PROVIDER MANUAL

2025

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This manual is reviewed and updated as needed and at least on an annual basis.

Introduction

Using this Guide

The United Physicians Network (UPN) Provider Manual contains essential information on the administrative components of UPN's operations including:

- Claims billing and submission, provider disputes, coordination of benefits
- Prior authorization information
- Health care access and coordination
- Provider portal access: eligibility, claims and authorizations
- Quality management and case management
- Program requirements and provider education

Definitions

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention couldreasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.
(4) "Active labor" means a labor at a time at which either of the following would occur: (a) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) A transfer maypose a threat to the health and safety of the patient or the unborn child.

"In Network" refers to UPN's entire network of providers that have entered into an agreement with UPN to provide covered services to members enrolled in specific Health Plan products.

"Out of Area" refers to the geography outside UPN's service area of any specific Health Plan product.

"Out-of-area coverage" means coverage while an enrollee is anywhere outside the service area of UPN and includes coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to UPN's service area.

"State" refers to the state of California.

Website

www.Unitedpn.com

Contracted Health Plans

Anthem Blue Cross
Brand New Day
Central Health Plan
CalViva Health
Health Net
Alignment

Checking Member Eligibility

Providers are responsible for verifying members' eligibility for all medical services they provide. Please check the Members Health Plan ID card at each visit and keep a copy of both sides of the Health Plan ID card for your records. Additionally, it is important that you verify eligibility and benefits before or at the point of service for each office visit.

Providers may verify member eligibility by contacting the Health Plan directly by calling the number located on the back of the members ID card or utilizing the Health Plans portal.

Health Plan Identification (ID) Cards

UPN members receive Health Plan ID cards containing information needed for providers to submit claims. Information may vary in appearance or location on the card for different payers or other unique requirements.

Participating Physicians

UPN has contracted with participating physicians in the Central Valley. Primary Care Physicians (PCP) access UPN's network. UPN is managed by NeueHealth **+1 (888) 293-6383**, which includes Customer Service, Utilization Management, Claims Processing, and Credentialing, etc.

Selection and Role of the Primary Care Physician

All UPN members are required to select a primary care physician (PCP) at the time of enrollment. To change the designated primary care physician, members are required to contact their Health Plan.

UPN members may choose a PCP based on proximity to either their home or work address. Members are required to visit their primary care physician for non-urgent or non-emergency care.

The PCP is responsible for providing and coordinating medical care for their patients, including referralsto specialists, hospitals, and other healthcare providers anywhere in the UPN Network.

Specialty Care

UPN provides a comprehensive network of physician specialists. UPN PCPs refer members for specialty services when clinically appropriate, choosing a participating UPN specialist. Referrals for some specialty care require prior authorizations. Additional details regarding prior authorizations are covered under the Utilization Management section. These specialties include but are not limited

to:

Allergist/ Immunologists	Neurologists	Radiologist/Therapeutic
Anesthesiologists	Obstetrics & Gynecology	Oncologists
Cardiologists	Oncologists	Rheumatologists
Dermatologists	Ophthalmologists	Cardiology Surgeons
Emergency Medicine	Orthopedics	Colon/Rectal Surgeons
Endocrinologists	Otolaryngology's	General Surgeons
Family Planning	Pathologists	Neurologist Surgeons
Gastroenterologists	Perinatologists	Orthopedic Surgeons
Geneticists	Physical Medicine & Rehab	Plastic Surgeons
Hematologists	Podiatrists	Thoracic Surgeons
Infectious Disease	Psychiatrists	Vascular Surgeons
Neonatologists	Pulmonary Medicine	Urologists
Nephrologists	Radiologist/Diagnostic	

Ancillary Providers and Services

UPN and each Health Plan have a network of ancillary providers. UPN members may access contracted, in-network ancillary or specialty providers with a physician referral. Prior authorization is not required for many services including the following ancillary services.

- Urgent care centers
- Routine laboratory tests (done at LabCorp)
- Diagnostic imaging: X-rays, Mammograms, Ultrasounds, Dexa, 3D Breast Tomo and Fluoroscopy

Lab Services

UPN Physicians should refer members to the LabCorp for all Laboratory testing. UPN is exclusively contracted with LabCorp for Laboratory services.

Behavioral Health Access, Triage and Referral

Contact the Health Plan on the back of the Members ID card for additional information.

UPN Preferred Hospitals:

Adventist Health Hanford
115 Mall Drive
Hanford, CA 93230
(559) 582-9000

Valley Children's Hospital
9300 Valley Children's Place
Madera, CA 93636
(559) 353-3000

Emergency Services

Emergency services and care means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Emergency services and care also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

All Emergency Services are covered without prior authorization and do not require medical record review. These requests cannot be denied for failure to obtain a prior approval when approval would be impossible, e.g., the member is unconscious and in need of immediate care, or where a prior approval process could reasonably be expected to result in any of the following: 1) placing the member's health inserious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organor part at the time medical treatment is required.

In the UPN service area, the Health Plan pays for all medically necessary facility services provided to a member who is admitted through the emergency room until the member's condition is stabilized. All requests for authorizations of medically necessary health care services after stabilization and all responses to such authorization requests will be fully documented in the Utilization Management tracking system. Treating physicians will document provision of all medically necessary health care services in their usual medical record.

When UPN's Utilization Management department denies requests for authorization of post stabilization medical care at outside facilities and elects to transfer a member to another health care provider, the following applies:

- A physician or other appropriate practitioner reviews presenting symptoms and discharge diagnoses for emergency services. UPN may not restrict emergency medical conditions based on lists of diagnoses or symptoms. Behavioral health care practitioners are available to review psychiatric emergency conditions. UPN shall inform the treating provider of the decision to transfer the member to another health care provider.
- UPN shall effectuate the transfer of the member as soon as possible.

The emergency screening fee (Medical Screening Exam) will be paid in a timely fashion by the responsible party for all ER claims when clinical data that would support a higher level of payment is not available. UPN has processes to review and address professional claims payment and provider disputes about emergency room claims that have been denied.

Non-contracted providers are paid for the treatment of the emergency medical condition, including medical necessary services rendered to a member, until the member's condition has stabilized sufficiently to permit discharge or referral and transfer to a contracted facility.

Out of Area Emergency Services

Emergency and urgent services are covered when a member is temporarily out of the service area and requires immediate medically necessary healthcare because 1) the illness, injury, or condition was unforeseen; and 2) it was not reasonable for the member to obtain the services through UPN providers given the circumstances. Members are responsible for payment of copays and/or coinsurance pertheir specific benefit plan but can never be balance-billed for emergency services. Under unusual and extraordinary circumstances, services may be considered urgently needed when they are provided within the service area by a non-UPN provider when a UPN provider is unavailable or inaccessible.

Sensitive Services

UPN members may access in-network and out-of-network providers without a prior authorization to be seen for the following Sensitive Services.

- Mental and/or behavioral health
- Pregnancy & family planning and birth control
- Pregnancy termination (abortion)
- Sexually transmitted infections (STIs)
- HIV/AIDS testing and treatment
- Sexual assault
- Substance or alcohol abuse
- Gender affirming care
- Intimate partner violence

Pursuant to UPN members health plan guidance, members may access in-network and out-of-network providers without a prior authorization to be seen for these services.

Provider Obligations and Plan Oversight

If a UPN member contacts a provider seeking to become a new patient and that provider is not accepting new patients, the provider will direct the patient to the Health Plan. Any provider not accepting new patients will contact UPN.

Claims Submission Information

Filing a Claim

UPN is delegated to pay claims indicated in this Provider Manual. UPN has contracted with NeueHealth, its Value Service Organization ("VSO"), to perform the claims processing on their behalf.

- Providers are encouraged to file claims electronically whenever possible. Submitted claims shouldprovide all required information; those submitted with missing data may result in a delay in processing or denial.
- UPN Website – https://unitedpn.com/ provides general information.
- NeueHealth Website https://eznetedi.neuehealth.com/EZ-NET60/ click New User Registration. This portal provides access to query and view status on claims, authorization inquiry and submission, eligibility, contracted providers,and other important information.

Electronic Claims Submission

UPN, through NeueHealth, contracts with the vendors listed below for submission of electronic claims. Additional clearinghouses/vendors may also submit using these channels. The benefits of electronic claim submission include:

- Reduction or elimination of costs associated with printing and mailing paper claims
- Improvement of data integrity using clearinghouse edits
- Faster receipt of claims by UPN, resulting in reduced processing time and quicker payment
- Confirmation of receipt of claims by the clearinghouse
- Availability of reports when electronic claims are rejected
- The ability to track electronic claims, resulting in greater accountability

Clearinghouse	Phone Number	Payer ID
Office Ally	1-866-575-4120	NEUEH
Availity	1-800-282-4548	NEUEH

Electronic Data Interchange (EDI) questions

For questions regarding electronic claim submission, please call NeueHealth at **1-888-293-6383** or the claims clearinghouses at the numbers listed above. NeueHealth Provider Services Department is open Monday – Friday 8:30-5:00 pm PST.

Paper Claims Submission and NeueHealth Contact Information

- Paper Claim Submissions P.O. Box 8350, La Verne, CA 91750
- Appeals & Provider Dispute P.O. Box 8350, La Verne, CA 91750
- NeueHealth Phone 1-888-293-6383
- NeueHealth Fax (Authorizations) 1-833-813-7600
- NeueHealth Fax (Admission Notification) 1-888-320-3851

Electronic Funds Transfer (EFT)

UPN provides EFT (with no fees) for its providers for claims. Providers may contact NeueHealth at **1-888-293-6383**. NeueHealth uses Zelis services. To register go to neuehealth.epayment.center or you may contact Zelis at **855-496-1571.**

Claims Questions

Contact the NeueHealth **1-888-293-6383**, Monday-Friday 8:30-5:00 PST. Or visit the provider portal 24 hours/day, 7 days/week at https://eznetedi.neuehealth.com/EZ-NET60/

Clean Claim Guidelines

A "clean claim" is a claim that can be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Reasons for claim denial include, but are not limited to, the following:

- Duplicate submission
- Member is not eligible for date(s) of service(s) ("DOS")
- Incomplete data
- Non-covered services

Timely Filing Guidelines

Medi-Cal

- Contractor Providers: Billing Limitation – within 90 calendar days (3 months) from the Date of Service. Refer to each provider's contract for variations in the claim filing limit.

Medicare

- Contracted Providers: Billing Limitation – within 90 calendar days (3 months) from the Date of Service. Refer to each provider's contract for variations in the claim filing limit.

Balance Billing

Balance billing is the practice of a participating provider billing a member for the difference

between thecontracted amount and billed charges for covered services. When participating providers contract with UPN, they agree to accept UPN' contracted rate as payment in full. Billing members for any covered services above and beyond the contracted rate is a breach of contract. Participating providers may only seek reimbursement from UPN members for appropriate cost-share amounts, including copayments, coinsurance, and/or deductibles.
Balance billing is prohibited for Medi-Cal members.

Member Financial Responsibility

UPN members are responsible for co-pays or coinsurance as determined by their individual benefit plan.

UPN providers agree to accept payment per their contract as payment in full. Balance billing for the difference between the contracting amount and billed charges for covered services is prohibited and is considered a breach of contract, as well as a violation of state and federal statutes. In some instances, balance billing of members can result in civil penalties.

- Providers may bill a UPN member when the member knowingly receives non-covered services. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services and must file the signed statement in the member's medical record.
- UPN members may not be reported to a collection agency for any covered services rendered by a UPN provider.
- UPN members may not be charged for services that are denied or limited due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization, of clean claim status.

Coordination of Benefits

Coordination of benefits ("COB") is required before submitting claims for members who are covered by one or more health insurers other than their primary Health Plan. UPN follows the applicable regulations regarding coordination of benefits between both commercial and government insurance products.

Participating providers are required to administer COB according to the applicable regulations. The participating provider should ask the member about coverage through another Health Plan and enter that other health insurance information on the claim.

Providing COB Information

For UPN to document member records and process claims appropriately, include the following information on all COB claims submitted to UPN:

- Name of the other carrier

- Subscriber ID number with the other carrier including contact information, primary subscriber,or preferable a COB form from the provider.

If a UPN member has other group health insurance coverage, follow these steps:

- File the claim with the primary carrier, as determined by the applicable regulations.
- After the primary carrier has paid, attach a copy of the *Explanation of Payment (EOP)* or Explanation of Benefits (*EOB)* to a copy of the claim and submit both to UPN within six months from the date of service. COB claims can also be submitted electronically with the details from the other payer Electronic Remittance Advice (ERA) appropriately submitted in the 837 transaction COB loops.
- If the primary carrier has not made payment or issued a denial, submit the claim to UPN prior to the timely filing limit of six months from the date of service. If denied based on timeliness,the claims are treated as non-reimbursable, and the member cannot be billed.

COB Payment Calculations

UPN coordinates benefits and pays balances, up to the member's liability, for covered services. However, in cases where UPN is not the primary payer, the dollar value of the balance payment cannot exceed the dollar value of the amount that would have been paid had UPN been the primary payer.

In some cases, members who have coverage through two carriers are not responsible for cost-shares orcopayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member.

Overpayments

UPN makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's Remittance Advice (RA). An automatic system offset, where applicable, might occur in accordance with the reprocessing of the claim for the overpayment, or on immediate subsequent check runs.

If a provider independently identifies an overpayment from UPN (such as a credit balance),the following steps are required to be taken by the provider:

Send the overpayment refund and applicable details to: UPN c/o NeueHealth P.O. Box 8350, La Verne, CA 91750

Include a copy of the RA that accompanied the overpayment to expedite UPN's adjustment of the provider's account. It takes longer for UPN to process the overpayment refund without the RA. If the RA is not available, the following information must be provided:

- Member name and UPN member ID number
- Date of service
- Payment amount
- Vendor name and number
- Provider tax ID number
- Reason for the overpayment refund

If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of UPN, the provider should follow the overpayment refund instructions provided by the vendor.

If a provider believes he or she has received a UPN check in error and has not cashed the check, he or she should return the check to the address above with the applicable RA and a cover letter indicating why the check is being returned.

Additional Information

If you have additional questions, please contact NeueHealth at **1-888-293-6383**, Monday – Friday 8:30 a.m. – 5:00 p.m. Pacific Time with questions regarding third-party recovery, coordination of benefits or overpayments.

Provider Disputes

Provider Disputes due to Claims Decisions

A provider dispute due to claims decision is a written notice from the provider to UPN (sent to UPN's claims administrator NeueHealth) that:

- Challenges, appeals or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested;
- Challenges a request for reimbursement for an overpayment of a claim; and/or seeks resolution of billing or another contractual dispute;

Providers should exhaust all claims processing procedures and follow the guidelines below before filinga claim dispute with UPN:

- If the provider has not received a Claims Remittance Advice (RA) identifying the status of theclaim, they should call NeueHealth to inquire whether the claim has been received and processed.
- Providers should allow 45 calendar days following claim submission before inquiring about aclaim. However, providers should inquire well before six months from the date of service because of the time frame for initial claim submission and for filing a claim dispute (*see* "Provider Dispute Time Frame" below).
- If a claim is pending in the NeueHealth claims system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim may be cause for a claim dispute on a pended claim provided all claim dispute deadlines are met (must

be filed with 12 months of the last payment).

Past Due Payments

If the provider dispute involves a claim and the outcome is determined to be in favor of the provider, UPN will pay any outstanding money due, including any required interest or penalties. When applicable, accrual of the interest commences on the day following the date by which the claim should have been processed.

Claims Payment Turnaround Time

Medi-Cal: Contracted Provider payment turnaround time is 30 working days.
Medicare: Contracted Provider payment turnaround time is 60 calendar days.

Provider Dispute Time Frame

Disputes are accepted if they are submitted no later than 365 calendar days for Medi-Cal and 120 calendar days for Medicare from the date of payment or denial. If the provider's contractual agreement provides for a dispute-filing deadline that is greater or less than 365 calendar days, the contract dispute filing deadline applies.

Provider Disputes due to Utilization Management (UM) Decisions

Providers should follow the same process as above. Members may appeal denials in accordance with Health Plan requirements. For health plan contact information, please refer to the separate Provider Training information.

- Calling the member's Heath Plan:
  - Contact **Alignment Health Plan** between 8 a.m. to 8 p.m. Pacific time, Monday through Friday, excluding holidays, toll free at 866-634-2247 Spanish: 877-399-2247. If you cannot hear or speak well, please call 711.
  - Contact **Anthem Blue Cross** between 7 a.m. to 7 p.m. Pacific time, Monday through Friday, excluding holidays, toll free at 800-407-4627. If you cannot hear or speak well, please call 711.
  - Contact **Brand New Day** between 8 a.m. to 8 p.m. Pacific time, Monday through Friday, excluding holidays, toll free at 1-866-255-4795. If you cannot hear or speak well, please call 711.
  - Contact **Central Health Plan** between 8 a.m. to 8 p.m. Pacific time, 7 days a week, toll free at 1-866-314-2427. If you cannot hear or speak well, please call 711.
  - Contact **CalViva *(Fresno, Kings, Madera Counties for Health Net members)***, 24 hours a day, 7 days a week, toll free at 1-888-893-1569. If you cannot hear or speak well, please call 711.

- Contact **Health Net Medi-Cal Member Services *(Tulare County Health Net members*)** 24 hours a day, 7 days a week, toll free at 800-675-6110. If you cannot hear or speak well, please call 711.

- Filling out an appeal form or write a letter and send it to:
  - **Alignment Health Plan**
    Attn: Member Services Department
    1100 W. Town & Country Road, Suite # 300
    Orange, CA 92868
  - **For Anthem Medi-Cal appeals:**
    Anthem Blue Cross
    Attn: Grievance Coordinator
    P.O. Box 60007
    Los Angeles, CA 90060-0007
  - **For Anthem Medicare Advantage appeals:**
    Medicare Complaints, Appeals and Grievances (MCAG)
    Attn: Member Appeals
    Mailstop: OH0205-A537
    4361 Irwin Simpson Road
    Mason, OH 45040
  - **Brand New Day**
    Attn: Appeals and Grievance Department
    P.O. Box 93122
    Long Beach, CA 90809
  - **Central Health Plan**
    Attn: Member Services Department
    PO Box 14244, Orange, CA 92863
  - **Health Net Medi-Cal**
    Attn: Member Appeals and Grievances Department
    P.O. Box 10348
    Van Nuys, CA 91410-0348
  - **CalViva**
    Attn: Grievance and Appeals Department
    21281 Burbank Blvd.
    Woodland Hills, CA 91367
- Visit the member's Health Plan's website
  - Alignment: https://www.alignmenthealthplan.com/members/grievance-and-appeals
  - Anthem (Medi-Cal): https://mss.anthem.com/california-mmp/benefits/coverage-decisions/appeals.html
  - Anthem (Medicare Advantage): https://www.anthem.com/ca/complaints-

grievances

- Brand New Day: https://www.bndhmo.com/Members/File-an-Appeal
- Central health Plan: https://www.centralhealthplan.com/Member/Appeals
- Health Net: https://providerlibrary.healthnetcalifornia.com/
- Calviva: https://www.calvivahealth.org/

Submitting Provider Disputes

Providers should submit provider disputes on a Provider Dispute Resolution Request form. If the disputeis for multiple and substantially similar claims, a Provider Dispute Resolution Request spreadsheet should be submitted along with the form. Providers may download an electronic copy of the Provider Dispute Resolution Request form by visiting https://eznetedi.neuehealth.com/EZ-NET60/. The provider dispute form must include the provider's name, NPI ID number, contact information including telephone number, and the number assigned to the original claim. Additional information required includes:

- If the dispute is regarding a claim or a request for reimbursement of an over or underpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the claim is regarding a UM decision, the dispute must include a copy of all correspondence including letters from the member's physician(s) and a copy of the pertinent member medical records.
- If the dispute is about another issue, a clear explanation of the issue and the basis of the provider's position.
- If the provider dispute does not include the required submission elements as outlined above, the dispute is returned to the provider along with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit an amended dispute along with the required missing information.
- UPN does not discriminate or retaliate against a provider due to a provider's use of the provider dispute process. A provider claim dispute is processed without charge to the provider; however, UPN has no obligation to reimburse any costs that the provider has incurred during the claim dispute process.
- Providers can send provider disputes to: UPN c/o NeueHealth P.O. Box 8350, La Verne, CA 91750

Provider Disputes - All Other Disputes

All other types of provider disputes between UPN and Providers for which the agreement between UPN and Provider does not specify specific procedures or timelines should be resolved, to the extent possible, by informal meetings or discussions between appropriate representatives of the parties. Providers may submit disputes to UPN by mailing a detailed description of the dispute and

any supporting documentation to UPN c/o NeueHealth P.O. Box 8350, La Verne, CA 91750. The parties will meet and confer within 30 calendar days of receipt to resolve the dispute. If the parties are unable to resolve the dispute within 60 days of the first meeting to discuss the dispute, then either party may provide written notification of their intent to proceed with arbitration or other dispute resolution process provided for in their Agreement with UPN. (Timeframes apply unless otherwise described in a provider's contract or as required by law or regulation).

Member Grievances and Appeals

UPN is not delegated by our Health Plans to review, process or manage member grievances or appeals. Health Plans shall be responsible for resolving all Member Grievances (complaints) or Appeals of benefit or claims decisions.

Resolution Time Frame

Member Appeals and Grievances are handled by each Health Plan's grievance and appeals departmentwithin DMHC regulated timeframes following receipt of the grievance/appeal and a written determination will be provided.

Utilization Management

Financial Prohibition

All utilization decisions regarding coverage and/or services must be based upon appropriateness of care and services and the existence of coverage. Financial rewards or incentives must not influence any utilization decisions. To assure that the risks of underutilization are considered, no rewards or incentives can be issued that will discourage appropriate care and services to the Members. In addition, UPN does not reward Practitioners, Providers, or employees for issuing denials of coverage or service. Compensation plans for individuals who provide utilization review services do not contain incentives, direct or indirect for these individuals to make inappropriate review decisions. All denials must be strictly based on insufficient medical appropriateness or not a covered benefit.

Prior Authorization

Utilization management authorization decisions are conducted by UPN. For clinical trials, out of area services and transplants the Health Plan makes and communicates all authorization decisions.

Referrals for the following services require prior authorization. **The list below is not all inclusive and may vary depending on individual member's benefit plans.**

- Admissions - Non-emergent inpatient admissions
- Bariatric-related services
- Cardiology procedures - Elective interventional cardiology procedures, including cardiaccatheterization and procedures requiring contrast
- CAR-T
- Chemotherapy / Infusion Therapy
- Clinical trials
- Dialysis
- Durable medical equipment, including prosthetics
- Experimental/investigational services and new technologies
- Gender reassignment surgery including drugs and consults
- GI Procedures
- Home health and home infusion services
- Injectables in office
- Out of network/ out of area referrals
- Outpatient surgery
- Pain management procedures
- PET Scans
- Radiation Therapy
- Radiology interventional procedures - Elective interventional radiology procedures requiringcontrast administration
- Rehabilitation therapies such as physical, occupational, and speech therapy

- Self-Injectables
- Skilled Nursing Facilities
- Transplant-related services

If a UPN member cannot obtain non-emergent/non-urgent medically necessary inpatient services at a UPN facility listed above, the member's physician may refer the member to a non-contracted facility. Utilization Management staff may approve services at a non-contracted facility that can offer such care. Prior authorization and medical review are required for non-emergent/non-urgent inpatient services at non-contracted facilities.

UPN conducts the following types of review per their respective policies and procedures, and in coordination with the member's health benefit plan, including but not limited to:

- Prospective Review
- Medically Urgent Services Review
- Concurrent Review of patients admitted to acute care hospitals, rehab facilities and skilled nursing facilities
- Discharge Planning
- Ancillary Services Management

Continuity of Care

In accordance with DHCS All Plan Letter 23-022 and California State Health Plans, Continuity of Care is applicable to Medi-Cal beneficiaries who are newly enrolled in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023. Members who have seen an out-of-network primary care physician, specialist, or specific ancillary providers (such as physical therapy, occupational therapy, respiratory therapy, behavioral health, or speech therapy) for non-emergency visits in the past 12 months before their enrollment in UPN, may request up to 12 months of "Continuity of Care" with that out-of-network provider (as listed in Health and Safety Code (HSC) section 1373.96) for the completion of that course of treatment.

To qualify for Continuity of Care, the provider must:

- Accept UPN's contracted rates or fee-for-service rates.
- Meet UPN's professional standards.
- Have no quality-of-care issues that would disqualify them from caring for a UPN member.
- Be a Medi-Cal approved provider under the California State Plan.

UM Contact

Authorization submission should be made on the NeueHealth portal at https://eznetedi.neuehealth.com/EZ-NET60/. You may fax authorizations to 1-833-813-7600.
You may also Contact NeueHealth Customer Service for further questions at **1-888-293-6383**.

Denial Notification

Verbal and written notice of denials and communications must meet Health Plan requirements.

Emergencies

Emergency services are covered both in-network and out-of-network and do not require prior authorization.

Notification of Admission

All elective acute care hospital and skilled nursing facility (“SNF”) admissions require authorization.

Notification of emergency admissions should be made to NeueHealth within 24 hours or the next business day of presentation.

Quality Management

The UPN Quality Management (QM) Program is directed by providers and the intent is ensure the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow up is planned where indicated. The QM Program structure is designed for continuous quality improvement efforts to promote a culture of improving quality of care and services. The QM activities yield data from multiple sources which, after analysis, is integrated and utilized for planning and guiding administrative and managerial decision-making for Quality Management.

The QM Program is designed to improve aspects of care delivered to Members in the health care settings. The goal of the QM Program is to continuously improve the quality of care and service delivered to Members; to include, but not limited to the following:

- Develop, implement, and coordinate activities that are designed to improve the process by which care and service are delivered
- Monitoring that the provision and utilization of services meets professionally recognized standards of practice
- Maintain compliance with accreditation and regulatory standards and provisions
- Alignment and Integration of Quality Initiatives with NeueHealth Population Health Management; to include, Behavioral Health Integration
- Annually structure a specific Quality Initiative to ensure the capacity to service diverse members. Objectives include, but not limited to reducing health disparities, improving cultural competence, or improving network adequacy for underserved populations
- Annually structure a specific Quality Initiative to ensure the capacity to service members with complex health needs. Objectives may include addressing the needs of members with physical disabilities, developmental disabilities, chronic conditions, and severe mental illness
- Develop and Implement integrated Quality Improvement Projects
- Facilitate Provider integration with the Quality Initiatives
- Implementation of an internal surveillance structure to identify and correct quality concerns
- Measure performance using industry standard quality measures and develop a system of transparency to display measures; to include, Member and Provider Satisfaction
- Annually review the effectiveness of the QM Program and make needed programmatic changes for future program design

Population Health Management

UPN Population Health Management (PHM) program structure and functionality support a commitment to providing quality healthcare that is accessible, easy, and affordable. The PHM program is centered on using evidence-based practice to coordinate care and provide services and benefits to make health insurance easy-to-understand and easy-to-use.

PHM Purpose

The purpose of the PHM program is to improve the health outcomes of a population. UPN deploys integrated, fully aligned population-based health programs focused on consumers, powered by technology, and aligned with Care Partners.

PHM Coordination

NeueHealth population health management teams perform triage functions to ensure coordination of programs and services that are deployed by Physicians, Health Plan sponsors, or community based or external management programs. The population health management teams will determine Member eligibility for other external programs and the services offered to Members (i.e. LTSS, CCS, Disease Management, Behavioral Health, Community Social Service). The Model of Care goals developed by Health Plan Sponsors are integrated into the NeueHealth policies and procedures.

PHM Scope

The PHM program encompasses a comprehensive model designed to objectively and systematically assess Members' needs across the continuum of care. The model entails the following core programs:

- Case Management Program: The Case Management Program is designed to stratify Members based on the population characteristics and provide an intensive case management approach to the high cost, high needs subpopulation.
- Health and Wellness Program: The Health and Wellness Program is designed to address health maintenance for the low-risk population and to maintain this subpopulation at their current level of functioning in partnership with the primary care physician.
- Transition of Care Program: The Transition of Care Program is designed to provide case management interventions to those Members at risk for adverse outcomes due to transitions across care settings.

PHM Objectives

The PHM strategy is designed to meet the Member's needs, preferences, and values across the continuum of care. The strategic objectives of the PHM Program include:

- Keeping Members healthy

- Managing Members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Access to Care

All UPN participating providers must meet the standards for appointment and telephone wait times.

DMHC Regulated Appointment Wait Times

UPN members have the right to appointments within the following time frames:

Type of Appointment	Wait time
Urgent	
• for services that do not require prior approval	48 hours*
• for services that require prior approval	96 hours*
Non-Urgent	
• Primary care	10 business days
• Specialist	15 business days
• Behavioral health care provider (non-physician)	10 business days
• Other services to diagnose or treat a health condition	15 business days

*As of 2024, Urgent appointment timeframes now include weekends and holidays.

Medicare Approved Appointment Wait Times

UPN Medicare members have the right to appointments within the following timeframes per the latest CMS Final Rule (2024).

Type of Appointment	Timeframe
Non-emergency and Non-urgent visits	Non-urgent but requires medical attention visit with seven (7) business days of request
Routine and preventative visit	Within thirty (30) business days
Behavioral Health	
Emergency or urgently needed services	Immediately
Non-emergency and non-urgent visits	Within seven (7) business days of request

but requires medical attention	
Routine and preventative visit care	Within thirty (30) business days

24/7 Availability Requirement

All UPN participating providers must make themselves available to members as needed 24 hours a day, 7 days a week, by telephone. During times when a provider is not available, an on-call provider must be available to take the call.

If staff or answering service is not immediately available, an answering machine may be used.

For after-hours calls regarding a medical emergency, an answering services or telephone system must direct members to either call 911 in the event they are experiencing a medical emergency or to go to the nearest emergency room.

For after-hours calls regarding a non-emergency situation, members should receive instructions on how to contact the on-call provider.

Providers should include an after-hours message that provides this information in both English and a non-English version to ensure clear communication with all patients.

All calls taken by an answering service must be returned.

Nurse Advice Line

Contact the members' Health Plan, as this service is provided by the member's Health Plan as a benefit.

General Administrative Requirements

Provider Responsibilities

Participating providers are responsible for:

- Providing health care services within the scope of the provider's practice and qualifications, that are consistent with generally accepted standards of practice;
- Accepting UPN members as patients on the same basis that the provider accepts other patients (nondiscrimination);
- Providing timely communication and feedback regarding member healthcare needs to affiliated physicians;
- Obtaining current insurance information from the member;
- Adhering to standards of care and UPN policies to perform utilization management and quality improvement activities, including prior authorization of necessary services and referrals;
- Informing the member that services may not be covered when referring to physicians outside the network unless prior authorization has been issued;
- Cooperating with UPN and its participating providers to provide or arrange for continuity of care to members according to state regulations undergoing an active course of treatment in the event of provider termination;
- Operating and providing contracting services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care, including federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729et. seq.), the anti-kickback statute (42 U.S.C. § 1320a-7b.), and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164;
- A covered entity or business associate may not use or disclose protected health information potentially related to reproductive health care without obtaining an attestation that is valid from the person requesting the use or disclosure;
- Provider agrees to disclose to contracted health plan(s) any interest, affiliation, or control by Provider or Provider's personnel, Provider's immediate family member of any other provider of medical, health, or administrative services to which Provider refers patients (including but not limited to pathology, radiology, imaging, and surgery centers), upon request;
- Provider represents and warrants that Provider and its personnel do not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to contracted health plan(s);
- Provider shall provide prompt notice to contracted health plan(s) of any conflicts of interest or any basis for potential violations by Provider with respect to laws, rules and regulations that

govern referrals required for the provision of certain healthcare services, including, Federal and State antikickback and anti-self referral laws, rules and regulations.

Program Requirements & Provider Education

UPN complies with all the below California program requirements and requires that its providers educate and familiarize themselves with each program and applicable NeueHealth policy.

- California Children's Services Program (CCS)
    - Description: **California Children's Services (CCS)** is a state program that treats children under 21 years of age with certain health conditions, diseases, or chronic health problems and who meet the CCS program rules.
    - For more information, please visit: https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
- Comprehensive Perinatal Services Program (CPSP)
    - Description: The **Comprehensive Perinatal Services Program (CPSP)** is a Medi-Cal program that provides individualized perinatal services during pregnancy and 60 days following delivery by or under the supervision of a physician approved by CPSP. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education.
    - For more information, please visit: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
- Sterilization Consent
    - Description: Members who have procedures performed for the purpose of reproductive **sterilization** shall receive adequate information to make an informed decision. A properly executed Consent Form PM 330 shall reflect this decision.
    - For more materials, please visit: https://www.dhcs.ca.gov/Pages/PermanentBirthControl.aspx
    - Consent Form PM 330 (English & Spanish): https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/reference?fn=pm-330_eng-sp.pdf
- Early Intervention (EI), Early Start (ES), Developmentally Disabled Services (DDS), Regional Center
    - Description: **Early Intervention (EI) services** means the services for the identification of children who may be eligible to receive services from the Early Start (ES) Program, including those with a condition known to lead to developmental delay, those whom a significant developmental delay is suspected, and those whose early health history places them at risk for delay. **Early Start (ES) Program** means Early Intervention services provided through the Regional Centers to children birth to three (3) years of age who have an established condition leading to developmental delay; a health history or risk factors that put them at risk for developmental delay; or in whom development delay is suspected. These

services are provided pursuant to Government Code, Title 14, Subsection 95000, Individuals with Disabilities Education Act and in accordance with applicable guidance required to treat or a condition identified as EPSDT by a PCP. **Development Disability Services (DDS)** means the federal / state funded program for the provision of medically necessary screening, preventive, and therapeutic services for Medi-Cal members with developmental disabilities, including services for diagnosis, counseling, case management, identification of all appropriate services, including medical care services, and provision of non-medical community services provided through the Regional Centers such as, but not limited to, respite, out-of-home placement, and supportive living services for members with mental retardation, cerebral palsy, epilepsy, and autism.

    - For more information, please visit: https://www.dds.ca.gov/services/early-start/ & https://www.dhcs.ca.gov/services/nhsp/Pages/ProviderRes.aspx#early

- Medi-Cal for Kids & Teens / Early and Periodic Screening ,Diagnostic, and Treatment Services (EPSDT)
    - Description: **Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)** services are a benefit of the Medi-Cal program as specified in Title XIX of the Social Security Act (SSA), Section 1905(r)(5), Title 42 of the United States Code, Section 1396d(r). The benefits covered under EPSDT provide comprehensive and preventative health care services for individuals younger than 21 years of age who are enrolled in Medi-Cal. These services are key to ensuring children and youth receive appropriate preventative medical, dental, vision, hearing, mental health, substance use disorder, developmental and specialty services, as well as all necessary services to address any defects, illnesses or conditions identified.
    - Providers must complete the EPSDT-specific training no less than every two years.
    - **Medi-Cal for Kids & Teens** is a state funded program, as required by federal and state regulations that covers full scope of early and periodic screening, diagnostic and treatment (EPSDT) services to Medi-Cal members under the age of 21.
    - Resources: DHCS EPSDT Training Medi-Cal for Kids & Teens Provider Training; EPSDT Manual
- Cognitive Health Assessment
    - Description: California Senate Bill (SB) 48 (Chapter 484, Statutes of 2021) expanded the Medi-Cal schedule of benefits to include an annual cognitive assessment for Medi-Cal Members who are 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare Program. The annual **cognitive health assessment** is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN).

- Medi-Cal Providers must complete training as specified and approved by the Department of Health Care Services (DHCS), and use validated tools recommended by DHCS.

- Initial Health Appointment (IHA)
  - Description: The **Initial Health Assessment (IHA)** is a complete medical history, head-to-toe physical examination and assessment of health behaviors by a Primary Care Physician. An IHA must be completed for all Members and periodically re-administered. The IHA must:
    - Be provided in a way that is culturally and linguistically appropriate for the Member.
    - Be documented in the Member's medical record.
    - Include all of the following: A history of the Member's physical and mental health; An identification of risks; An assessment of need for preventive screens or services; Health education; and the diagnosis and plan for treatment of any diseases.
  - Member outreach to facilitate compliance with IHA participation is required. At least two attempts shall be made to schedule an IHA. Initial outreach may include:
    - New Member enrollment package/materials;
    - IHA reminder messages;
    - Member Newsletters;
    - Member Website; and
    - Phone calls
  - IHA medical record documentation is required and includes:
    - Missed appointments;
    - Attempts for follow-up;
    - Monitoring and intervention processes used to ensure appropriate utilization of Initial Assessment standards in the medical record.
  - For more information please visit: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf

- Palliative Care
  - Description: **Palliative Care** is specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness, no matter the diagnosis or stage of disease. Palliative care teams aim to improve the quality of life for both patients and their families. There is a Pediatric Palliative Care Waiver Program for CCS eligible children as well.
  - For more information, please visit: https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx & https://www.dhcs.ca.gov/services/ppc

- Behavioral Health Treatment
    - Description: **Behavioral Health Treatment (BHT)** is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are based on reliable evidence and are not experimental. BHT services include a variety of behavioral interventions that have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.
    - For more information, please visit: https://www.dhcs.ca.gov/services/Pages/BHS.aspx
- End of Life Services – End of Life Option Act (EOLA)
    - Description: The **End of Life Option Act (EOLA)** allows an adult diagnosed with a terminal disease, who meets certain qualifications, to request the aid-in-dying drugs from their attending physician. The Act requires physicians to submit specified forms and information to the California Department of Public Health (CDPH). CDPH will collect data from forms submitted by physicians. Annual reports will be made pursuant to the Act and relevant privacy requirements.
        - Contact the Medi-Cal and Provider Helpline at 800-541-555. Outside of CA, call 916-636-1980.
    - For more information, please visit: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx

For program requirements listed above, you may reach out to your provider representative for a list or copy of NeueHealth's policies for further education. Updates to these policies or program requirements are reviewed by the UM Committee on an as needed or at least annual basis and the manual will be updated accordingly. It is the responsibility of the provider to check the provider manual for updates periodically.

An additional resource for more information on these programs can be found in the health plan provider manuals provided by contracted health plans listed in section one of this manual.

Provider Rights to Advocate on Behalf of the Member

UPN validates that its providers, acting within the lawful scope of their practices, are not prohibited or otherwise restricted from advising or advocating, on behalf of members who are the providers' patients, for the following:

- The member's health status, medical care or treatment options, including any alternative treatmentthat may be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions

Nondiscrimination

UPN and its participating providers must not discriminate against any provider that serves high-risk populations or specializes in conditions that require costly treatment.

Credentialing and Re-credentialing

Credentialing and re-credentialing of physicians and licensed individual practitioners is delegated to NeueHealth. UPN's Chief Medical Officer chairs the UPN's Credentialing Committee which oversees credentialing activities.

Credentialing Adverse Action

If a practitioner's credentials are suspended or terminated the practitioner will be provided written notification to include the reason for the action and a summary of the appeal rights process. The appeals process allows practitioners to request a hearing and submit supporting documentation within (30) calendar days after the notification was submitted to the practitioner.

Practitioners have the right to be represented by an attorney or another person of their choice. UPN may not have an attorney present if the practitioner does not have attorney representation.

When a timely request for appeal is received a peer panel of individuals will be appointed to review the appeal. The hearing panel members will be peers of the affected practitioner. A peer is an appropriately trained and licensed practitioner in a practice like that of the affected practitioner. Panel members do not have to possess identical specialty training.

When the hearing concludes, the panel will submit a written notification to the practitioner to include the appeal decision and the specific reasons for the decision.

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Network Education & Contracting Questions	contracting@unitedpn.com	1-866-818-4UPN (4876)
NeueHealth Call Center – General Questions		1-888-293-6383