UnitedHealthcare
Golden Rule Insurance Co.

Mental Health Parity and Addiction Equity Act Disclosure
Provider Reimbursement/Coding Edits Frequently Asked Questions

This document includes standard responses to questions related to Mental Health Parity (MHP) and Non-Quantitative Treatment Limitations (NQTL). This communication is not intended, nor should it be construed, as legal advice. Federal and state laws and regulations are subject to change. The content provided is for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Please note, your plan documents govern all benefit determinations and in the case of conflict with this document your plan controls. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

The following explanations apply to both Medical/Surgical benefits and Mental Health/Substance Use Disorder benefits unless stated otherwise.

How are benefits reimbursed?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
The member's plan documents will outline how benefits are reviewed and paid in agreement with the Plan's Provider Reimbursement/Coding Edit policies.	

Who do Provider Reimbursement/Coding Edit policies apply to?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Provider Reimbursement/Coding Edit policies apply to all claims from In-Network and Out-of-Network providers.	

How is a Provider Reimbursement/Coding Edit policy created?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
The Plan leverages and utilizes United Healthcare's (UHC) broader company policies as it applies to provider reimbursement/Coding edits. UHC's Provider Reimbursement Policies are created using the following five steps: 1. Triage/Prioritization: Confirming source and data is available to support a Provider Reimbursement/Coding Edit policy. 2. Research/Analysis: The Plan will request input from internal business areas on any possible provider and/or member concerns. 3. Governance: The policies are reviewed and approved by the Plan. 4. Communication: Providers are notified of new policies through external provider portals. Additional provider communication is completed based on provider impact. 5. Deployment: The Plan develops the system programming to support the published Provider Reimbursement/Coding Edit policy. Based upon the programming logic, claims may be paid upon auto- adjudication; pended to request additional information from the provider; or administratively denied for various reasons such as unbundling code combinations, incorrect or missing modifiers, exceeding daily frequency limitations, etc.	

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How often are Provider Reimbursement/Coding Edit policies updated?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Policies are reviewed at least once a year. They may be reviewed and updated more frequently: • If the Plan becomes aware of new information related to reimbursement of the service • If clarification is needed • Based on provider feedback	

What factors, sources, and evidentiary standards are involved in developing Provider Reimbursement/Coding Edit policies?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
The following factors may be included in the Plan's methodology: • Identification of claims that do not meet the industry standards, according to the Evidentiary Standards, and as described in the reimbursement policies • Assessment of submitted claim(s) against industry standards, according to the Evidentiary Standards, and as described in the reimbursement policies The sources and evidentiary standards may include: • The most current edition of the Current Procedural Terminology (CPT®) published by the AMA • The most current edition of the Healthcare Common Procedure Coding System (HCPCS) published by CMS • The most current edition of the UB-04 Manual and other resources maintained by the National Uniform Billing Committee (NUBC) • CMS claims processing manuals • The most current version of International Classification of Diseases (ICD) • Plan terms, e.g., standard exclusions • Coding guidelines established by recognized professional associations • Internally developed coding guidelines reviewed by internal and external medical professionals In addition, the following sources may also apply: • Outside (external) physician specialty panels • Industry Payer Analysis • Data outliers • Spend trends • Office of the Inspector General (OIG) reports • Department of Justice (DOJ) rulings • Network/Tips/Post-pay Fraud, Waste, Abuse, and Error (FWAE) findings • Industry publications	

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When the Plan develops Provider Reimbursement/Coding Edit policies, does the Plan treat Mental Health/Substance Use Disorder differently than Medical/Surgical "as written"?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. The Plan found the strategy, process, factors, evidentiary standards, source information, and the structure of the committee for the development of Provider Reimbursement/Coding Edit policies is similar for Medical/Surgical and Mental Health/Substance Use Disorder and therefore comparable and no more stringent for Mental Health/Substance Use Disorder.	

Are Mental Health/Substance Use Disorder decisions about Provider Reimbursement/Coding Edit policies made any differently than Medical/Surgical decisions "in operation"?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. The Plan concluded the factors, evidentiary standards, and source information used to develop Mental Health/Substance Use Disorder Provider Reimbursement/Coding Edit policies are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to develop Medical/Surgical Provider Reimbursement/Coding Edits policies "in operation."	