

**WISCONSIN MEDICAID AND CHIP
REGULATORY REQUIREMENTS APPENDIX
DOWNSTREAM PROVIDER**

THIS WISCONSIN MEDICAID AND CHIP REGULATORY REQUIREMENTS APPENDIX (this “Appendix”) supplements and is made part of the provider agreement (the “Agreement”) between UnitedHealthcare Insurance Company or one of its Affiliates (United) and the party named in the Agreement (“Provider”).

**SECTION 1
APPLICABILITY**

This Appendix applies to benefit plans sponsored, issued or administered by United under the State’s Medicaid program, CHIP program and, as applicable, benefit plans for other state-based healthcare programs (the “State Program”) as governed by the State’s designated agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law.

**SECTION 2
DEFINITIONS**

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

- 2.1 Covered Service** means health care service or product for which a Member is enrolled with United to receive coverage under the State Program.
- 2.2 Medicaid Agency** or Agency means the single State agency of administering or supervising the administration of the State Program.
- 2.3 State** is the State of Wisconsin.
- 2.4 State Contract** is the contract between United and the Medicaid Agency for the purpose of providing and paying for Covered Services to Members enrolled in the State Program.

**SECTION 3
PROVIDER REQUIREMENTS**

The State Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that United and Provider agree to undertake, which include the following:

- 3.1 Definitions Related to the Provision of Covered Services.** Provider shall follow the applicable State Contract’s requirements for the provision of Covered Services. Provider’s decisions

affecting the delivery of acute or chronic care services to Members shall be made on an individualized basis and in accordance with the following definitions:

- i) **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to body functions; or (c) serious dysfunction of any body organ or part.
- ii) **Emergency Services** means inpatient and outpatient Covered Services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.
- iii) **Medically Necessary or Medical Necessity** has the same meaning as contained in 42 C.F.R. § 438.210(a)(5) and as indicated in State statutes and regulations, the State Contract, and other State policy and procedures.
- iv) **Poststabilization Care Services** means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under circumstances described in condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 422.113(c), to improve or resolve the enrollee's condition.

3.2 Provider Participation Requirements. Provider hereby acknowledges and certifies to the best of its knowledge the following:

- i) **State Program Participation.** Provider is enrolled as, or has applied to enroll as, a participating provider with the State Program. United may terminate Provider from its State Program Provider network immediately upon notification from the State that Provider cannot be enrolled or has been terminated from the State Program, or the expiration of one 120 day period without enrollment of Provider.
- ii) **Licensure.** Provider has all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement and will maintain such necessary licenses, certifications, registrations and permits at all times throughout the term of the Agreement. If at any time during the term of the Agreement, Provider is not in compliance with this Section, Provider shall discontinue providing services to Members. Additionally, payment will not be made for any items or Covered Services provided during any time period of noncompliance with this Section.
- iii) **Excluded Individuals and Entities.** Provider nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider are: (a) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or b) excluded from participation in federal health care programs under either 42 U.S.C. §§

1320a–7 or 1320a–7a. Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual or entity pursuant to 42 C.F.R. § 1001.1901(b).

3.3 Compliance with Law. Provider shall comply with all federal and State laws and regulations applicable to Provider in performance of the Agreement, including but not limited to, the following:

- i) **Civil Rights.** Provider shall comply with Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act (see 42 CFR 438.3; 42 CFR 438.100(d)).
- ii) **Lobbying.** Provider certifies to the best of Provider’s knowledge and belief, pursuant to 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq. that no federally appropriated funds have been paid or will be paid to any person by or on Provider’s behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- iii) **Medicaid Laws and Regulations.** Provider agrees to abide by all federal and state Medicaid laws, regulations and State Program requirements, including but not limited to:
 - a. 5 C.F.R. § 900.601 et seq., Administration of the Standards for a Merit System of Personnel Administration.
 - b. The following HHS Regulations in 45 C.F.R. subtitle A:
 - i. 45 C.F.R. § 16.1 et seq., Procedures of the Departmental Appeals Board;
 - ii. 45 C.F.R. § 75.1 et seq., Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards;
 - iii. 45 C.F.R. § 80.1 et seq., Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services: Effectuation of Title VI of the Civil Rights Act of 1964;
 - iv. 45 C.F.R. § 81.1 et seq., Practice and Procedure for Hearings Under 45 C.F.R. § 80.1 et seq.;
 - v. 45 C.F.R. § 84.1 et seq., Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting from Federal Financial Assistance.
 - c. **Availability of Services.** Provider will comply with 42 C.F.R. § 438.206 and any applicable State Program regulations and requirements related to availability of services to Members including, but not limited to, meeting State Program

standards for timely access to care and services, taking into account the urgency of the need for services. Additionally, Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service beneficiaries, if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary. In addition, Provider will provide physical access, reasonable accommodations and accessible equipment for Members with physical or mental disabilities.

- d. **Claims Information.** Provider shall promptly submit to United the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third-party liability payment before submitting claims to United.
- e. **Continuity of Care.** Provider shall cooperate with United and provide Members with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's participation with United terminates during the course of a Member's treatment by Provider, except in the case of adverse reasons on the part of Provider.
- f. **Cultural Competency and Access.** Provider shall participate in United's and the State's efforts to efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex, and shall provide interpreter services in a Member's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Members regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Member's condition and ability to understand. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.
- g. **Data; Reports.** Provider agrees to cooperate with and release to United any information necessary for United to comply with the State Contract and federal and state law, to the extent applicable to Provider in performance of the Agreement. Such information includes timely submission of reports including child health check-up reporting, EPSDT encounters, and cancer screening encounters, if applicable, as well as complete and accurate encounter data in accordance with the requirements of United and the State, including but not limited to the requirements set forth in Wis. Admin. Code, Chapter DHS 106.02(9), as may be amended from time to time. . By submitting data to United, Provider represents and attests to United and the State that the data is accurate, complete and truthful, and upon United's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.
- h. **Fraud, Waste, and Abuse.** Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from

participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. United performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to United upon its request in order to determine appropriateness of coding. Further, when Provider has received an overpayment, Provider will return the overpayment to United within 60 calendar days after the date on which the overpayment was identified, and to notify United in writing of the reason for the overpayment.

- i. **Government Audit; Investigations.** Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

Hold Harmless. Provider will accept, as payment in full, the amounts paid by United to Provider for Covered Services to Members, plus any deductible, coinsurance or copayment required to be paid by the Member, and will hold Members harmless in the event that United cannot or will not pay for such Covered Services. If a service is not a Covered Services, prior to providing the service, Provider shall inform the Member the service is not a Covered Service and have the Member acknowledge the information. If the Member still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If United determines a Member was charged for Covered Services inappropriately, such payment may be recovered, as applicable. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

Furthermore, neither United, Providers nor their subcontractors may bill a Medicaid SSI Member for co-payments and/or premiums for medically necessary services provided during the Member's period of enrollment with United.

- j. **Marketing.** Provider will comply with 42 C.F.R. § 438.104 and any applicable State Program guidance and regulations related to marketing materials including, but not limited to, seeking approval from the Medicaid Agency prior to distributing any marketing materials to Members.

- k. **Physician Incentive Plans.** If Provider participates in a physician incentive program (“PIP”), Provider must comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, including but not limited to the following: a) Provider will not make specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to any Member; and b) if the PIP places Provider at substantial financial risk for services that Provider does not furnish itself, Provider must have stop-loss protection in accordance with 42 C.F.R. § 422.208(f).
- l. **Preventable Conditions.** No payment will be made by United to a Provider for provider preventable conditions, as identified in the State Program. Provider shall identify and report to United any provider preventable conditions in accordance with 42 C.F.R. §§ 434.6(a)(12)(i) and (ii) and 42 C.F.R. § 447.26(d).
- m. **Privacy; Confidentiality.** Provider shall safeguard Member privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular Member and shall comply with all federal and state laws and State Program requirements regarding confidentiality and disclosure of medical records or other health and enrollment information.
- n. **Quality; Utilization Management.** Provider agrees to cooperate with United’s quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by United or as required under the State Contract to ensure that Members have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.
- o. **Records.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Members. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law.

Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Members. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

- iv) **Stark Law and the Anti-Kickback Statute.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a

member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals (see, 42 U.S.C. 1395nn; 42 U.S.C. 1320a-7b; 42 C.F.R. § 411.350).

3.4 Requirements for Specific Provider Types. The following provisions apply to certain provider types as indicated:

- i) **Advance Directives.** When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 C.F.R. §§ 417.436(d), 422.128, and 438.3(i).
- ii) **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by United. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.
- iii) **Electronic Visit Verification (EVV).** Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.
- iv) **Long-Term Services and Supports (LTSS) Providers.** Any LTSS Covered Services under the State Contract that could be authorized through a waiver under section 1915(c) of the Social Security Act (the "Act") or a State Program amendment authorized through sections 1915(i) or 1915(k) of the Act must be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4).

3.5 Disclosure. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

3.6 Termination. In the event of termination of the Agreement, Provider shall promptly supply to United all information necessary for the reimbursement of any outstanding Medicaid claims.

SECTION 4 UNITED REQUIREMENTS

4.1 Prompt Payment. United shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State

third party liability law and the terms of the State Contract. Unless United otherwise requests assistance from Provider, United will be responsible for third party collections in accordance with the terms of the State Contract.

- 4.2 Provider Discrimination Prohibition.** United shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. United shall not discriminate against Provider for serving high-risk Members or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting United from limiting a provider's participation to the extent necessary to meet the needs of Members. This provision also is not intended and shall not interfere with measures established by United that are designed to maintain quality of care practice standards and control costs.

- 4.3 Provider-Member Communications.** United may not prohibit, or otherwise restrict, Provider when acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; or (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

United also shall not prohibit a Provider from advocating on behalf of a Member in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

- 4.5 Termination, Revocation and Sanctions.** In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in United's reasonable judgment Provider's performance under the Agreement is inadequate. United shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

SECTION 5 OTHER REQUIREMENTS

- 5.1 Compliance with State Contract.** All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that United has provided or delivered to Provider. The provisions of the State Contract applicable to Provider are incorporated into the Agreement by reference. Nothing in the Agreement relieves United of its legal liability under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.
- 5.2 Monitoring.** United shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, United shall identify to Provider any deficiencies or areas for

improvement mandated under the State Contract and Provider and United shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by United and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which United and Provider practice and/or the performance standards established under the State Contract.

- 5.3 Enrollment.** The parties acknowledge and agree that the State Program is responsible for enrollment, reenrollment and disenrollment of Members.
- 5.4 No Exclusivity.** Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than United or as prohibiting or penalizing United for contracting with other providers.
- 5.5 Delegation.** Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties.
- 5.6 Offshoring.** Neither Provider nor any of Provider's subcontractors shall perform or have performed any work outside the U.S. that involves access to, or the disclosure of, the protected health information of any Member.
- 5.7 Regulatory Amendment.** United may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities including, but not limited to, Medicaid Agency. Unless such laws, regulations, or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

SECTION 6 STATE SPECIFIC REQUIREMENTS

- 6.1 Medically Necessary or Medical Necessity.** In addition to Section 3.1(iii) and as required by the State Contract, Medically Necessary has the meaning in Wis. Admin. Code DHS §101.03(96m): Medicaid services (as defined under Wis. Stat. § 49.46 and Wis. Admin. Code § DHS 107) that are required to prevent, identify or treat a Member's illness, injury or disability; and that meet the following standards:

Are consistent with the Member's symptoms or with prevention, diagnoses or treatment of the Member's illness, injury or disability;

Are provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

Are appropriate with regard to generally accepted standards of medical practice;

Are not medically contraindicated with regard to the Member's diagnoses, symptoms, or other medically necessary services being provided to the Member;

Are of proven medical value or usefulness and, consistent with Wis. Admin. Code § DHS 107.035 are not experimental in nature;

Are not duplicative with respect to other services being provided to the Member;

Are not solely for the convenience of the Member, the Member's family or a provider;

With respect to prior authorization of a service and other prospective coverage determinations made by DHS, are cost-effective compared to an alternative medically necessary service which is reasonably accessible to the Member; and

Is the most appropriate supply or level of service that can safely and effectively be provided to the Member.

For the home and community-based waiver services medically necessary means that the service is reasonable, appropriate and cost-effectively addresses a Member's assessed long-term care need or outcome related to any of the following purposes:

The prevention, diagnosis, and treatment of a disease, condition, and/or disorder that results in health impairments and/or disability;

The ability to achieve age-appropriate growth and development;

The ability to attain, maintain, or regain functional capacity; and

The opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

- 6.2 Active Member Capacity Limits.** To the extent applicable, Provider shall cooperate with United if the Department informs United that the number of Active Members from all populations serviced under the Agreement exceeds capacity limits under the State Medicaid Contract. Provider shall cooperate with United to resolve any capacity limit that has been exceeded and will submit to United, upon request, an attestation indicating the number of Active Members from all populations serviced by Provider as of the date of the request. For the purposes of this provision, "Active Member" means a Member who is seen by the same primary care physician, or by a physician assistant or advanced nurse practitioner under the supervision of the primary care physician, at least three (3) times within a calendar year.
- 6.3 Confidentiality of Family Planning Services.** Provider agrees to ensure the confidentiality of family planning services, as required by State laws and regulations, and the State Contract.
- 6.4 Restraint policy.** Provider agrees to abide by United's restraint policy, which will be provided upon request. Members have the right to be free from any form of restraint or seclusion used as a means of force, control or reprisal.
- 6.5 Emergency and Urgent Care.** Provider agrees to abide by the terms of the State Contract for the timely provision of emergency and urgent care. Where applicable, Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by United in accordance with the State Contract.
- 6.6 Supportive Home Care and In-Home Respite Services.** Providers of supportive home care or in-home respite care services shall comply with the Family Care Training and Documentation Standards for Supportive Home Care and In-home Respite, <https://www.dhs.wisconsin.gov/publications/p01602.pdf>.

- 6.7 Restrictive Measures.** Provider must adhere to regulatory requirements and standards set by the State and United relative to restrictive measures including any type of restraint, isolation, seclusion, protective equipment, or medical restraint.
- 6.8 Incident Report.** Provider must identify, respond to, document, and report Member incidents.
- 6.9 Cooperation with Member Investigations.** To the extent permitted by law, Provider shall fully cooperate with any Member-related investigation conducted by the United, the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity.
- 6.10 Telehealth or Remote Service Delivery.** Provider may not require Member to receive a service via interactive telehealth or remotely if in-person service is available.
- 6.11 Abuse and Neglect Policies.** Provider agrees to follow United's policies for United employees and contracted providers that prohibit all forms of abuse, neglect, exploitation and mistreatment of Members.
- 6.12 Member Records.** Provider agrees to make records available to Members and individuals the Member has authorized in writing to receive records within ten (10) business days of the record request if the records are maintained on site and sixty (60) calendar days if maintained off site in accordance with the standards in 45 C.F.R. Wis. Stats. § 164.524 (b)(2).

Provider agrees to forward records to United pursuant to grievances and appeals within fifteen (15) business days of United's request or, immediately, if the appeal is expedited. If Provider does not meet the fifteen (15) business day requirement, Provider must explain why and indicate when the records will be provided.

- 6.13 Timely Filing.** Provider has no less than 120 days from the date of service to submit claims to United or third-party administrator. For claims with multiple dates of service, the 120 day deadline is applied using the last date of service on the claim.

The Department may override the 120-day deadline for submission of claims when there is a coordination of benefits issue or other exceptional situation. The Department will not unreasonably exercise its authority.