CLAIMS AND APPEALS

If a plan does not have out-of-network (OON) benefits, will the plan pay for COVID-19 OON care? New 5/12

Yes, for a plan that doesn't have OON benefits but related to the COVID treatment during this COVID emergency period, we would pay at the network (INN) level including inpatient care.

If a member is not feeling well and has some symptoms but is not tested for COVID-19 (for example they receive a flu test) and the visit and test are not coded as COVID-19, how will the care be paid? New 4/20

The provider should bill for the services conducted. In this case there is no COVID-19 testing diagnosis or test codes billed or COVID-19 diagnosis code associated with the care, then it would be paid based on the members normal benefit plan and standard cost share applies.

Are items like Pedialyte and Gatorade covered as a COVID-19 test-related expense? New 4/20

No. These are not covered under medical benefits.

Do UnitedHealthcare commercial out of network programs satisfy the requirement in the CARES Act that states "the plan may negotiate a rate with a provider for less than the cash price"? New 4/20

Yes. CARES Act provision (3202) requires plans to reimburse providers for COVID-19 tests at the contract rate negotiated before the COVID-19 emergency, or, if there is no contract, a cash price posted by the provider as listed on a public internet website, or the plan may negotiate a rate with the provider for less than the cash price.

Where UnitedHealthcare has an out-of-network program in place, the price may be negotiated based on the rule.

Will standard programs apply to OON claim processing, e.g., R&C cutbacks, MNRP, shared savings etc.? Update 7/24

Yes, standard OON programs apply. Any plan that has R&C would be managed on the back end and we would negotiate up to posted cash price. If that is not available, the standard OON reimbursement would apply.

Does UnitedHealthcare require a COVID-19 test claim to be present in order for a testing-related office visit claim to pay at no member cost share? Update 5/12

A COVID-19 diagnosis code or COVID-19 test code is required on the claim to waive cost share.

If the presence of a COVID-19 test claim is not required, then will only a COVID-19 diagnosis code on the claim pay at no member cost share? Update 5/12

A COVID-19 diagnosis code or COVID-19 test code is required on the claim to waive cost share.

If there is a COVID-19 test claim, but the testing-related office visit does not have a COVID-19 diagnosis code, would the office visit claim be paid at no member cost share? Update 5/12

To waive member cost share, a COVID diagnosis code or COVID-19 procedure code must be on the claim.

If a COVID-19 testing or treatment diagnosis code is required for a testing-related office visit claim and there is not one present on the claim, will the provided need to submit a revised claim with a COVID-19 diagnosis for the claim to pay at no cost share for the member? Update 5/12

Yes

How are appeals team handling claims that do not have appropriate COVID-19 codes on the claim? Update 6/15

UnitedHealth Group has waived member cost-sharing for COVID-19 testing and treatment from the onset of the pandemic. Some members received bills early on when there were not yet specific COVID-19 billing codes and during a period in which code adoption was first taking place. We are waiving those charges and have been proactively evaluating claims from early February and March to ensure claims were paid correctly and cost-sharing was appropriately waived. We urge members who may have concerns about charges to call us to resolve any issues.

If there is no indication of COVID in the diagnosis or procedure codes, and no admission for COVID or subsequent COVID test within a reasonable time frame – the claim will pay according to plan benefits and member cost share may apply.

We are proactively reviewing claims using specific clinical guidance and 3 CDC identified COVID symptoms as a guide for handling upfront for claims with dates of service 2/4 to 3/31.

Any appeals are being reviewed through an exception process on a case by case basis for those claims. Providers have been sent information and coding and process information is posted on uhcprovider.com

Can members submit claims if they have to pay upfront for a test or test-related visit? New 5/15

Care providers are responsible for submitting accurate claims in accordance with state laws, federal laws and UnitedHealthcare's reimbursement policies. Regardless of upfront payment, the provider's office should be submitting the claims. Therefore, members would not submit receipts for UnitedHealthcare to process.

How does the Final Rule change timing for claim submission? Update 7/13

The Final Rule mandates that plans disregard the Outbreak Period for purpose of applying certain plan deadlines, including the timeline for submitting a claim for benefits.

Prior to the Final Rule, the timeframe for submitting a claim to a group health plan was set by the terms of the plan and each day from the date of service to the date the claim was submitted was counted. Many plans gave participants 365 days to submit a claim. Under the final rule, time between March 1, 2020 and the end of the Outbreak Period is not counted. Assume that a member received services on March 1, 2020 (the effective date of the Final Rule) but did not file the claim until more than a year later, April 1, 2021. Under the final rule, the claim is valid even though it was not filed until April 1, 2021. The claim is timely because time from March 1 through the end of the outbreak period, is not counted for purposes of determining whether a claim is timely.

UnitedHealthcare is updating EOBs and appeal letters for claims and appeal decisions we issue during the Outbreak Period identified in the DOL's final rule issued May 4, 2020. The EOB and appeal letters will advise claimants that the deadline for subsequent reviews are extended until further notice and encourage members to seek additional information and guidance from their plan/employer. When claims and appeals are submitted during the Outbreak Period—even though members are not obligated to do so—UnitedHealthcare will continue to render a claim or appeal decision within normal timeframes. UnitedHealthcare is using that opportunity to advise members about the extensions. Our systems are operationalized to compute and apply the correct tolling period to determine timely filing for claims, appeals and reviews when submitted.

How does the Final Rule change timing for FSA or HRA claim submission? New 6/6

Since they are ERISA-governed plans, the Final Rule requires that the time period to submit Health Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs) claims be extended in accordance with the Final Rule. This Final Rule affects the deadline to submit reimbursement requests under a Health FSA or HRA which are generally a few months after the end of the plan year. For example, if a calendar year Health FSA plan had a runout period that ended on April 30, 2020, this means the plan could not require that participants forfeit any remaining balance during the Outbreak Period. Plans may need to flag claims that were previously denied for failure to timely file claims or appeals. Dependent Care FSAs are not ERISA plans and are not subject to the Final Rule.

APPEALS

How does the final rule affect appeals for adverse determinations and filing a request for external review? Update 7/13

Prior to the rule, a member must be given at least 180 days within which to appeal an adverse benefit determination. The Final Rule mandates that plans disregard the Outbreak Period for purpose of applying certain plan deadlines including the date on which a claimant must file an appeal of an adverse benefit determination under the plan and the timeline for filing a request for external review and for perfecting such a request.

UnitedHealthcare is currently in the process of updating our EOBs and appeal letters for claims and appeal decisions we issue during the Outbreak Period identified in the DOL's final rule issued May 4, 2020. The EOB and appeal letters will advise claimants that the deadline for subsequent reviews are extended until further notice and encourage members to seek additional information and guidance from their plan/employer. When claims and appeals are submitted during the Outbreak Period — even though members are not obligated to do so — UnitedHealthcare will continue to render a claim or appeal decision within normal timeframes. UnitedHealthcare is using that opportunity to advise members about the extensions. Our systems are operationalized to compute and apply the correct tolling period to determine timely filing for claims, appeals and reviews when submitted.