MEDDATA SERVICE BUREAU

MEDTRON SOFTWARE INTELLIGENCE

050516 NEWS BLAST

UNITED HEALTHCARE – COMPASS PLANS, MORE INFO

****REQUIRES ELECTRONIC PCP REFERRALS****

United Healthcare (UHC) Compass is offered as an Individual Healthcare Exchange plan in certain states which include Louisiana and Mississippi. Members choose a primary care physician (PCP) to help them navigate to obtain high-quality, cost-effective care.

Compass network service area includes all counties/parishes in Louisiana and Mississippi.
No coverage is provided outside the network service area, except for emergency and urgent services.

To review more on the Louisiana Healthcare Exchange, see the websites: www.marketplace.cms.gov, www.healthcare.gov, and/or http://lahealthexchange.com/ and review the previously published newsblasts:

- 030916 United Healthcare – Compass Plans
- 080113 Healthcare Reform - The Marketplace
- 071813 Health Insurance Exchange How-To for Practices

NEWS FLASH!

Per an article dated April 22, 2016 in *The Advocate*, UHC is terminating all Healthcare Exchange plans at the end of 2016. In addition, Ochsner is withdrawing from the UHC Compass network effective May 15, 2016.
http://theadvocate.com/news/neworleans/neworleansnews/15566736-123/unitedhealth-ochsner-cutting-ties-likely-leaving-3000-in-no-area-without-local-health-provider

Provider Participation

If a provider participates in other UHC commercial benefit plans, the provider is considered a Compass network provider for the UHC Compass benefit plan if it is offered in his/her market, unless the plan is specifically excluded in his/her participation agreement. Providers will also be listed in the UHC provider directory for each benefit plan.

Not all providers will be included in every network as UHC is trying to create a more focused networks to meet member requests for additional options at affordable prices.

Providers can determine their UHC plan participation by reviewing the General Physician Directory:
https://www.unitedhealthcareonline.com/b2c/providerDirectoryAction.do

Identifying Patients

Because of the referral requirements for the UHC Compass plan, MEDTRON strongly encourages providers to use Online eligibility (ONELIG) via **MED**PM/**MED**EHR and/or the UHC website to identify patients' plan coverage at each visit. Providers should also review the patient's insurance card for plan specific information, specifically look for the word 'Compass' and for a PCP.

Insurance cards will display: 'United Healthcare Compass' and 'Referrals required' with PCP name and phone number.

UnitedHealthcare
Health Plan (80840) 911-87726-04
Member ID: 123456789 Group Number: 902725
Member: SUBSCRIBER SMITH
Mississippi's Hlth Ins Mktplc
Gold Compass 1300
Payer ID 87726
PCP: FIRSTNAME LASTNAME
PCP Phone: (999) 999-9999
Copays
Office: $15 ER $150
UrgCare: $75 Spec $30
OPTUMRx
Rx Bin: 610279
Rx PCN: 9999
RX Grp: UHEALTH
Referrals Required
UnitedHealthcare Compass-HSA
Underwritten by [Appropriate Legal Entity]
DOI-0501

Members: We're here to help. Check benefits, view claims, find a doctor, ask a question and more. PCP to send electronic referrals.
Web: myuhc.com
myNurseLine: 866-847-5298
Phone: 877-887-0441
Providers: 877-842-3210 or UnitedHealthcareOnline.com
Medical Claims: PO Box 740800, Atlanta GA 30374-0800
Shared Savings Logo Here
Pharmacists: 888-290-5416
Pharmacy Claims: OptumRx PO Box 29044, Hot Springs AR 71903

Online eligibility (ONELIG) F5 via **MED**PM/**MED**EHR through any United Healthcare Insurance Code will display 'Ins Type: C1 – Commercial United Healthcare Compass' and display patients' PCP. Validate the 'PCP information' from the F6 view ONELIG response from Patient Insurance Maintenance screen for the 'ins code'.

MEDPM: F6 view

```
                         ELIGIBILITY INFORMATION                  Date: 05/02/16
                                                                  Time: 10:57:21
Our Request# > 000490421        Web MD Transaction Reference No > 829529216
Patient No -->  42119212        Requested Elig Date ------------> 05/02/2016
Patient Name > AUGUST,VERA                    OL COMPASS PCP
Insured Name > AUGUST,VERA                                      Prv#/TID/NPI Sent
Insurance ---> COM  UNITED HEALTH / COMPASS                       1292305427
Policy No ---> 647038292
PCP ---------> CLINIC OF WELSH
Phone -------> 337/734-4500

 Subscriber Info: INSURED/SUBSCRIBER  is a PERSON  Name: AUGUST,VERA  ID
      Type: MEMBER ID #  ID: 647038292
 Reference ID Type: SOCIAL SECURITY #  Reference ID: 436820901
 Reference ID Type: GROUP #  Reference ID: 761682
 Address 1:647300 AUGUSTINE RD
 City: IOWA  State: LA  Zip: 706476129
 Date/Time Type: PREMIUM PAID TO DATE END  Date/Time Period: 05/31/2016
 Date/Time Type: PLAN BEGIN  Date/Time Period: 01/01/2016
 Elig/Benefit Info: ACTIVE-PENDING INVESTIGATION  Service Type: HEALTH BENEFIT
      PLAN COVERAGE
   Ins Type: C1-COMMERCIAL  UNITEDHEALTHCARE COMPASS
 Date/Time Type: PERIOD START  Date/Time Period: 06/01/2016
 Date/Time Type: PERIOD END  Date/Time Period: 08/31/2016
  INDIVIDUAL EXCHANGE GRACE PERIOD
                                                                       More...
   Information Retrieved on 05/02/2016 at 10:54 by ANGELA
 F3=Exit   F6=Print   F10=Move to top   F11=Go to bottom   F12=Prior screen
                                                                    DE002E-10
```

Information in these fields will update the Patient Insurance Maintenance screen

NOTE: INDIVIDUAL EXCHANGE GRACE PERIOD

MEDEHR:

INSURANCE ELIGIBILITY INFORMATION

OUR REQUEST NUMBER	437559
WEB MD TRANSACTION REFERENCE NUMBER	721190731
REQUESTED ELIGIBILITY DATE	12/18/2015
PATIENT ACCOUNT NUMBER	198819
PATIENT NAME	AARON, JESSICA
INSURED NAME	AARON, JESSICA
INSURANCE	COM COMPASS/UNITED HEALTHCARE
PROVIDER NUMBER /TID / NPI SENT	1649351529
POLICY NUMBER	947019019
PRIMARY CARE PHYSICIAN	HEINEN, JOHN
PRIMARY CARE PHYSICIAN PHONE NUMBER	(985) 652 - 3344

Information in these fields will update the Patient Insurance Maintenance screen

SUBSCRIBER INFO: INSURED/SUBSCRIBER IS A PERSON NAME: AARON, JESICA ID

TYPE: MEMBER ID # ID: 947019019

REFERENCE ID TYPE: SOCIAL SECURITY # REFERENCE ID: 468121102

REFERENCE ID TYPE: GROUP # REFERENCE ID: 902682

ADDRESS 1: 621 HIGHWAY 190

CITY: EDGARD STATE: LA ZIP: 700492420

DATE/TIME TYPE: PREMIUM PAID TO DATE END DATE/TIME PERIOD: 12/31/2015

DATE/TIME TYPE: PLAN BEGIN DATE/TIME PERIOD: 01/01/2015

ELIG/BENEFIT INFO: ACTIVE COVERAGE SERVICE TYPE: HEALTH BENEFIT PLAN COVERAGE

INS TYPE: **C1-COMMERCIAL UNITEDHEALTHCARE COMPASS**

To house and track the referral requirements unique to the UHC Compass plan, if per ONELIG or UHC website or copy of patients insurance card, patient is identified as having a UHC Compass plan, MEDTRON suggests use of a special unique Ins Code: COM

```
Mode: DISPLAY          INSURANCE COMPANY MASTER              Date: 02/26/16
                                                              Time: 09:00:25

Status Code ------> _
Company Code -----> COM
Insurance Type ---> O (F4)

Carrier Aff ------> UHC UNITED HLTHCARE-ALL ELSE
Company Name -----> COMPASS/UNITED HEALTHCARE
Group Name -------> _________________________

Address Line 1 ---> P O BOX 740800
Address Line 2 --->
City/State/Zip ---> ATLANTA         GA (F4) 303740800  Country -> US (F4)
Telephone --------> 877-842-3210  Extension: ____
Fax --------------> ____________  Prt on Clm: _ (Y/N)
Web Address ------> ________________________________________
E-mail Address ---> ________________________________________

Alt DME Carrier --> N (Y/N)

Prov #: NO  Pol Edt: YES    Last Changed:  1/12/2016 @  9:22:23 by TRACY
 F3=Exit   F8=Policy # Edits   F11=Provider Numbers   F12=Prior Screen
                                                        1 of 5  DE200-01
```

At Patient Insurance Maintenance screen:

- Update fields:
  - 'Referral Req' → Y
  - 'Pri Care Phy' → key PCP name and phone #

NOTE: If provider is PCP, 'Referral Req' → N.
NOTE: If multi-specialty practice and PCP is a member of the group, i.e., same TID, 'Referral Req' → M.

```
Mode: DISPLAY        PATIENT INSURANCE MAINTENANCE           Date: 02/26/16
                                                              Time: 09:02:46

Patient:   1020662 - AARON, JESSICA  B

Status Code ------> _
Insurance Code ---> COM      Company Name -----> COMPASS/UNITED HEALTHCARE

Pri/Sec ----------> P        Rel to Insured ---> M (S,C,M,O)
Plan Type --------> _____    Insured (P,R,O) --> O AARON, ANTHONY

Group/Plan -------> 902682                   Effective ----> 11/01/2015
Policy Number ----> 970826313                Expires ------> __________

Coverage Verification   OL ELIG PCP 02/18/2016   Co-Pay Amounts
Contact-----------> ________________________ Primary Care ---> ________
Phone ------------> ____________ Ext-> ______ After Hours ----> ________
MSP Type ---------> __                        SPC ------------> ________
Referral Req -----> Y                         X-Spcl ---------> ________
Pri Care Phy -----> PATEL,HARSHAD 5044663702  L-Spcl ---------> ________
                                              DftCoI ---------> ________
OUTSTANDING CLAIMS ON FILE           Last Changed 10/29/2015 by MOLLYB
 F3=Exit   F5=Rqst Elig   F6=Dsp Elig   F12=Prior Screen   F24=More Keys
                                                                DE002-01
```

At Patient Demographics, Add/Change Patient Information screen:

- Update fields:
  - 'Master Comment Line (MCL)' → COMPASS PLAN PER ONLINE ELIG: REQUIRES REFERRAL FROM PCP

If F5 Online Eligibility is requested via **MED**PM/**MED**EHR, the PCP information is automatically updated to the Patient Insurance Maintenance screen, and for MEDDATA clients, 'Referral Req' → Y. MEDTRON strongly suggests review of the F6 view ONELIG response to confirm information available.

DASHBOARD | PATIENT INFO | TASKS | REPORTS | RECOVERY ROOM | CONTROL PANEL | MESSAGES | TO DO LIST | REFILL REQUEST | NEW RX QUEUE | DIAGNOSTICS | IMAGE RESULTS

PATIENT : 1020662, JESSICA AARON, 05/16/1975, 438-12-1102

ELIGIBILITY MESSAGE Y — DISPLAY ELIGIBILITY | INS COMPANY | POLICY # EDIT

POLICY	
INSURANCE CODE	COM COMPASS/UNITED HEALTHCARE **OUTSTANDING CLAIMS ON FILE**
INSURANCE COMPANY NAME OVERRIDE	
PRIMARY / SECONDARY	P
RELATIONSHIP TO INSURED	S
INSURED	P AARON, JESSICA
GROUP / PLAN TYPE	902682 /
POLICY NUMBER	947019019
EFFECTIVE DATE	01/01/2015
EXPIRATION DATE	
COVERAGE VERIFICATION	
CONTACT	
PHONE / EXTENSION	/
MEDICARE SECONDARY PAYER TYPE	
REFERRAL REQUIRED	Y
PRIMARY CARE PHYSICIAN	PATEL,HARSHAD 5044663702

Referrals

The member's Primary Care Physician (PCP) coordinates the member's care and via the website generates **online electronic referrals** to network specialists. **PCPs cannot provide referrals via phone, fax or paper!** Referrals must be submitted by the PCP to UHC prior to the member seeking care with any network physician who is not practicing under the same TIN as the PCP. **If the PCP does not follow referral requirements, the member may face financial penalties.**

Each electronic PCP referral may include **up to six visits**. Any unused visits **expire after six months** from the date the referral was entered. After the six visits are used or expire, the PCP may submit another referral to the network specialist for up to six visits. The referral is effective immediately and will be viewable online within 48 hours.

Per calls to UHC Compass, and email to Amy Spivey with UHC (030816):
PCP referral numbers will start with the letter 'R' followed by 9 digits and are not required on the claim.
If billing for a specialist, the PCP name is not required to be on the claim as long as the PCP the member is assigned to matches the PCP referral on file with UHC. A primary care provider providing services must be the patient's PCP of record (per online eligibility) or obtain PCP referral from listed PCP.

For members with certain chronic conditions, the online referral screen allows standing referrals to be entered for 99 visits if the member's diagnosis is included in the Referrals for Chronic Conditions policy on www.unitedhealthcareonline.com.

Referral Submission Requirements:

- Referrals must be submitted by the member's PCP or a PCP with the same tax ID number.
- Users must have security access to submit referrals and check referral status.
- Referrals can be backdated up to five days prior to the date of entry and have a start date of date of submission or a future date

To learn how to request/submit/view referrals, go to www.unitedhealhcareonline.com > Help > Quick Reference > Referral Submission & Status.

Eligible services that **do not require a PCP referral** include:

- Services from physicians with the same tax ID as the member's PCP
- Network obstetricians/gynecologists, including perinatologists
- Network urgent care centers or convenience clinics
- Routine refractive eye exams from network providers
- Mental health disorder and substance abuse services from network behavioral health clinicians
- Services from pathologists, radiologists or anesthesiologists
- Services in any emergency room or emergency ambulance
- Physician services for emergency/unscheduled admissions
- Any services from inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons, or network team surgeons
- Any non-physician services, i.e., not billed by a physician specialist, including:
  - Outpatient labs, x-rays or diagnostics
  - Physical therapy, network rehabilitation services, with the exception of physician services such as manipulative treatment and vision therapy
  - Durable medical equipment, home health, prosthetic devices and hearing aids

Specialists must confirm a referral is on file prior to seeing the member, see above Status. The information also determines member benefits, since some plans either have no benefit or higher member cost share if a referral is not obtained. Facilities should also confirm the referral is on file for the admitting specialist for planned admissions.

If the member **does not** have a referral to see the specialist for planned admissions, then the facility and specialist claims will be denied for no referral. **However, unlike many managed care plans, the member is responsible and can be billed!**

Plan Models	Network Provider With Referral	Network Provider Without Referral	Non-network Provider*
Compass	Network benefits	No coverage*	No coverage
Compass Balanced	Network benefits	Lower-level benefit	No coverage
Compass Plus	Network benefits	Lower-level benefit	Non-network benefit

** Except for emergency services and related admissions.*

Prior Authorizations (PA#)

Advance notification and prior authorization is required for certain planned services so UHC can determine if the services are covered under the member's benefits. Prior authorization is granted only for services determined to be medically necessary according to the member's benefit plan and applicable policies and guidelines; and may be required in addition to a PCP referral on file.

The Notification Requirements section of the UHC Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("Administrative Guide") covers protocols about services requiring advance notification and prior authorization and the process for providing advance notification. It is the physician's responsibility to follow the advance notification or prior authorization procedures as outlined in the Administrative Guide.
https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/100-6088_UHC_admin_guide_2011_bookmarked.pdf

Admission notification is required for every inpatient admission. The admission notification requirement applies even if a referral or prior authorization is on file. Admission notification is the hospital's responsibility, as outlined in the current Administrative Guide

Prior authorization or notification requests that also require a referral will not be accepted unless a completed referral is on file with UHC.

The responsibly of obtaining prior authorization resides with the ordering/rendering provider whether it be the PCP or a specialist with an active PCP referral.

Three Month Grace Period for Patients

Health plans are required per The Patient Protection and Affordable Care Act (PPACA) to provide a rolling three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Exchange. The grace period applies to those who receive Federal subsidy assistance in the form of an advanced premium tax credit, and who have paid at least one full month's premium within the benefit year. It is only triggered when a member that receives federal subsidies does not pay their portion of the monthly premium.
https://www.uhc.com/content/dam/uhcdotcom/en/HealthReform/PDF/Provider/Three_Month_Grace_Period.pdf

How the grace period works:

- **Month One** – UHC will process or pay claims even if the member has not paid their premium.
- **Months Two and Three** – UHC will send a letter to the primary care provider advising them that the member is delinquent in paying their premium and their claims cannot be processed until the member's full premium payment is received by the end of the three-month grace period. A copy of the letter is also sent to the member. During this time, the member **may not** be balanced billed since they still have coverage through the health plan.
- **After Three-Month Grace Period** – If premiums are paid in full within the three-month grace period, claims will be released for processing. If the premium is not paid in full by the end of the grace period, the member's health plan will be **retroactively terminated** to the end of the first month. Any claims for services received during the second and third months of the grace period will be **denied**. This means care providers may not be paid, or may be **required to refund any payments** made by UHC, for services the member received in the last two months of the grace period. Care providers would have to **seek payment for their services directly from the member**.

Providers **must** review online eligibility via **MED**PM, **MED**EHR and/or UHC website to verify if patient has paid premiums.

UHC added an "Exchange participant claim eligible through date" at the bottom-right of the Eligibility and Benefits screen for care providers to indicate if the member has paid premiums in full or is delinquent.

If the "claim eligible through date" has passed, the member is in a grace period pending termination due to payment default. The "claim eligible through date" is the beginning of the three-month grace period, and claims would only be paid for one month out of the three if the member's coverage is terminated due to non-payment.

Patient Search

Eligibility for:	Firstname1 Lastname1 (click on pulldown menu for next patient)	View Patient's ID Card View Health Messages	
Subscriber #:	123456789	Effective Date:	mm/dd/yyyy
Group #:	123456	Termination Date:	mm/dd/yyyy
Product:	Choice Plus	Funding Status:	Not Available
Insurance Type:	Commercial	Eligible for Language Assistance:	No
Electronic Payer ID:	Child	Verbal Language Preference:	
Claims Address:	P.O. Box 12345 Anytown, NY 12345	Written Language Preference:	
HRA Balance:	Not Available	Exchange participant claim eligible through: 1	mm/dd/yyyy 2

MEDPM/**MED**EHR Eligibility will display:

```
Date/Time Type: PREMIUM PAID TO DATE END  Date/Time Period: 05/31/2016
Date/Time Type: PLAN BEGIN  Date/Time Period: 01/01/2016
Elig/Benefit Info: ACTIVE-PENDING INVESTIGATION  Service Type: HEALTH BENEFIT
     PLAN COVERAGE
  Ins Type: C1-COMMERCIAL  UNITEDHEALTHCARE COMPASS
Date/Time Type: PERIOD START  Date/Time Period: 06/01/2016
Date/Time Type: PERIOD END  Date/Time Period: 08/31/2016
INDIVIDUAL EXCHANGE GRACE PERIOD
```

NOTE: The grace period starts over each time the member defaults on their premium.

Billing Patients

In accordance with the terms of the participation agreement, **providers may bill a member for non-covered services** under certain circumstances.

REMINDER: Most Exchange plans have high deductibles and/or coinsurance amounts that patient must meet before plan plans a portion of services rendered.

For example, while joint replacements are generally covered benefits, a medical necessity review (*assume when authorization requested)* may determine a particular joint replacement for a member is not covered. If the services you provide are not covered under the member's benefit plan for reason of not being medically necessary, you may bill the member **only if** he/she has been informed of the decision of non-coverage prior to the date of the service and have specifically agreed in writing to accept financial responsibility. The written agreement must indicate the member understands UHC has determined the service is non-covered and the member chooses to receive the service and be financially responsible for payment.

For all services to Compass patients MEDTRON suggests completing a Verification of Benefits (VOB) which should include any out of pocket information (cost share, deductible, coinsurance) and request for prior authorization and confirm PCP referral on file for all services and use of an Advanced Beneficiary Notice (ABN).

MEDTRON emailed Amy Spivey, UHC representative to clarify if providers can bill patients if the referral is not obtained:

From: Spivey, Amy C [mailto:amy_c_spivey@uhc.com]
Sent: Wednesday, October 28, 2015 11:26 AM
Subject: RE: UHC Compass plan / 102715
For a United Healthcare Compass or Navigate member, the Member is responsible for obtaining a referral from the PCP prior to seeking services with the specialist. If the member see's the specialist without a referral the Member is responsible, and **you (the provider) may bill the patient**. Normally when this happens it only happens 1 time then the patient fully understands that they have to have a referral in place before seeing a specialist (through 2015, a one-time exemption was allowed, however that reprieve has been retired).

Resources

UHC Compass:

https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=c8cd9c8e9633e310VgnVCM2000002a4ab10a
https://www.hcms.org/uploadedFiles/Harris_County_Medical_Society/Practice_Resources/Payers/Health_Insurance_Marketplace/External%20Compass%20Product%20Overview%20PCA14826_Final%2012032014%20HCMS.pdf

Contact Software Support for assistance or any questions via:

From **MED**PM or **MED**EHR Sign On screens, double click on 'support@medtronsoftware.com' to compose an email to the Software Support Dept.

-OR-

Phone: (985) 234-0599 (local), (800) 978-0599 (toll free)

-OR-

Fax: (985) 234-0609