:
 - A mental health specialist
 - Dental care specialist
 - Vision care specialist
 - Transportation coordination specialist
 - Pharmacy benefits specialist
 - The option to leave a message, including instructions on how to leave a message and when that message will be returned
 - All voicemail call-backs will be completed by close of business the following business day
 - Ability to submit an appeal or grievance for quick and efficient resolution

Training and focus on first call resolution

Current average member wait time for calls answered is 16 seconds
90% of member calls are answered in less than 30 seconds

Summary of Services

Sample List of Member Services Offered:

- Validation of member address and phone number (all calls)
- Explanation of policies and procedures
- Prior authorizations
- Eligibility questions/checks
- Benefit questions
- PCP questions, changes and appointments
- Care access information. If appropriate, member may be warm transferred to a clinical care coordinator for further support and servicing.

Interpreter Services:

- Translation services are available through our Language Line. All primary languages identified by Kansas are offered :
 - French
 - Spanish
 - Japanese
 - German
 - Vietnamese
 - Russian
 - Arabic
 - Korean
 - Chinese
- More than 140 languages are available so as additional languages needs are identified by census data, UHC can readily accommodate changing member needs
- Services for the blind or deaf, hard of hearing or speech-impaired

Creating the Local Connection

Oversight/Governance

Local Member Services Leadership:

- Focus on identifying local issues
- Address trends in member complaints or issues
- Define requirements and member experience process improvements
- Work to coordinate across all of operations teams to ensure local priorities and metrics are achieved

Metrics available and reviewed by Plan President

Availability for Plan President to listen in to actual calls

Regularly Schedule Meetings to review/discuss:

- Metrics and actual member calls
- Root drivers of metrics, member issues, call volume, etc
- Quality metrics and identify areas of improvement and training updates
- Marketing activities and impacts to call volumes and member questions
- Member Services communication plans

Highly trained 'Subject Matter Experts' embedded within Member Services available to:

- Answer Member Services questions real-time including KanCare program and state specific nuances
- Reinforce local member population needs
- Follow-up on escalated issues
- Coordinate with local leadership team to address issues in quality, member trends, performance, etc.

Questions?