Network Notes

United Behavioral Health News and Updates UBH Network Clinicians and Facilities

FALL 2010

VP Corner By Michelle Brennan-Cooke, Ph.D.

This has been a very busy and exciting year. We, along with our parent company, UnitedHealth Group, have been engaged in national and regional discussions related to Healthcare Modernization. We have been working with health plans to pave the way for effective implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. We have reviewed existing programs and looked for ways to improve our efficiency and our collaboration with partners such as you.

OUR MISSION
To provide evidence-based health and wellness programs that empower the people we serve to lead healthier and more productive lives.

All of this has caused me to pause and reflect on just a few of your contributions to the success of our mission to help people lead healthier and more productive lives through evidence-based health and wellness services:

ALERT® (**Al**gorithms for **E**ffective **R**eporting and **T**reatment) – When you submit Wellness Assessments (WA), you are engaging in an outcomes measurement process. Comparison of subsequent WA submissions to baseline WA global distress scores measures clinical change over time.

Campaign for Excellence (CFE) – When you enroll in CFE, you are joining colleagues who recognize that achieving sound clinical outcomes is the key measure of quality.

Facility Quality Measure (FQM) – Facilities who qualify for FQM receive a scorecard and are taking a collaborative approach to improving quality processes and clinical outcomes.

HEDIS® **Follow-up After Hospitalization (FUH) and Antidepressant Medication Management (AMM) Measures** – We appreciate your help in providing timely follow-up appointments for patients leaving the hospital and in supporting patient compliance with depression management guidelines.

Brain Solutions – We continue to develop creative programs that our members can use to improve brain health. We appreciate your coordination with your UBH patients and care advocates to offer these new programs.

Looking ahead, you can expect more innovations as we leverage online capabilities for treatment services and efficient solutions to your administrative functions. With plenty of changes on the horizon for all of healthcare, we are committed to working with you to simplify processes to meet the needs of the individuals we serve.

Parity News – You can expect to see greater variance in your patients' benefits. This is because, for applicable plans, the Mental Health/Substance Use benefits must mirror the medical plans offered. For example, some companies offer multiple medical plans for their employees and we will be aligning the behavioral benefits

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to those different plans. It is more important than ever that you contact us for benefit information to determine both coverage and certification or notification requirements.

Parity Reminders:

- The effective date of the law is tied to the benefit plan renewal. So, beginning July 1, 2010 and continuing forward as each individual plan renews, your patients covered under applicable plans will be phasing into the new parity coverage as their benefit plan is renewed.

- The new Parity regulations do not apply to all plans; exclusions include, but are not limited to, small employer groups (under 50 employees).

- Some public sector plan offerings are awaiting separate regulations in compliance with the law.

- Continue to seek prior certification for services as you do today. Your standard benefit inquiry results will include notice about prior certification or notification requirements.

- Please visit Parity Corner on the home page of ubhonline to link to our Parity Information Resources page. We will post updates and resources on a regular basis so return often to see what's new.

- We strongly encourage both outpatient and facility providers to become registered users of ubhonline. You can make critical eligibility and benefit inquiries in real-time and track the status of claims. (See New to the Network article on page 8 for more reminders about online capabilities.)

Together we will continue to empower the people we serve to lead healthier and more productive lives.

Crisis Management Can Involve More Than Simply Calling 911

By M. J. Bailey, M.D., USBHPC Chief Medical Director &
D. J. Arsenault, MFT, Ph.D., ALERT Care Advocate & Psychological Assistant

It's your last psychotherapy session of the workday. During this time, your patient is extremely tearful, anxious, unfocused, admits suicidal ideation, and struggles to plan for safety. You switch into assessment mode to determine how well he can handle weekend stressors. You find that he has not slept well the past few nights and has discontinued anxiolytic medication against medical advice. Looking at the clock, you realize that the session time has flown by. It's 4:58 pm on a Friday afternoon and you have plans after work. The patient states that a significant other will be present all weekend for assistance. As you consider what to do, you grow tense, wondering if you will need to pick up the phone to call 911. Obviously your patient is in crisis. What do you do?

Dealing with patient crises is nothing new for health care providers. A crisis arises when a situation or event is distressing enough to be overwhelming and cannot be managed with usual coping mechanisms (Kavan, Guck, & Baron, 2006). The patient is in distress and seeks relief. This is often when patients come in for therapy, see their physician, or even seek help through emergency services. In 2007, one out of eight emergency department visits were related to mental health and/or substance abuse diagnoses, with about 40% of these related visits resulting in hospitalization (Owens, Mutter, & Stocks, 2010). However, as the volume of mental health referrals to the emergency departments increase, concerns have been raised that this overcrowding may decrease the quality of care for these and other patients in these facilities as well as increasing the likelihood of medical errors or adverse outcomes.

As healthcare providers, we all have varying skills in crisis assessment and intervention. Crisis intervention can be thought of as a sequence of stages through which distress is identified, stabilized, and reduced, with a return to previous functioning ideally with intrapersonal growth (Everly, 2000). While there may be an initial impulse to call emergency services in crisis situations, it is not always necessary or indicated. Aiding the patient in the successful management of a crisis outside of the psychotherapy session can be helpful to a patient's therapeutic progress and self-efficacy. In addition, the therapeutic alliance is enhanced by the collaboration you achieve with the patient to assist in the resolution of the crisis.

Understanding the nature of the crisis, the contributing factors and the patient's ability to cope with the crisis are all effective in determining which interventions are most appropriate in a given situation. As we know, each patient has particular strengths that can be utilized for managing crises and improving functioning. In the case scenario, you remember that he is high

functioning and can be counted on to be proactive in seeking care, yet open to collaboration on problem-solving.

To identify the distress in the introductory scenario above, the patient may be questioned regarding the nature and intensity of the experienced stress. Kavan et al's approach is to first support the patient and normalize the crisis. Continuing our scenario, he reveals feeling despondent over a family member's death, recounts experiences of minimization from others when seeking support for grieving, and notes passive suicidal ideation about wanting to get away from it all. There is a history of psychiatric hospitalization several years ago. As the provider, using listening skills and reflecting back what is heard can be helpful. Noting that this level of distress may be normal reaction to a loss can be helpful to the patient.

A risk assessment to ensure the safety of the patient and others is the next step. Any potential safety issues, such as suicidal ideation, dangerousness to others, psychosis, substance abuse, medical illness, etc, should be addressed immediately. While interventions may include voluntary or involuntary hospitalization, other options include close monitoring through friends or family, or arranging for the patient to be removed from what may be an overwhelming environment.

Next, development of an action plan can be undertaken to stabilize the crisis, with the patient as an active, rather than passive, collaborator. The goal of this stage is to foster the understanding that responses to the crisis can be managed by creating a plan and working within it. To alleviate the physiological arousal, mindfulness techniques such as relaxation exercises and deep breathing techniques can help him to recognize his level of control over responding to the crisis. Social support can be utilized in order to assist in working through the crisis. Identification and incorporation of support within his occupational, social and/or religious structure is the goal

of this stage. For example, does he have any friends upon whom he can rely? If he is employed, are there any colleagues who might lend assistance and provide support? If he is involved in the community, perhaps there is a key figure who can offer assistance, by meeting with him and talking about concerns. In the above scenario, you find that he attends a local church each Sunday and knows the pastor. You offer to assist in calling the pastor to set up an appointment for tomorrow. In addition you find that his significant other will be present all weekend. You suggest he make a call within the session to request support from the significant other, offering to coach during the conversation, as needed.

A review of the patient's insurance benefit can be helpful. Assisting the overwhelmed patient by calling the insurance company is a quick way to get information about benefit coverage of different treatment options being considered. Additionally, incorporation of other healthcare resources may be helpful, such as his primary care physician and other healthcare providers to develop a comprehensive treatment plan. In this scenario, it was discovered that the patient had discontinued anxiolytic medication because of side effects. Coordinating an urgent consultation and/or appointment with the prescriber allows this obstacle to be addressed and resolved quickly and effectively.

As part of returning to previous functioning and contributing to

intrapersonal growth, assess the crisis management once the crisis has been surmounted. See if any additional assistance might be helpful at that time. Commend the patient for coming in for assistance, for working through the action plan, and for any gains resulting from the management of the crisis. Guide him to learn from the situation and grow from the experience. At this point when the crisis is past, an action plan can be set up in the event of future crises, with the patient leading the discussion. Careful consideration of crisis factors, along with identification and implementation of potential support figures, can result in the successful management of suicidal ideation and better patient care. Planning in advance with difficult patients can help reduce the sense of being overwhelmed when these crisis scenarios occur at 4:58 pm on a Friday afternoon.

For Further Reading

Everly, G.S. (2000). Editorial: Five principles of crisis intervention: Reducing the risk of premature crisis intervention. International Journal of Emergency Mental Health, Issue 1, pp 1-4.

Kavan, M.G., Guck, T. P, & Barone, E.J. (2006). A practical guide to crisis management. American Academy of Family Physicians, Issue 74, pp 1159-1164. Downloaded from www.aafp.org/afp

Owens, P. L., Mutter, R, & Stocks, C. (2010). Mental health and substance abuse-related emergency department visits among adults, 2007. Healthcare Cost and Utilization Project, Issue 92, pp 1-12.

What is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS®) is the leading set of standardized healthcare performance measures. Designed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS allows comparisons among managed care plans. HEDIS reports on major public health issues such as cancer, heart disease, smoking, depression, and diabetes. HEDIS includes four major measures related to behavioral health services in the United States:

• Follow-Up After Hospitalization for Mental Illness

• Antidepressant Medication Management

• Follow-Up Care for Children Prescribed ADHD (Attention-Deficit/Hyperactivity Disorder) Medication

• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

The measures correspond with best clinical practices and are based on scientific evidence. By standardizing these measures, NCQA has established a level playing field on which managed behavioral health organizations — and their clinician networks — can compete. With your help, the quality of care delivered to health plan enrollees will improve.

NCQA publishes the results for the HEDIS measures in its State of Health Care Quality (SOHCQ) report. The SOHCQ is available for free download at www.ncqa.org. From the NCQA home page left sidebar menu, select "Newsroom" and then select "State of Health Care Quality". In the 2009

SOHCQ, NCQA noted that behavioral health measures had not improved over the last several years and remained at a relatively low level. UBH actively works to improve the HEDIS rates of its customer health plans. You may receive mailings or faxes from us with our recommendations on how to comply with the HEDIS measures. In addition, we may call you to find out if a patient has kept an appointment with you. We appreciate your cooperation with these activities, and appreciate any feedback you have about what we can do to help you meet these measures. You can contact our Quality Improvement department at qimail@uhc.com.

Important Tax Notice: Change of Tax Identification Number (TIN) will affect the Form 1099-MISC for tax year 2010

The final legal merger of PacifiCare Behavioral Health, Inc. and PacifiCare Behavioral Health of California, Inc (PacifiCare) into UnitedHealth Group's behavioral health operations under United Behavioral Health (UBH) and U.S. Behavioral Health Plan, California (USBHPC), respectively, is now complete. **Therefore, effective July 2, 2010, the Tax Identification Numbers**

(TIN) for PacifiCare have changed as outlined in the following table.

For the 2010 tax year, these TIN changes will only be reflected on the Form1099-MISC that you receive from UBH and/or USBHPC. Providers seeing this membership have and will continue to receive payments from PacifiCare (checks will continue to reflect the PacifiCare brand).

It is important that you be aware that all payments you received in 2010 for services provided to PacifiCare membership will be reported in the Form 1099-MISC that you receive from UBH and/or USBHPC. The Form 1099-MISC for the 2010 tax year will be sent to you in 2011 in accordance with federal timelines.

PacifiCare Entity	Old TIN (retiring)	New TIN July 2, 2010	1099-MISC Issuer
PacifiCare Behavioral Health, Inc. (PBH)	33-0538634	94-2649097	United Behavioral Health (UBH)
PacifiCare Behavioral Health of California, Inc. (PBHC)	95-4166547	94-3077084	U.S. Behavioral Health Plan, California (USBHPC)

EAP Claim Submissions – Ensuring Timely Payment

As announced in May, the claim submission requirements for EAP services are being standardized. **Effective October 1, 2010, claim submissions using formerly accepted proprietary claim forms or codes will no longer be accepted and will delay payment.**

Claims for EAP services must be filed on ubhonline (available through secure Transactions for registered users) or using an Electronic Data Interchange or CMS-1500 form. In all cases, the "HJ" modifier code, signifying EAP service, must be placed in the modifier field next to the appropriate CPT billing code. For example, CPT code 90806, Individual Therapy, modified with "HJ", indicates an individual appointment for an EAP service. For more information, visit the HJ Requirements page of ubhonline.

Keep Practice information Up to Date

Members need to have an accurate and up-to-date list of practitioners who are easily accessible and can address their particular clinical needs. As a network clinician, it is your contractual responsibility to notify us when there is a demographic change pertaining to your practice, when your practice is full, or when you are not able to accept new UBH patients for any reason. You may initiate these changes in our system by:

- Submitting the change directly on ubhonline at "My Practice Info" using the secure "Transactions" available only to registered users

- Select "Contact Us" from the right side of the horizontal menu bar on ubhonline, select "Provider Record Maintencance – Demographic and Tax Identification Number (TIN) Changes and Updates" then complete and fax the Clinician Add/Change form to the Network Management team for your state

Please note that both fax and phone number information for your Network Management teams are available through the "Search for Network Management Staff" feature on the "Contact Us" page.

It is vital that you inform us directly of any and all changes within your practice so we can provide accurate contact information to individuals seeking behavioral health care services. In addition, notifying UBH of changes to your practice information ensures new patient referrals can reach you and helps to prevent potential claims payment issues.

Important Demographic Update Reminder

Sending updated demographic information to UBH Claims or through CAQH does not get it updated in the UBH systems. Please make changes or provide updates through ubhonline or fax to your Network Management team.

The following practice information may also be updated directly on ubhonline:

- Changes in practice location, billing address, telephone or fax number

- Your Tax Identification Number (TIN) used for claims filing

- The programs you offer (services you provide must continue to meet our credentialing criteria) and the hours you are available

- Languages you speak and your areas of expertise

Network Management remains the appropriate contact regarding your availability in the UBH Network.

Revised Credentialing Plan Posted

The UBH Clinician and Facility Credentialing Plan has been revised. You can find the updated Plan on ubhonline under Guidelines/Policies > Credentialing Plans.

To request a paper copy, please contact Network Management.

Maintaining Clinical Gains through Effective Discharge and Treatment Follow-up

Effective discharge planning is key to ensuring the ongoing health and well-being of a patient following acute care. Timely follow-up after hospitalization promotes continuity of care and supports a patient's return to baseline functioning. That's why UBH has adopted HEDIS® measures that the National Committee for Quality Assurance (NCQA) developed and healthcare purchasers rely upon to assess follow-up after hospitalization for mental illness.

NCQA guidelines state:

- Follow-up should occur with a behavioral health clinician within seven (7) days of discharge

- Follow-up should occur with a behavioral health clinician within 30-days of discharge

Follow-up within seven (7) days is optimal as it:

- Facilitates stabilization

- Increases the likelihood that gains made during the hospitalization will not be lost

- Detects early post-hospitalization reactions or medication problems

- Provides on-going evaluation, education and treatment

- Improves treatment outcomes by reducing the occurrence of re-hospitalization

Care Advocates work closely with hospital discharge planners to ensure that a timely post-discharge follow-up appointment has been scheduled with a practitioner before a UBH member leaves the hospital. This is especially important for those individuals who did not have a relationship with a behavioral health practitioner prior to their hospital admission. Without this prior relationship, an initial appointment may otherwise be difficult to obtain within the seven-day time period. We appreciate the efforts of behavioral health practitioners to accommodate requests for appointments within seven days of discharge from psychiatric hospitalization. Your partnership with us in this initiative helps to improve the lives of the individuals we mutually serve.

Our inpatient follow-up program staff evaluate treatment compliance by contacting UBH network practitioners to verify that recently hospitalized patients have scheduled aftercare appointments and that the appointments have been kept. As a network practitioner with a signed agreement with UBH, you are able to release appointment information to us without violating HIPAA guidelines. Further, the UBH Compliance department and HIPAA guidelines state that you may disclose personal health information (PHI) for

the purposes of treatment, payment or health care operations without signed authorization from the patient to:

- A treating practitioner** (including a physician, therapist, hospital or other facility)

- The enrollee's health plan where UBH is administering benefits

- Another UBH business associate (with a signed business associate agreement to perform treatment, payment or health care operations activities on behalf of UBH)

Your help in ensuring timely and adequate follow-up for patients discharged from inpatient care is vital to facilitating therapeutic gains and successful outcomes. Thank you for your assistance.

** For our disability program, you must receive a signed Patient Release of Information before you can disclose PHI to the treating practitioner.

WHEN AND HOW TO COMPLAIN

If you have an issue with specific UBH policies, procedures, or practices you may file a complaint. You may also file a complaint on behalf of the member. Every UBH staff member is able to record your complaint which will be routed to a complaint specialist to determine how to resolve your complaint.

To identify the Network Management contact for your state, go to the "Contact Us" page and select "All Other Network Questions". Or you may file a complaint through our intake or care advocate departments by using the toll-free number on the member's insurance card. Feel free to state directly that you wish to file a complaint.

Effective Treatment of ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed childhood behavioral health disorders, affecting an estimated three to nine percent of school-age children. These children exhibit inattentiveness and may also appear hyperactive and impulsive. Many children exhibit these common behaviors periodically, but a child with ADHD exhibits these behaviors persistently, intensely, and in a variety of settings. Boys are diagnosed with ADHD between two and three times as often as girls.

Symptoms are usually first noticed in preschool or early elementary school years. The effects of this disorder frequently persist into adolescence and adulthood. ADHD is often associated with other conditions, such as Mood and Anxiety Disorders, Conduct Disorder, Substance-related Disorders, and Personality Disorders, such as Antisocial Personality Disorder.

The appropriate diagnosis of ADHD requires a comprehensive medical evaluation to rule out potential physical conditions. The reliability of diagnosing ADHD improves when appropriate guidelines are used, and when additional history is collected from both parents and teachers. Treatment works best with a team approach when behavioral health clinicians, doctors, parents, teachers, and other healthcare professionals, along with the family and child, all work together. The treatment plan usually includes behavioral therapy, medication, parent training, and education. This combination aids the child to focus his or her attention and to control any behavior issues. It is important to monitor the child's progress. Visits with a behavioral health clinician are recommended at least monthly until optimal results are achieved.

For participating health plans, the National Committee for Quality Assurance (NCQA) rates performance on the following HEDIS® measures for children with ADHD between 6-12 years old:

- The percentage with a new prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescriptive authority within 30 days of the initiation of treatment (Initiation Phase)

- The percentage with a prescription dispensed for ADHD medication that remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within nine months after the Initiation Phase ends

Visit ubhonline for ADHD information and resources, including Best Practice Guidelines (from the home page you can select the "Guidelines/Policies" Quick Link in the left sidebar menu, scroll down to the Guidelines link) or on the UBH Mental Health Condition Center (the link is located under "Clinical Resources"). Effective Treatment of ADHD.

New to the Network *www.ubhonline.com*

We welcome you to an outstanding network of clinicians and facilities across the country. You will find ubhonline to be great resource for completing secure transactions; obtaining helpful forms and patient resources; accessing guidelines and policies; and getting the latest news.

This year, we introduced state-by-state welcome pages that provide links to a few key resources to help newly credentialed clinicians and facilities get started with us.

Secure Transactions

Eligibility & Benefits – search for member eligibility and benefits in real-time

Cert Inquiry & Cert Request (professional claims only) – clinicians can search for or request certification for routine outpatient services

Claim Entry (professional claims only) – Enter and submit outpatient MH/SA and EAP claims

Claim Status – look up status of facility or professional claims

Electronic Payments and Statements (EPS) – enroll for and receive electronic payments and statements – including electronic 835 downloads

And more!

Forms and Patient Resources

Forms – includes Wellness Assessments, EAP forms, Psychological/Neuropsychological Test Requests; forms are accessible through the Quick Links menu on the home page or the Clinical Resources index (horizontal green menu bar)

Patient Resources – From the Clinical Resources section, select "mental health condition centers" to link to clinical information available on our member web site or "patient education" for handouts on a variety of clinical and wellness topics

Quick Links Highlights – Home Page Resource

Guidelines/Policies – Manuals, Level of Care and Best Practice Guidelines, Credentialing Plans and more

Clinical and Quality Programs – ALERT, Facility Quality Measure (FQM), and Campaign for Excellence (CFE) all have quick links to more information about these programs

Become a Registered User of ubhonline

To request a user id:

Select the "First-time User" link in the upper right hand corner of the home page

Click the ubhonline Support icon to access our Live Chat feature

Or

Call 1(866) 209-9320

The ubhonline Support Center is available from 7 a.m. to 9 p.m. Central Time Monday through Friday, excluding holidays.

Facility Quality Measure (FQM) Goes On Line

FQM program announces that facilities are now able to view their scorecards on our industry-leading provider web site, ubhonline®.

FQM provides facilities with a scorecard of their relative performance using industry-standard quality and efficiency metrics. Making the scorecard available online is a significant enhancement in how we communicate the scorecard to facilities. Previously, the scorecards were mailed on a quarterly basis.

Facilities must obtain a ubhonline User ID and Password to perform online, self-service transactions.

Once registered, follow these steps to access the scorecard for your facility:

• Log on to ubhonline

• Select the "Provider Reports Tab"

• Select "FQM" and the scorecard will populate

• The scorecard can also be printed

Reminder for facilities: after the July scorecard mailing, FQM scorecards will no longer be mailed and must be viewed online.

To qualify for a scorecard, a facility must have 15 or more discharges of either commercial members or Medicare/Medicaid members, or both, in a 12-month data-collection period and must have sufficient data to be evaluated on each of the quality metrics.

To learn more about FQM, please visit ubhonline. Click on the FQM button under the "Quick Links" located on the home page for more information.

Thank you for your continued work in providing the highest quality services to our members. Any questions should be directed to the FQM e-mail address at fqm@uhc.com.

Coming Soon…

We will begin publishing stars next to acute care facility names on member search web sites (UBH Provider directories) in late fall 2010. This FQM enhancement supports transparency in healthcare, providing member access to quality and efficiency status

of Acute Care facilities in our network. Facilities will receive one star if they have met or exceeded quality benchmarks (a facility that achieves an average quality score greater than 2 on the FQM scorecard). A second star will be added for those facilities that also meet or exceed efficiency metrics (a facility that achieves an in range ranking for efficiency on the FQM scorecard). Please take time to review the recent letter about the star designation on the FQM page of ubhonline.

New York Legislation Impacts UnitedHealthcare and Healthcare Practitioner Processes

The State of New York recently implemented Chapter 237 of the Laws of 2009 which amended statutes related to claims processing for all insurers and managed care organizations. These changes impact members in fully insured commercial groups sitused (policy was issued) in the State of New York and providers who practice in New York. The results of some of these statutory changes are noted below. These changes are important to healthcare providers with patients in commercial group plans as described above:

Healthcare Provider Claim Submission Deadlines:

All participating and non-participating providers submitting claims with a date of service of April 1, 2010 or after must do so within 120 days from the date of service. This is likely a change for most providers.

Claim Processing Timeframes:

Effective January 1, 2010, claims submitted electronically must be paid within 30 days, and paper or facsimile claim submissions must be paid within 45 days. The 30 day timeframe for requesting additional information has not changed.

Adverse Reimbursement Changes:

Health care professionals are to receive written notice from UBH at least 90 days prior to an adverse reimbursement change. The health care professional may, within 30 days of the notice, give written notice to UBH of the intent to terminate the contract. An adverse reimbursement change is defined under the legislation as one that could "reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional."

Reconsideration of Denials of Untimely Claims:

For claims with a date of service of April 1, 2010 or after, UBH must permit a participating provider to request reconsideration of a claim that is denied exclusively because it was untimely submitted as noted above (120 days). Insurers shall pay an untimely claim if the provider can demonstrate that:

- Non-compliance was the result of an unusual circumstance; and

- The provider has a pattern or practice of timely submitting claims in compliance with deadlines.

If the above two circumstances are met, UBH may reduce the reimbursement due to a provider for an untimely claim by an amount not to exceed 25% of the amount that would have been paid had the claim been submitted timely.

UnitedHealthcare defines an unusual circumstance as a one-time event that could reasonably cause a delay in timely filing such as flood, fire or other natural disaster, or proof of incapacitation.

Overpayments to Healthcare Providers:

The application of existing recoupment provisions has been expanded to include health care providers rather than just physicians. The definition of a health care provider is fairly broad and includes, but is not limited to hospitals, home care services, hospices and New York licensed facilities.

UBH always offers the health care provider the opportunity to appeal an overpayment recovery attempt. Providers should follow the appeal process directions included in the overpayment notification letter.

Coordination of Benefits:

An insurer cannot deny a claim, either in whole or in part, on the basis that it is coordinating benefits and another insurer or entity is liable for the payment of the claim; unless it has a reasonable basis to believe that the insured has other health insurance coverage which is primary for that benefit.

If the insurer does not have current information from the insured regarding other coverage and requests such information (in accordance with the prompt pay timeframes), it must provide the insured 45 days to respond. If there is no response to the request, the insurer must then adjudicate the claim. The claim must not be denied based on the insurer not having received such information.