2022
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

California Medi-Cal

San Diego County

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United Healthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic transactions on our website at **UHCprovider.com**.

For other line of business

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information.

Easily find information in this manual using the following steps:

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

If available, use the binoculars or magnifying glass icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our members.

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services**.

Important information about the use of this manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Terms and definitions as used in this manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement.
- "You," "your" or "provider" refers to any health care provider subject to this manual, including physicians, health care professionals, facilities and ancillary providers; except when indicated and all items are applicable to all types of health care providers subject to this guide.
- Community Plan refers to UnitedHealthcare's Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us.
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide.
- Any reference to "ID card" includes both a physical or digital card.

Table of Contents

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan of California Quick Reference Guide

Need to contact us about UnitedHealthcare Community Plan? This reference guide provides you with quick access to a variety of resources.

Provider Services

Phone: 866-270-5785

- Confirm member eligibility and benefits
- Provide care coordination notification
- Check claims status
- Request prior authorization
- Update facility/practice data
- Submit an appeal request

Representatives are available weekdays, 8 a.m. – 5 p.m. PST (except major holidays).

Provider Portal and UHCprovider.com

Use the Provider Portal to perform secure transactions such as checking member eligibility and benefits, managing claims and requesting prior authorization. To access the Provider Portal, go to UHCprovider.com.

If you don't have a One Healthcare ID, go to UHCprovider.com.

To learn more about using the Provider Portal, please visit UHCprovider.com.

Eligibility and Benefits

Please call 866-270-5785 or use the Eligibility & Benefits application on the Provider Portal.

Network Referrals

Find a network provider online or by calling us.

Online: UHCprovider.com > Find Dr. (Go to UHCprovider.com and select the Provider Portal to sign in or create a user ID.)

Phone: 866-270-5785

Behavioral health services may require coordination with UnitedHealthcare or the county. For more information, see Chapter 7 or call 866-270-5785.

Prior Authorization Requests

Phone: 866-270-5785

Prior Authorization forms are available at UHCprovider.com/cacommunityplan > Prior Authorization and Notification.

To view a complete list of services that require prior authorization, please go to UHCprovider.com/cacommunityplan > Prior Authorization and Notification.

Prescription Drugs

Please visit medi-calrx.dhcs.ca.gov/home/cdl for most updated Contract Drug List (CDL).

Claims Submission

Electronic Claims:
Please submit claims within 180 days of service to:
UHCprovider.com/claims

Payer ID: 87726

Paper Claims:
Please mail claims to:
UnitedHealthcare Community Plan – California
P.O. Box 30884
Salt Lake City, UT 84130-0884

Claims Management and Provider Dispute

Please call 866-270-5785 or use the Claims Management and Provider Dispute applications on the Provider Portal.

Provider Dispute Submission

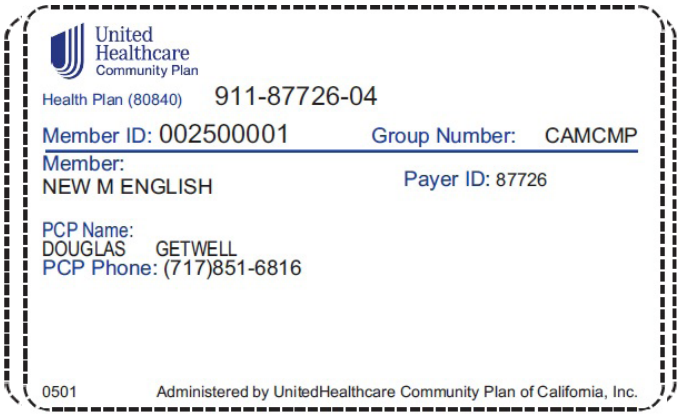
The provider dispute form is located at UHCprovider.com/claims.

Please mail the completed form to:
UnitedHealthcare Community Plan - California
Attention: Provider Dispute
P.O. Box 31364
Salt Lake City, UT 84131

Other Resources

For more information, please contact your Physician Advocate or visit UHCprovider.com/cacommunityplan.

Sample Member ID Card



UnitedHealthcare® Community Plan

Chapter 1: Introduction

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	866-270-5785
Provider Portal	UHCprovider.com, then Sign In using your One Healthcare ID or go to Provider Portal Self Service: UHCprovider.com/en/resource-library/link-provider-self-service.html New users: UHCprovider.com > New User and User Access	866-270-5785
CommunityCare Provider Portal Training	CommunityCare Provider Portal User Guide	866-270-5785
Provider Portal Support	email: ProviderTechSupport@uhc.com	855-819-5909
Resource Library	UHCprovider.com > Menu > Resource Library	

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

UnitedHealthcare Community Plan provides Medi-Cal benefits and service to members, including:

- **Low-income adults**
- **Families with children**
- **SPD — Seniors and Persons with Disabilities**
- **Pregnant women**

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at **866-270-5785**.

How to join our network

For instructions on joining the UnitedHealthcare Community Plan provider network, go to UHCprovider.com/join. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

Already in network and need to make a change?

To change an address, phone number, add or remove physicians from your TIN, or other changes, go to My Practice Profile.

Supporting individuals and families enrolled in Medi-Cal

Case management model

The Case Management (CM) program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community partners to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. CM examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. CM provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. CM provides:

- Market-specific care management encompassing medical, behavioral and social care.
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.
- Options that engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plans.
- Assistance with appointments with PCP and coordinating appointments. The Clinical Health Advocate (CHA) refers members to a Registered Nurse (RN), Behavioral Health Advocate (BHA) or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The CM goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates.
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames.
- Identify and discuss behavioral health (BH) needs, measured by number of behavioral health care provider visits within identified time frames.
- Improve access to pharmacy.
- Identify and remove social and environmental barriers to care.
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®).
- Empower the member to manage their complex/chronic illness or problem and care transitions.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

To refer your patient who is a UnitedHealthcare Community Plan member to CM, call Member Services at **866-270-5785**, TTY 711. You may also call **Provider Services**.

Compliance

HIPAA mandates NPI usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all health care providers who handle business electronically.

Cultural resources

Serving Medi-Cal members requires supporting their cultural and linguistic needs while meeting the Affordable Care Act Section 1557 Language Assistance Requirements outlined in Chapter 2. To help you meet the diverse needs of our Community Plan members, we developed a Cultural Competency Program. You must support UnitedHealthcare Community Plan's Cultural Competency Program.

To support the care plans you develop with patients and to help you meet the state/federal requirements, we offer:

- **Language Interpretation Line:** UnitedHealthcare Community Plan provides oral interpreter services 24 hours a day, seven days a week to its members free of charge at medical and non-medical points of contact. Services for over 240 non-English languages and services for the hearing impaired are available. If a UnitedHealthcare Community Plan member needs interpreter services, they can call the phone number on their ID card. Interpreter services are available over the phone, video interpreting or face-to-face. If you need a professional interpreter during regular business hours between 8 a.m. - 5 p.m. Monday through Friday, call **Provider Services**. After hours, call **877-261-6608** and enter the Client ID 209677 (do not hit #). Press 1 for Spanish and 2

for all other languages.

- **Materials for limited English speaking members:** We provide simplified materials written at or below a 6th grade reading level to members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials to visually impaired members, and in alternative formats. For more support for translated materials or materials format, call **Provider Services**. For more information, go to **uhc.com/legal/nondiscrimination-and-language-assistance-notices**.
- **Cultural Competency Training:** Every care provider must undergo training in cultural competency, integrity and compliance. You can access the Cultural Competency Training and additional resources on **UHCprovider.com**.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses Interqual care guidelines for care determinations.

Online resources

UHCprovider.com is your home for care provider information with access to Electronic Data Interchange (EDI), Provider Portal online services, medical policies and news bulletins. It also includes resources to support administrative tasks such as eligibility, claims, claims status, and prior authorizations and notifications. Go to **Self Service** for Self Service Tool online training and information.

Electronic Data Interchange

EDI is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837),
  - Eligibility and benefits (270/271),
  - Claims status (276/277),
  - Referrals and authorizations (278),
  - Hospital admission notifications (278N), and
  - Electronic remittance advice (ERA/835).

Visit **UHCprovider.com/EDI** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeEDI**.

Getting Started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system.
- Contact clearinghouses to review which electronic transactions can interact with your software system.

Read our **Clearinghouse Options** page for more information.

Provider Portal - secure care provider website

The UnitedHealthcare Provider Portal provides a secure online portal to support your administrative tasks including eligibility, claims and prior authorization and notifications. To sign in to the Provider Portal, go to **UHCprovider.com** and click the Sign In button in the upper right corner. For more information about all online services, go to **Self Service Tools and Eligibility** or go to the Provider Portal Self Service page at **UHCprovider.com/en/resource-library/link-provider-self-service.html**.

For Provider Portal training, go to Community Care **Provider Portal User Guide**.

To access the Provider Portal, the secure care provider website, go to **UHCprovider.com** and either sign in or create a user ID. You will receive your user ID and password within 48 hours.

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limits.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box on UHCprovider.com titled "what can we help you find?" The search results will display all documents and/or web pages containing that code.
- Find certain web pages more quickly using direct URLs. You'll see changes in the way we direct you to specific web pages on our UHCprovider.com provider portal. You can now use certain direct URLs, which helps you find and remember specific web pages easily and quickly. You can access our most used and popular web pages on UHCprovider.com by typing in that page's direct URL identified by a forward slash in the web address, e.g. UHCprovider.com/claims. When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

You will conduct business with us electronically. Using electronic transactions is fast, efficient, and supports a paperless work environment. Use both EDI and UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically. **To access the Provider Portal, go to UHCprovider.com, then Sign In**.

Here are the most frequently used transactions on the Provider Portal:

- **Eligibility and Benefits** — View patient eligibility and benefits information for most benefit plans. For more information, go to UHCprovider.com/eligibility.
- **Claims** — Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to UHCprovider.com/claims.
- **Prior Authorization and Notification** — Submit notification and prior authorization requests. For more information, go to UHCprovider.com/paan.
- **Specialty Pharmacy Transactions** — Submit notification and prior authorization requests for

certain medical injectable specialty drugs. Go to UHCprovider.com/pharmacy for more information.

- **My Practice Profile** — View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to UHCprovider.com/mypracticeprofile.
- **Document Library** — Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, and can only be pulled at the individual practitioner level. For more information, go to UHCprovider.com/documentlibrary.
- **Paperless Delivery Options** — The Paperless Delivery Options tool can send daily or weekly email notifications to alert you to new letters when we add them to your Documents and Reporting. With our delivery options, you decide when and where the emails are sent for each type of letter. This is available to Provider Portal One Healthcare ID password owners only.
- **Training** — Watch live broadcasts and on-demand programs on topics important to you. Visit UHCprovider.com/training for more information.

Watch for the most current information on our self-service resources by email, in the Network Bulletin, or online at UHCprovider.com/EDI or the Provider Portal at UHCprovider.com.

For more instructions, visit UHCprovider.com/training or Self Service Tools for online self- service training and information.

California Required Provider Trainings

DHCS requires all Medi-Cal Managed Care contracted care providers to participate in required trainings. We offer these trainings:

Introduction to UnitedHealthcare Community Plan of California/Medi-Cal — This training covers the following topics and more:

- Our mission and vision
- UnitedHealthcare Community Plan of California overview
- Member eligibility and benefits
- Notification and prior authorization
- Pharmacy services
- Doing business with us
- Care provider resources

Capitated and Delegated Providers: Please see Chapter 14, Additional Info for Delegated/Capitated Providers regarding submission of attestation of new provider training.

Cultural Competency and Americans with Disability Act — This training discusses why cultural competency and the Americans with Disabilities Act (ADA) requirements are important to care providers, including information on:

- Cultural competency overview
- ADA overview
- Impact of these requirements on care providers
- Provider's role in complying with these requirements

These trainings are available through the Provider Portal.

Initial Health Assessment (IHA) – This training covers:

- IHA Requirements
- Components of IHA
- Preventive Services
- Comprehensive Physical and Mental Status Exam
- Diagnoses and Plan of Care
- Stay Healthy Assessment (SHA)
- Coding Guide

Timely Access to Care – This training covers:

- Urgent Care Appointment
- Non Urgent Appointment
- Telephone Wait Time
- Interpreter Services for Scheduled Appointments

These trainings are available at UHCprovider.com/training.

Additional care provider trainings are required, such as:

- Blood Lead Screening
- Maternal Mental Health
- Adverse Childhood Experiences

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with a network provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Provider Services

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

Provider Services works closely with all departments in UnitedHealthcare Community Plan.

Contact information

You can address questions and concerns by using the Provider Portal, **UHCprovider.com** or calling Provider Services at **866-270-5785**. Here are additional resources that may help meet specific, less general needs.

We no longer use fax numbers for most departments, including benefits, prior authorization and claims.

Topic	Contact	Information
Benefits	**UHCprovider.com/benefits** 866-270-5785	Confirm a member's benefits and/or prior authorization.
California Smokers' Helpline (Kick It California)	**kickitca.org** 800-300-8086	Ask about free services for quitting tobacco/ smoking.
Cardiology	For prior authorization or a current list of CPT codes that require prior authorization, visit **UHCprovider.com/ cardiology**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Case Management	866-270-5785 **UHCprovider.com**	Refer high-risk members (e.g., asthma, diabetes, obesity).
Claims	Use the Provider Portal at **UHCprovider. com/claims** 866-270-5785 Mailing address: **UnitedHealthcare Community Plan of California, Inc.** P.O. Box 30884 Salt Lake City, UT 84130-0884 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Ask about a claim status or about proper completion or submission of claims.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access the Provider Portal, then select the UnitedHealthcare Online app 866-270-5785 Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Electronic Data Intake Claim Issues	**ac_edi_ops@uhc.com** 800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	866-270-5785	Information is also available at **UHCprovider.com/edi**.
Eligibility	To access eligibility information, go to UHCprovider.com then Sign In to the Provider Portal or go to **UHCprovider.com/eligibility**. Interactive Voice Response (IVR): 855-918-2265	Use our IVR system any time to get a summary of benefits, check eligibility, and find claim and prior authorization status.
Enterprise Voice Portal	877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud and Abuse (Payment Integrity)	Payment Integrity Information: UHCprovider.com/CAcommunityplan > **Integrity of Claims, Reports, and Representations to the Government**. Reporting: **uhc.com/fraud** 800-455-4521 or 877-401-9430	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory Services	**LabCorp.com** 800-833-3984 Quest Diagnostics **questdiagnostics.com** Provider Services 866-270-5785	LabCorp and Quest Diagnostics are the preferred lab providers.

Topic	Contact	Information
Medical Claim Reconsideration and Appeal	Sign in to the Provider Portal at UHCprovider.com or go to **UHCprovider.com/claims** for more information. 866-270-5785 Mailing address: **UnitedHealthcare Community Plan** P.O. Box 31341 Salt Lake City, UT 84131 Provider Dispute mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** Attn Provider Disputes P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	866-270-5785	Assist members with issues or concerns. Available 7 a.m. – 7 p.m. Pacific Time, Monday through Friday.
Mental Health & Substance Abuse (OptumHealth Behavioral Solutions of California)	For general information and contractual questions: Optum Health Behavioral Solutions **providerexpress.com** 877-614-0484 For eligibility, claim status, or customer service: 866-270-5785 See **Chapter 7** for more contact information.	Refer members for behavioral health services. A PCP referral is not required.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	866-270-5785. After hours, you may contact 877-261-6608 and enter the Client ID 209677 (do not hit #) Press 1 for Spanish and 2 for all other language TDD 711	Available 8 a.m. – 5 p.m. Pacific Time, Monday through Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Team	866-574-6088	This is the provider relations team. Ask about contracting, credentialing status and care provider services.

Topic	Contact	Information
Network Management Resource Team	Networkhelp@uhc.com 877-842-3210	Self-service functionality to update or check credentialing information.
NurseLine	866-270-5785	Nurseline is a triage service available to members 24 hours a day, seven days a week. Available 24 hours a day, seven days a week.
Obstetrics and Baby Care	800-599-5985 Healthy First Steps: uhchealthyfirststeps.com 800-599-5985	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to uhchealthyfirststeps.com to sign up for Healthy First Steps Rewards.
Oncology Prior Authorization	UHCprovider.com > Prior Authorization > Oncology Optum 888-397-8129 Monday -Friday 7am – 7pm CST	For current list of CPT codes that require prior authorization for oncology
One Healthcare ID Support Center	email: ProviderTechSupport@uhc.com 855-819-5909	Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.
Pharmacy Services	medi-calrx.dhcs.ca.gov/home/ 800-977-2273	Magellan oversees and manages the pharmacy network for MediCal Rx. Use the MediCal Rx provider portal to look up contracted drug list (CDL), submit a prior authorization, access beneficiary eligibility lookup and review web claims submissions.
Prior Authorization Requests & Advance Admission Notification	To notify us or request a medical prior authorization: EDI: Transactions 278 and 278N Online tool: UHCprovider.com/paan Phone: Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications." Or call 866-270-5785	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/prior authorization lists: Visit UHCprovider.com/CAcommunityplan > Prior Authorization and Notification
Provider Portal Support	Email: ProviderTechSupport@uhc.com	Available 5 a.m. – 7 p.m. Pacific Time (PT), Monday through Friday; 4 a.m. – 4 p.m. PT, Saturday; and 7 a.m. – 4 p.m. PT, Sunday.

Topic	Contact	Information
Provider Services	866-270-5785	Available 8 a.m. – 5 p.m. Pacific Time, Monday through Friday.
Radiology Prior Authorization	**UHCprovider.com/radiology** 866-889-8054	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Referral Submission	UHCprovider.com > Menu > **Referrals** or use Referrals on the Provider Portal. Click Sign in in the top right corner of **UHCprovider.com**, then click Referrals. 866-270-5785	Submit new referral requests and check the status of referral submissions.
Reimbursement Policy Updates	UHCprovider.com/CAcommunityplan > **Policies and Clinical Guidelines**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Technical Issues	**UHCprovider.com/en/contact-us/technical-assistance.html** email: **ProviderTechSupport@uhc.com** 866-209-9320 for Optum support or 866-842-3278, Option 1 for web support	Call if you have issues logging in to the Provider Portal, you cannot submit a form, etc.
Transportation	ModivCare Facilities and provider offices: arrange transportation for members or request a physician certification (PCS) form 866-529-2128 Members: 844-772-6623	To request transportation, please call three business days in advance of the appointment or call as soon as you can when there is an urgent appointment, Monday – Friday, 7a.m. – 7p.m. Pacific Time.
Utilization Management	Provider Services 866-270-5785	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Call to request a copy of our UM guidelines or for information about the program. For UM policies and protocols, go to UHCprovider.com, then select **Policies and Protocols**.
Vaccines for Children (VFC) program	877-243-8832	You must participate in the VFC Program administered by the Department of Health Care Services (DHCS) and must use the free vaccine when administering vaccine to qualified eligible children. You must enroll as VFC providers with DHCS to bill for the administration of the vaccine.

Topic	Contact	Information
Vision Services	marchvisioncare.com	For eye exams, members can select a vision provider using MARCH Vision Care.
Website for CA Community Plan	UHCprovider.com/cacommunityplan	Access your state-specific Community Plan information on this website.

Chapter 2: Care Provider Standards and Policies

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	866-270-5785
Enterprise Voice Portal		877-842-3210
Eligibility	UHCprovider.com/eligibility	866-270-5785
Referrals	UHCprovider.com > Menu > Referrals	866-270-5785
Provider Directory	UHCprovider.com > Find Dr.	866-270-5785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

General care provider responsibilities

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management (UM) or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

UnitedHealthcare Community Plan members and/or their representative(s) may take part in the planning and implementation of their care. To help ensure members and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires you:

1. Educate members, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.

Provide official notice

Write to us within 10 calendar days if any of the following events happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

You may use the Provider Demographic Change Form for demographic changes or to update NPI information for care providers in your office. This form is located at the Provider Portal at UHCprovider.com > then Sign In > Provider Practice Profile.

Behavioral health providers contracted through OptumHealth Behavioral Solutions of California (OHBS-CA) should contact Network Management at 866-574-6088.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

Arrange coverage

If you cannot provide care and must find an alternate care provider, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals.

For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com/cacommunityplan. Behavioral Health providers contracted through OHBS-CA can update their practice information on providerexpress.com.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need. To accurately list care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for one year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for one year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a health care provider

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available on the Provider Portal at UHCprovider.com > Sign In > My Practice Profile.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Send this information to the email listed on the bottom of the demographic change request form.

Delegated groups submit provider demographic changes to either pacific_delprov@uhc.com or delprov@uhc.com (whichever is appropriate for their group). The submission must contain all required data needed to update the provider's TIN as outlined on the "Newly Cred – TIN Additions" tab found on the UnitedHealthcare Provider Data template.

The template is not mandatory. However, our template outlines the data requirements that must be included regardless of the format the delegate uses to submit the change.

Behavioral health providers who are contracted through OHBS-CA can make changes to their TIN information on providerexpress.com.

Updating your practice or facility information

You can update your practice information through the Provider Portal application on UHCprovider.com. Go to UHCprovider.com then select Sign In. Or submit your change by:

- Completing the Provider Demographic Change Form and emailing it to the appropriate address listed on the bottom of the form.
- Calling our Enterprise Voice Portal at **877-842-3210**.

Behavioral health providers who are contracted through OHBS-CA can update their practice information on providerexpress.com.

Care provider directory

Online care provider directory

The medical, dental and mental health care provider directory is located at UHCprovider.com. Click Find Dr. icon.

UnitedHealthcare Community Plan ongoing updates to our provider directories

The state requires us to perform ongoing updates to our care provider directories, both online and hard copy.

We are required to contact all participating care providers annually and independent physicians every six months. We require you to confirm your information is accurate or provide us with applicable changes. If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you. If these attempts are unsuccessful, we notify you that if you continue to be non-responsive we will remove you from our provider directory after 10 business days.

If we receive notification the Provider Directory information is inaccurate, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we are required to make outreach if we receive a report of incorrect provider information. We are required to confirm your information.

Ability to accept new patients

You are required to tell us, within five business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, you must direct them to report any inaccuracy in our Provider Directory to:

- UnitedHealthcare Community Plan for additional assistance in finding a care provider, and, as applicable, either the California Department of Managed Health Care or the California Department of Insurance.

Quarterly reviews, updates and attestations

You or an entity delegated to conduct credentialing activities on behalf of UnitedHealthcare (a “delegate”) are expected to review, update care provider records and attest to the information available to our members, including the information listed here, at least quarterly.

- If you or the delegate cannot attest to the information, you or the delegate must supply corrections to UnitedHealthcare online or through the Provider Service Center.
- At least 30 calendar days before the change is effective, you or the delegate must notify us of changes to all care provider information. This includes adding new information and removing outdated information, as well as updating the paragraph.
- Delegates are responsible for notifying us of these changes for all of the participating providers credentialed by the delegate.
- You and the delegates are required to update all care provider information, including but not limited to the following:
  - The status as to whether the participating care provider is accepting new patients or not
  - The address(es) of the office locations where the participating care provider currently practices
  - The phone number(s) of the office locations where the participating care provider currently practices
  - The email address of the participating care provider
  - Whether or not the participating care provider is still affiliated with listed care provider groups
  - The hospital affiliation(s) of the participating care provider
  - The specialty of the participating care provider
  - The license(s) of the participating care provider
  - The TIN used by the participating care provider
  - The NPI(s) of the participating care provider
  - The languages spoken/written by the participating care provider and the staff
  - The ages/genders served by the participating care provider

- Completion of the Cultural Competency Training by the participating care provider

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

If a member calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center.

We provide telephone triage or screening services 24 hours a day. Members can get help to determine how urgent their condition is, including a return call within 30 minutes.

Additionally, you must have a physician or an appropriate licensed professional available for after-hours calls.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. The state's priorities determine the initiatives. See Chapter 10 for more details.

Timely access to care standards

The Department of Managed Healthcare and DHCS require you to complete appointment requests within these timelines. These standards guarantee that patients have timely access to care.

- Urgent Appointments Wait Time
  - for services that do not need prior approval: 48 hours
  - for services that do need prior approval: 96 hours
- Non-Urgent Appointments Wait Time
  - Primary care appointment: 10 business days
  - Specialist appointment: 15 business days
  - Appointment with a mental health care provider (who is not a physician): 10 business days
  - Appointment for other services to diagnose or treat a health condition: 15 business days
  - Opioid treatment program: within 3 business days of request

Annual monitoring

To help you follow the timely access to care standards, we ask certain care providers to complete a Provider Appointment and Availability Survey each year. UnitedHealthcare Community Plan of California closely monitors grievance reports to identify access and availability issues. Issues will be tracked and, may result in an Improvement Action Plan, if needed.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 10 years or longer if required by applicable statutes or regulations.

Performance data

You must allow the plan to use care provider performance data for quality monitoring purposes.

Comply with protocols

You must comply with UnitedHealthcare Community Plan's and Payer's Protocols, including those contained in this manual.

You may view protocols at UHCprovider.com/cacommunityplan.

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan members as those

offered to commercial members. In our service area, we have a range of primary, specialty, facility and ancillary services available and accessible to our members.

Protect confidentiality of member data

Members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law.

If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

We use member information for treatment, operations and payment. We have safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference **Chapter 9** for Medical Record Standards.

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through the Member Handbook and other communications. Please document in a prominent place in the medical record whether a member has an advance directive form.

Contract questions, disputes and arbitration

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member Handbook at **UHCCommunityPlan.com** > For Members > CA Medi-Cal Plan Details > Member Information.

Also reference **Chapter 12** for information on Provider Claim Disputes, Appeals and Grievances.

Notification of departure of physicians or other care providers

In the event of a departure of health care providers from your practice, we ask that you notify us immediately to allow sufficient time for member notification.

To help ensure we have your most current provider directory information, submit applicable changes to:

For Delegated providers, email your changes to **pacific_delprov@uhc.com** or **delprov@uhc.com**.

For Non-delegated providers, visit **UHCprovider.com** for the Provider Demographic Change Submission Form and further instructions.

Provider attestation

Confirm your provider data every quarter through the Provider Portal at **UHCprovider.com** or by calling Provider Services. If you have received the upgraded My

Practice Profile and have editing rights, access the My Practice Profile in the Provider Portal to make many of the updates required in this section.

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services, and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

You should take the following steps before providing medical services and/or medication to UnitedHealthcare Community Plan members:

- Verify eligibility using the Provider Portal at UHCprovider.com/eligibility or by calling Provider Services. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization:
  1. To access the Prior Authorization app, go to UHCprovider.com, then click Sign In.
  2. Select the **Prior Authorization and Notification app**.
  3. View notification requirements.

You may also find information on UHCprovider.com/cacommunityplan > Prior Authorization.

Identify and bill other insurance carriers when appropriate.

If you have questions, please call UnitedHealthcare Web Support at **866-842-3278**, option 2, 7 a.m. – 9 p.m. Pacific Time, Monday through Friday.

Outpatient injectable cancer therapy prior authorization requirement

Prior authorization is required when adding a new injectable chemotherapy drug or cancer therapy to an existing regimen.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- Urgent: 24 hours
- Non-urgent: 10 business days

Requirements for morbidity surveillance and reporting

You are required to follow reporting requirements listed on cdph.ca.gov/HealthInfo/ Documents/Reportable_Diseases_Conditions.pdf.

Treatment plans, or other clinical information may be requested. You will need to cooperate with the treatment plan developed by the Local Health Department. Regular updates must be provided to the Local Health Department until treatment is completed. For members with known or suspected Tuberculosis (TB), referrals to the Direct Observation Therapy (DOT) program are made, as applicable.

The reportable disease reporting forms may be found at: cdph.ca.gov/pubsforms/forms/Pages/CD-Report-Forms.

Health department communicable disease contact information:

San Diego County
1600 Pacific Highway, Room 206
San Diego, CA 92101

Sexually Transmitted Disease (STD): **619-692-8541**

TB: **619-692-5516**

Epidemiology (Epi): **858-715-6458**

stdsandiego.com

sdepi.org

Requirements for PCP and specialists serving in PCP role

Specialists include internal medicine, pediatrics, or obstetrician/gynecology

PCPs are an important partner in the delivery of care, and California Community Plan members may seek services from any participating care provider. The CA Department of Health Care Services (DHCS) requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, seven days a week coverage and backup coverage when they are not available.

Medical doctors (M.D.s), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family practice
- Pediatrics
- Obstetrics/gynecology

NPs may enroll with the state as solo providers, but PAs cannot. They must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Customer Service is available 7 a.m. - 7 p.m., Monday through Friday.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Direct access for women's health care services

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

Office hours and coverage

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include anytime availability. During non-office hours, access by phone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

Consult with other appropriate health care professionals to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due for preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well-baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by phone any time.
- Tell members about appropriate use of emergency

services.
- Discuss available treatment options with members.

Responsibilities of PCPs and specialists serving in PCP role

Specialists include internal medicine, pediatrics, and/or obstetrician/gynecology

In addition to meeting the requirements for all care providers, PCPs must:

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Schedule member appointments directly. You are responsible for following up with members who miss appointments.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- An Initial Health Assessment (IHA) must be completed within 120 days of enrollment. This consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). Follow the Staying Health Assessment (SHA) Periodicity Schedule. Find the SHA policy letter, forms, and provider training materials at **dhcs.ca.gov**
- For members younger than age 21, the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment must be completed concurrently with the IHA. Be sure their immunizations are up to date. If the member requires a referral to a program such as California Child Services (CCS), Early Start or California Department of Developmental Services (DDS), perform the appropriate baseline health assessments and diagnostic evaluations to show that a member has an CCS-eligible medical condition.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to **Provider Services** or our Clinical or Pharmacy departments as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Disabilities (ADA) standards.
- Complying with the CA DHCS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in **Chapter 2** of this manual.

Language Assistance Requirements — Section 1557 of the Affordable Care Act

Federal legislation requires that all limited English proficient (LEP) beneficiaries' language access needs be met for all medical appointments. To refuse an LEP beneficiary access to language services is a violation of that individual's civil rights. It also prohibits care providers from requesting a beneficiary to provide their own interpreter or rely on a staff member who is not qualified to communicate directly with the LEP individual. It is the care provider offices' responsibility to ensure that the qualified interpreter has been assessed for bilingual proficiency. Also, it is the care provider offices' responsibility to report languages spoken by care providers and/or office staff to the plan as well as any changes.

Meeting a patient's language needs requires collaboration between provider, health plan, and patient. Section 1557 of the Affordable Care Act stipulates that both care provider and health plan are covered entities under the law, and therefore, we must work together to meet the language needs of our members.

If you cannot identify the language needs of a member, call the plan to receive this information. Additionally, It is required that you document all interpreter services requests in the member's medical record, including refusal of services.

IHA components and requirements

PCPs are responsible for reviewing each member's IHA in combination with:

- Medical history, conditions, problems, medical/ testing results, and member concerns.
- Social history, including member's demographic data, personal circumstances, family composition, member resources, and social support.
- Local demographic and epidemiologic factors that influence risk status.

Components

The IHA consists of:

- Comprehensive History – must be sufficiently comprehensive to assess and diagnose acute and chronic conditions
- History of present illness
- Past medical history
  - Age-appropriate immunization status
  - Age-appropriate feeding and dietary status
  - Allergies
  - Current medications
  - Prior hospitalizations
  - Prior major illnesses and injuries
  - Prior operations
- Social history
  - Current employment
  - Level of education
  - Marital status and living arrangements
  - Occupational history
  - Sexual history
  - Use of alcohol, drugs and tobacco
  - Any other relevant social factors
- Review of systems
- Preventive services
  - Asymptomatic healthy adults – must adhere to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counseling services. Document status of current recommended services.
  - Members younger than 20 years of age - adhere to the CDC Child and Adolescent Immunization Schedule for members ages 18 and younger.
  - Perinatal services for pregnant members must be provided based on the most current standards of guidelines of the American College of Obstetrics and Gynecology (ACOG). A DHCS approved comprehensive risk assessment tool must be used for all pregnant members. This must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up and documented in the medical record.
- Comprehensive Physical and Mental Status exam must be sufficient to assess and diagnose acute and chronic conditions.
- Diagnoses and Plan of Care – the plan of care must include all follow up activities
- Individual Health Education Behavioral Assessment (IHEBA)
  - IHEBA requirement – administer an age-specific IHEBA as part of the IHA. Assessment tools used to complete the IHEBA must be approved by the Medi-Cal Managed Care Division (MMCD) prior to use.
  - Exceptions for transferring members – the IHEBA requirement for members transferring from an outside group may be met if the medical record indicates in the IHEBA tool or a behavioral risk assessment has been completed within the last 12 months. The age specific and age appropriate behavioral risk assessment should cover:
    - Diet and weight issues
    - Dental care
    - Domestic violence

- Drugs and alcohol
- Exercise and sun exposure
- Medical care from other sources
- Mental health
- Pregnancy
- Birth control
- STIs/STDs
- Sexuality
- Safety prevention
- Tobacco use and exposure

Requirements

Who Can Perform the IHA

- The member's PCP of record
- Perinatal Care Providers
- Primary Care Providers
- Non-Physician Mid-Level Practitioners

Timelines for the Provision of the IHA

- New Plan Members – within 120 calendar days of enrollment
- Members Changing PCP – if a member initiates a change in PCP within the first 120 days of enrollment and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within 120 calendar days of enrollment

IHA Visit Settings

- An IHA may be performed in settings other than ambulatory care for members who are continuously enrolled for 120 days:
  - Nursing facility (NF)
  - Home visits
  - Hospitals

Initial health assessment care provider training

UnitedHealthcare Community Plan of California partners with our care providers to help ensure patients receive an Initial Health Assessment. This allows you to have a comprehensive view of your patients' healthcare needs. For this reason, the Quality Department has created a short training that encompasses the Department of Health Care Services (DHCS) Policy Letter 08-003. It is a new requirement from the state for participation in the Medi-Cal program. You can complete the Initial Health Assessment Care Provider Training within 15 minutes or less. Follow the next steps below.

Next steps

1. Go to **UHCprovider.com/training** and click on Initial Health Assessment Care Provider Training.
2. Review all the educational topics and links.

The Quality Department routinely monitors Initial Health Assessment completion rates through random sampling of practice sites. Your office may be selected as part of the random sample methodology. If requested, please return pertinent medical record content including the Staying Healthy Assessment Form, immunization records, lab results, and evidence of a complete physical. Results of the Initial Health Assessment review will be shared with you and published in the Annual Quality Management Program Evaluation. We thank you and your staff for participation in this monitoring activity.

Staying Healthy Assessment (SHA) periodicity schedule

- Members must complete a SHA based on the following guidelines and time frames listed. Document a member's refusal to complete the SHA on the appropriate age-specific form and keep in their records.
- **New members** must complete the SHA within 120 days of the effective date of enrollment. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System (MEDS) that a member is eligible to receive services.
- **Current members** who have not completed an updated SHA must complete it during the next preventive care office visit, based on the SHA periodicity table.
- **Pediatric members** – Members 0 –17 years old must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA yearly with the patient (parent/guardian or adolescent) before the patient reaches the next age group.

  Adolescents (12–17 years) should complete

the SHA without parental/guardian assistance beginning at 12 years old, or at the earliest age possible. This helps to get accurate responses to sensitive questions. You should determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

- **Adult and senior members** – There are no designated age ranges for the adult and senior assessments. It is intended for use by 18 to 55 year olds. The age at which the PCP should begin administering the senior assessment to a member should be based on the patient's health and medical status, and not exclusively on age. The adult or senior assessment must be re-administered every three to five years, at a minimum. You must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

Although not required, SHA annual administration is highly recommended for the adolescent and senior groups because behavioral risk factors often change during these years.

	Periodicity	Administer	Administer/Re-administer		Review
DHCS Form Numbers	**Age Groups**	**Within 120 Days of Enrollment**	**1st Scheduled Exam** (after entering new age group)	**Every 3-5 years**	**Annually** (intervening years)
DHCS 7098 A	0-6 Months	✓	✓		
DHCS 7098 B	7-12 Months	✓	✓		
DHCS 7098 C	1-2 Years	✓	✓		✓
DHCS 7098 D	3-4 Years	✓	✓		✓
DHCS 7098 E	5-8 Years	✓	✓		✓
DHCS 7098 F	9-11 Years	✓	✓		✓
DHCS 7098 G	12-17 Years	✓	✓		✓
DHCS 7098 H	Adult	✓		✓	✓
DHCS 7098 I	Senior	✓		✓	✓

SHA Documentation by PCP

A. Sign, print your name, and date the "Clinic Use Only" section of a newly administered SHA to verify you reviewed and discussed it with the member.

B. Document specific behavioral-risk topics and patient counseling, referral, anticipatory guidance, and follow-up provided, by checking the appropriate boxes in the "Clinical Use Only" section.

C. Sign, print your name, and date the "SHA Annual Review" section of the questionnaire to document that an annual review was completed and discussed with the member.

D. If a member refuses:
   - Enter the member's name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire.
   - Check the box "SHA Declined by Patient."
   - Sign, print your name, and date the "Clinic Use Only" section of the SHA.
   - Keep the SHA refusal in the member's medical record.

Rural health clinic, federally qualified health center, Indian health clinic or primary care clinic as PCP

Members may choose a rural health clinic (RHC), a federally qualified health center (FQHC), Indian Health Clinic or a primary care clinic (PCC) as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a care provider, PA, NP and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.
- **Indian Health Clinics:** The Indian Health Clinics provide access to care to our Native American members who are part of a federally recognized tribe.
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

PCP checklist

- Verify eligibility and benefits on UHCprovider.com. Click "Sign In" in the top right corner to access the Provider Portal, or call Provider Services.
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/paan.
- Refer patients to UnitedHealthcare Community Plan participating specialists when needed.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

Specialist care providers responsibilities

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the CA DHCS Access and Availability standards for scheduling routine visits. Appointment standards are covered in **Chapter 2** of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician when they are not available. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Ancillary care provider responsibilities

Ancillary care providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care providers. PCPs and specialist care providers must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary care provider checklist

Take the following steps when providing services to UnitedHealthcare Community Plan members:

- Verify the member's enrollment before rendering services. Go to the Provider Portal at **UHCprovider.com** or contact **Provider Services**. Failure to verify member enrollment and assignment may result in claim denial.
- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/cacommunityplan** > Prior Authorization.
- Identify and bill other insurance carriers, when appropriate.

Chapter 3: Care Provider Office Procedures and Member Benefits

Key contacts

Topic	Link	Phone Number
Member Benefits	UHCCommunityPlan.com/CA	866-270-5785
Member Handbook	UHCCommunityPlan.com/CA	Go to Plan Details, then Member Resources, View Available Resources
Provider Services	UHCprovider.com	866-270-5785
Prior Authorization	UHCprovider.com/paan	866-270-5785
DSNP	UHCprovider.com > Health Plans by State > California > Medicare	866-270-5785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

Benefit information

View member benefit coverage information online at UHCCommunityPlan.com/CA. The following benefits are not all-inclusive.

Members must use network care providers. Out-of-network services require prior authorization

Acupuncture Services.	We cover acupuncture services to prevent, modify or alleviate severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of needles) are limited to two services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services. If further medically necessary services are needed, submit a prior authorization request for our clinical team to review.
Audiology Services.	We cover two outpatient audiology services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services. If further medically necessary services are needed, submit a prior authorization request for our clinical team to review. These limits do not apply to individuals younger than 21 years.

Cancer Clinical Trials.	We cover routine costs of cancer clinical trials. To qualify for this coverage, the member must: • Be diagnosed with cancer, • Be referred to the cancer clinical trial by a doctor who is in our network, • Receive prior authorization or approval from us, and • Be accepted into an approved clinical trial for the type of cancer. This means that the cancer clinical trial must have a meaningful potential to benefit the member and must be approved by the National Institutes of Health, the United States Food and Drug Administration (FDA), the United States Department of Defense, or the United States Department of Veterans Affairs. Contact Provider Services for more information.
Cancer Screening.	• Cervical cancer screenings, including human papillomavirus (HPV) screening. HPV vaccinations for Members ages 18 through 26 are covered. For children younger than age 18, HPV vaccines are provided by the Vaccines for Children program. • Mammography for breast cancer screening. • Prostate cancer screening and diagnosis. • Colo-rectal cancer screening
Chiropractic Services.	Limit of two services in any one calendar month. Services must be provided at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). There may be additional services available under some circumstances.
Community-Based Adult Services (CBAS)	A member may qualify for CBAS if they have health problems that make it hard for them to take care of themselves. If a member qualifies, we send them to a CBAS center that best meets their needs. CBAS services are free. Covered services include, but are not limited to: • Meals. • Personal care. • Physical therapy. • Occupational therapy. • Skilled nursing care. • Social services. • Speech therapy. CBAS centers offer training and support to member's family and/or caregivers. Members may qualify for CBAS if they are approved to get CBAS and: • They used to get these services from an Adult Day Health Care (ADHC) center, or • Their primary care doctor refers them for CBAS, or • A hospital, skilled nursing facility (SNF) or community agency referred them.

Dental Screenings.	Members are entitled to an annual dental screening as part of initial and periodic health assessments completed by the PCP. A dental screening should include, at a minimum, documentation of the dental history, examination of the teeth and gums and dental education. For members younger than 21 years, the dental screening is performed as part of every periodic assessment and annual dental referrals to appropriate Medi-Cal dental providers are made beginning at age three or earlier if necessary. Covered medical services are those services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered prescription drugs; laboratory services; and, pre admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure, including facility fees and anesthesia services for both inpatient and outpatient services. For children under six years of age, topical application of fluoride up to three times in a 12-month period is a Medi-Cal Managed Care Plan benefit. When the procedure follows a protocol established by the attending care provider, then nurses and other appropriate personnel may apply fluoride varnish. We do not cover routine dental services for anyone 21 years and older. Refer to the Dental Provider Manual for applicable exclusions and limitations and covered services. Standard ADA coding guidelines apply to all claims. Either you or the member may contact the Medi-Cal Dental Program using the Beneficiary Telephone Service Center at **800-322-6384**. The call is free. Medi-Cal dental program representatives are available 8 a.m. to 5 p.m., Monday through Friday Pacific Time.
Diabetic Services.	• Insulin, glucagon, needles and certain prescribed medications under the prescription drug benefit. • Blood glucose monitors and blood glucose testing strips. • Blood glucose monitors designed to assist those who are blind or otherwise visually impaired. • Insulin pumps and all related necessary supplies. • Ketone urine testing strips. • Lancets and lancet puncture devices. • Pen delivery systems for the administration of insulin. • Podiatric devices to prevent or treat diabetes-related foot problems. • Insulin syringes • Visual aids, excluding eyewear, to help the visually impaired with the right insulin dosing. Members younger than 21 years with diabetes are eligible for California Children's Services (CCS).

Durable Medical Equipment (DME).	We cover DME when medically necessary. Here are some examples of the DME we cover (not a complete list). • Apnea monitors. • Blood glucose monitors. • Oxygen equipment. • Standard curved handle cane. • Standard crutches. • Wheelchair. • Hearing aids and batteries for hearing aids. • Batteries for pacemakers. • Colostomy bags, urinary catheters and supplies.
Emergency Care Services.	• 24 hours a day, seven days a week, anywhere in the United States. • Emergency care in Canada or Mexico is covered.
Enteral Nutrition Products.	• For adult members age 21 or older, medically necessary enteral nutrition products that given through a feeding tube. • For members who are less than 21 years of age, enteral nutrition products even if they are not given through a feeding tube.

Family Planning Services.	• Health education and counseling to help the member make informed choices and to understand contraceptive methods. • Limited history and physical examination. • Laboratory tests if medically indicated as part of the member's decision-making process for deciding what contraceptive methods they want. • Contraceptive pills, devices, and supplies. • Follow-up care for complications associated with the contraceptive methods provided or prescribed by the family health planning provider. • Pregnancy testing and counseling, including counseling and surgical procedures for pregnancy termination (abortion). • Tubal ligation (for females). • Vasectomies (for males). • Diagnosis and treatment of a sexually transmitted disease if medically indicated. • Screening, testing and counseling of at risk individuals for HIV and referral for treatment. • Self-Administered Hormonal Contraceptives - Care providers, pharmacists or locations licensed or authorized to dispense drugs or supplies may dispense or furnish members at one time with up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives. - We reimburse a 12-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches or hormone-containing contraceptive vaginal rings when dispensed at one time at a member's request by a qualified family planning provider or pharmacist, including out-of-network care providers. - When furnished by a pharmacist, self-administered hormonal contraceptives must be dispensed following the protocol approved by the California State Board of Pharmacy and the Medical Board of California. A registered nurse, who has completed required training, may also dispense contraceptives when evaluation and management procedures are billed accordingly.
HIV Testing and Counseling.	Confidential HIV testing from any health care provider licensed to provide these services. No Prior Authorization or a referral from PCP or from UnitedHealthcare Community Plan of California, Inc. is needed. Members can be tested for HIV confidentially at: • PCP or doctor • Family Planning Service providers • Local health department • Prenatal clinics • Certain San Diego County clinics Minors 12 years and older may get medical care to diagnose or treat HIV without parental consent. Members with HIV or AIDS may be eligible for other programs that provide special care like the California Children's Services Program and the AIDS Medi-Cal Waiver Program.
Home Health Services.	Home health care services are limited to services that are covered by Medi-Cal, such as medical social services, medical supplies, part-time home health aide care, and part-time skilled nursing care. Care may be provided for by home health aides, medical social workers, nurses, and/or physical, occupational or speech therapists.

Hospice Care.	• Two 90-day periods, beginning on the date of hospice election, followed by unlimited 60-day periods. • A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends. • Member is certified as terminally ill with a life expectancy of 12 months or less if the illness runs its normal course. For recipients younger than age 21: • Recipient younger than 21 years of age and certified by a care provider as having a life expectancy of six months or less may elect to concurrently receive hospice care in addition to curative treatment of the hospice related diagnosis. • Non-hospice providers will be able to bill Medi-Cal for medically necessary, curative treatments provided within their scope of practice and are considered a benefit under the Medi-Cal program. All services are subject to current utilization review mechanisms. Hospice and palliative care are voluntary. Members can receive hospice care services if they have been certified as terminally ill with a life expectancy of 12 months or less if the illness runs its normal course, and the member and their representative choose to receive hospice services. Hospice care can be provided in their home, or they can choose to be admitted to a nursing facility (NF). If they choose an NF, this is not considered to be long-term care. They will not lose their eligibility with us, regardless of how long they expect or actually stay in the NF. If members are 21 years or older and choose to receive hospice care, they waive all rights to be provided with, or to have payment made for, covered services related to the treatment of their terminal illness. If the member is younger than 21 years, choosing hospice care does not waive these rights. Hospice care includes: • Nursing services. • Physician services. • Home health aide and homemaker services. • Medical supplies and appliances. • Counseling services, including bereavement, grief, dietary, and spiritual counseling. • Care for pain control or symptom management.
Hospital Care.	Requires prior authorization except for emergencies or urgent care services. Care providers are required to notify UnitedHealthcare Community Plan of an admission within one business day. Hospital services are not covered outside of the United States, except for emergency services requiring hospitalization while in Canada or Mexico.
Laboratory Services.	Lab services include blood work, throat cultures, and urine tests. Lab services must be provided at a contracted doctor's office, a hospital or laboratory and must be medically necessary. We do not cover laboratory services provided under the State serum alpha-fetoprotein-testing program administered by the California Department of Health Care Services.
Long Term Care (LTC)	We cover medically necessary LTC from admission into an appropriate facility to either the member's release from the facility or to the member electing to receive hospice services. We help ensure the member is placed in a facility that provides the level of care appropriate to their medical needs. These health care facilities include SNF/NF, sub-acute facilities, and intermediate care facilities (ICFs).

Mastectomy.	Services include prosthesis and re-constructive surgery.
Maternity Care.	We cover these maternity care services: • Prenatal care. • Postpartum care. • Nutrition counseling. • Labor and delivery care. • Diagnostic testing. • Genetic testing. • Inpatient care for 48 hours after normal vaginal deliveries. Longer stays must be authorized. • Inpatient care for 96 hours after a delivery by Cesarean section (C-section). Longer stays must be authorized.
Minor Consent Services.	Minor consent services are available for members younger than 18 years without permission or consent from their parent or guardian. Minor consent services are related to: • Sexual assault, including rape. • Drug or alcohol abuse for children 12 years or older. • Pregnancy. • Family planning. • Sexually transmitted diseases (STD) for children 12 years or older. • Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where: (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.
Newborn Care.	A newborn baby is covered under mother for the month of their birth and for the following month.
Obstetrical/ Gynecological (OB/GYN) Care.	Female members do not need a referral or permission from their PCP or from us to see an OB/GYN who contracts with us (also called a network provider). Members can call Member Services at 866-270-5785, TTY: 711.
Occupational Therapy.	We cover occupational therapy evaluation, treatment planning, treatment, instruction and consultative services. Occupational therapy services are limited to two services per month in combination with acupuncture, audiology, chiropractic and speech therapy services. If further medically necessary services are needed, submit a prior authorization request for our clinical team to review.

Outpatient Mental Health Services.	Outpatient mental health services are covered for members who are determined by a mental health screening to be in mild to moderate distress. • Outpatient mental health services. • Individual and group mental health evaluation and treatment (psychotherapy). • Psychological testing when clinically indicated to evaluate a mental health condition. • Psychiatric consultation for medical management. • Screening and Brief Intervention (SBI). • Outpatient laboratory, supplies and supplements. • Drugs (excluding anti-psychotic drugs which are covered by Medi-Cal fee-for-service). • Family counseling. • Neuro behavioral testing. • Neuro psychological testing. • Outpatient mental health services do not require a referral from your PCP. Specialty mental health services such as residential services, inpatient services and specialty outpatient services are covered by the county mental health plan. For help finding more information on specialty mental health services provided by the county mental health plan, call the county at 888-724-7240.
Palliative Care.	Pediatric: Members younger than 21 years may be eligible for palliative care and hospice services concurrently with curative care. • The family and/or legal guardian agree to the provision of pediatric palliative care services; and • There is documentation of a life-threatening diagnosis. For more information, see ALL PLAN LETTER 18-020 on **dhcs.ca.gov.** Adult: Palliative care does not require the member to have a life expectancy of six months or less. It may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if the member meets the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. Disease-specific eligibility criteria: • Congestive heart failure (CHF) • Chronic obstructive pulmonary disease • Advanced cancer • Liver disease For more information on Adult Palliative Care criteria please see ALL PLAN LETTER 18-020 on **dhcs.ca.gov.**
Pharmacy.	See Pharmacy Services section.
Provider Office Visits.	• All routine visits, exams, treatments, and immunizations • Specialty Care – Some services may require prior authorization.
Physical Therapy.	Physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medications.

Podiatry Care Services.	We cover medically necessary podiatry services for diagnosis and medical, surgical, mechanical, manipulative and electrical treatment of the human foot. This includes the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.
Reconstructive Surgery Services.	We cover reconstructive surgery services to repair or correct problems with body parts caused by tumors or disease, infection, accidents or trauma, or birth defects or other abnormal development. Contact Provider Services for more information.
Skilled Nursing Facility (SNF) Services.	Benefits limited to 90 days per calendar year.
Speech Therapy.	We cover up to two medically necessary services per month, in combination with acupuncture, audiology, chiropractic and occupational therapy. We may offer prior authorization for further services as medically necessary.
Substance Use Disorder Services	Provided by Drug Medi-Cal Organized Delivery System Services (DMC-ODS) in San Diego County at 888-724-7240. The plan covers: • Expanded alcohol screening for members 18 years of age and older who are identified as positive in a prescreen or identified by their PCP as having a potential for alcohol misuse. • Brief interventions for members who screen positive for risky or hazardous alcohol use or potential alcohol use disorder. • Any member identified with possible alcohol use disorders will be referred to the alcohol and drug program in the county where the member resides for evaluation and treatment.
Transportation Services.	• Emergency medical transportation (ambulance) services • Non-emergency medical transportation services: - Provided to members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. - Covered Medi-Cal benefit when a member needs medically necessary covered services and has a written prescription from a physician, dentist, podiatrist, or mental health or substance use disorder provider. - - Rides to social determinate locations to access things like support groups, food, exercise, work, school or places of worship. *This is in addition to unlimited rides to/ from the doctor's office and pharmacy. - Subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a SNF or an intermediate care facility. - Treating physicians must complete a physician certification statement (PCS) form to prescribe the member's form of NEMT service and to certify that medical necessity was used to determine the type of transportation requested. - For urgent appointments, members should call as soon as possible. - Treating physicians may call to request or schedule a ride for a member or request a PCS form for NEMT services.

Vision Services.	Vision services are administered by MARCH Vision Care. The Plan covers: • Routine eye exam once every 24 months; UnitedHealthcare Community Plan of California, Inc. may pre-approve (prior authorize) additional services as medically necessary. • Eyeglasses (frames and lenses) once every 24 months; contact lenses when required for medical conditions such as aphakia, aniridia, and keratoconus.
X-Ray Services.	• X-ray services, including advanced imaging. • Service is received in a doctor's office, a hospital or a laboratory, and medically necessary.
Services not covered by UnitedHealthcare Community Plan or Medi-Cal.	• All services excluded from Medi-Cal under state or federal law. • Circumcision (routine), unless medically necessary. • Cosmetic surgery with the exception of approved reconstructive surgical procedures. • Eye appliances. • Experimental services. • Immunizations for sports, work or travel. • Infertility. • Personal comfort items while in the hospital.

Member assignment

Assignment to UnitedHealthcare Community Plan

CA DHCS assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. CA DHCS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

At enrollment time, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Handbook online at UHCCommunityPlan.com/CA. Go to Plan Details, then Member Resources, View Available Resources.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members, including newborns, may change from Fee for Service (FFS) to Medi-Cal Managed Care during hospitalization. To avoid delays in claims processing and payment, have the payer assignment of newborns checked daily.

Get eligibility information by calling Provider Services.

Newborn enrollment

We provide covered services to a child born to a member for the month of birth and the following month. For a child born in the month immediately preceding the mother's membership, we provide covered services to the child during the mother's first month of enrollment.

Encourage your patients to notify the CA DHCS when they know they are expecting. DHCS notifies Managed Care Plans (MCP) daily of a pending birth when CA Medi-Cal learns a woman associated with the MCP is expecting. The MCP or you may use the online change

report through the CA website to report the baby's birth. With that information, DHCS verifies the birth through the mother. The MCP and/or the care provider's information is taken as a lead. To help speed up the enrollment process, the mother should notify DHCS when the baby is born.

Members may call **866-270-5785** TTY: 711 Monday-Friday; 7 a.m. – 7 p.m. Pacific time.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled her baby in a managed care plan.

Newborn PCP selection

Although children cannot be enrolled with an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

UnitedHealthcare Community Plan Members can go to **myuhc.com/communityplan** to look up a care provider.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with California's DHCS, California's Medi-Cal program. The CA DHCS determines program eligibility. An individual who becomes eligible for the CA DHCS program either chooses or is assigned to one of the CA DHCS-contracted health plans.

Initial selection of a PCP

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new members. UnitedHealthcare Community Plan will assign members to the closest and most appropriate PCP.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics.

If the member changes the initial PCP assignment, the effective date will be the day the member requested the change.

Members electing enrollment with a capitated/delegated group

Members may select a PCP that is participating with a capitated/delegated Primary Medical Group. Members are required to access care within the assigned group or obtain a referral from their PCP/group before seeing another in-network care provider.

Assignment to PCP panel roster

Once a member is assigned a PCP, view the panel rosters electronically on the Provider Portal at **UHCprovider.com** then Sign In. The portal requires a unique user name and password combination to gain access.

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, it is removed from auto-assignment. DHCS requires us to monitor individual physicians with a panel more than 2,500 members to help ensure adequate access. To update PCP panel limits, including the availability of Physician extenders and or any capacity concerns, contact your UnitedHealthcare network representative.

To access panel rosters, go to **UHCprovider.com**. Select Sign In on the top right. Log in. Click on Community Care.

The Community Care Roster has member contact information, clinical information to include HEDIS measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. You may also use Document Library for member contact information in a PDF at the individual practitioner level.

You may also find the "Document Library" Quick Reference Guide at UHCprovider.com > Menu > Resource Library > UnitedHealthcare Provider Portal

> Document Library > Learn more about Document Library.

Changing a PCP — member request

Members can request to change their PCP at any time. A member may select a new medical group/IPA/FQHC or PCP by calling Member Service or by accessing myuhc.com. Assignment changes are made effective on the request date.

Members with a delegated group

Members assigned to a delegated medical group may have a waiting period for the effective date of a PCP change, including transfers from one medical group to another.

If a member calls and requests a PCP change between the 1st and 15th of the month, the change will be effective the first day of the following month. If the requested change is received after the 15th, the change will not be effective until the first day of the following (second) month.

Transfer of members receiving ongoing care

Transfers from one participating medical group/IPA/FQHC to another, or PCP transfers initiated outside of member's enrollment period, will not be effective until the first day of the second month following the member's discharge from care, if at the time of the request for transfer or on the effective date of transfer, the member is currently:

- Receiving inpatient care at an acute care facility;
- Receiving inpatient care at a skilled nursing facility (SNF), at a skilled level;
- Receiving other acute institutional care; and
- In the third trimester of her pregnancy (defined as when the member reaches the 27th week of pregnancy).

We do not recommend the member change PCPs while an inpatient in a facility, SNF, or other medical institution, or undergoing radiation therapy or chemotherapy, as a change may negatively affect the coordination of care.

PCP-initiated transfers

A PCP may transfer a UnitedHealthcare Community Plan member due to an inability to start or maintain a professional relationship or if the member is non-compliant. The PCP must provide care for the member until a transfer is complete.

1. To transfer the member, contact a UnitedHealthcare Community Plan physician advocate with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, UnitedHealthcare identification number, current address, current phone number and the care provider's name.
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Member ID card

Check the member's ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.

If a fraud, waste and abuse event arises from a care provider or a member, go to uhc.com/fraud. Or you may call the Fraud, Waste, and Abuse Hotline.

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

Member identification numbers

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member.

Verifying member enrollment

Verify member eligibility prior to providing services. Determine eligibility in the following ways:

- Provider Portal: access the Provider Portal through **UHCprovider.com/eligibility**
- **Provider Services** is available from 7 a.m. - 5 p.m. Central Time, Monday through Friday.
- Medi-Cal Point of Service Network

Member enrollment

How to enroll

Once a member has been approved for Medi-Cal, they will receive an enrollment packet from Health Care Options for enrolling into Managed Medi-Cal. Members may select a managed care plan through completing the Choice Enrollment Form through Health Care Options by calling 800-430-4263 or TTY 711.

Newborns

Newborns are automatically covered under the mother's eligibility for the birth month and the month following. Members may contact Member Services at **866-270-5785** if they have questions about enrolling newborns.

Recertification

Each County, under the direction of the Department of Health Care Services (DHCS), is required to complete the annual eligibility redetermination once every 12 months. Members should receive the annual redetermination packet within 60 days prior to the redetermination date.

Disenrollment/changing health plans

Members may select a different MCP at any time by calling Health Care Options (HCO) at 800-430-4263 or TTY 711. The HCO representative will mail them the Choice Enrollment Form. The disenrollment process takes 15 to 45 days to complete. Members can also select a different MCP during the annual recertification period. The following conditions require MCP disenrollment:

- Member requests to be disenrolled
- Member loses Medi-Cal eligibility
- Member moves outside the MCP's approved service area
- Member's Medi-Cal aid codes changes to an aid code not covered
- Member requests disenrollment as a result of a MCP merger or reorganization
- Member is eligible for carve-out services that require disenrollment Long Term Care (approximately 60 days after admission to a SNF)
- Major organ transplant except kidney and cornea
- Member's enrollment violates the state's marketing and enrollment regulations

Language assistance program and documentation in treatment record

You are required to post written notice in your waiting room regarding the availability of free language assistance program (LAP) services. You are also required to offer interpretation services to Limited English Proficiency (LEP) members at their initial assessment. You must offer this even if you can conduct treatment in the member's language and/or when a family member or friend interprets on their behalf. We discourage the use of family and friends, especially minors, as interpreters. Instead, we encourage the use of UnitedHealthcare Community Plan interpreter services.

Document the offer of interpretation services, as well as the member's acceptance or declination of that assistance, in the treatment record. It is important that you have a process in place for your staff to identify members who desire language assistance.

Chapter 4: Medical Management

Key contacts

Topic	Link	Phone Number
Referrals	UHCprovider.com > Menu > Referrals	866-270-5785
Prior Authorization	UHCprovider.com/paan	866-270-5785
Pharmacy	professionals.optumrx.com	866-270-5785
Transportation - ModivCare		844-772-6623
Healthy First Steps	uhchealthyfirststeps.com	800-599-5985

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Medical management improves the quality and outcome of health care delivery. We offer the following services as part of our medical management process.

Ambulance services

Air ambulance

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:

- Great distances or other obstacles keep members from reaching the destination.
- Immediate admission is essential or
- The pickup point is inaccessible by land.

Non-emergent air ambulance requires prior authorization.

For authorization, go to UHCprovider.com/paan or call Provider Services.

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:

- Injury to their overall health.
- Impairment to bodily functions. Or
- Dysfunction of a bodily organ or part.

Emergency transports (in- and out-of-network) are covered. They do not require an authorization.

Bill ambulance transport as a non-emergency transport when it doesn't meet the definition of an emergency transport. This includes all scheduled runs and transports to nursing facilities or the member's residence.

Non-emergent transportation

UnitedHealthcare Community Plan members may get non-emergent transportation services through ModivCare for covered services. Members may get transportation when they are bed-confined before, during and after transport.

For non-urgent appointments, members must call for transportation at least three days before their appointment by phone at **844-772-6623**.

Schedule transportation up to 30 days in advance.

Members can also call Member Services for help with using their transportation benefit.

Non-emergency medical transportation services

Non-emergency medical transportation (NEMT) services are available through ModivCare. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

California case management and care management Programs

Enhanced Care Management and Community Supports are benefits that will replace Health Homes and elements of the WPC pilots. These offerings build on positive outcomes from those programs over the past several years. Enhanced Care Management and Community Supports are effective as of Jan. 1, 2022.

To refer a member to any of the following case management programs, call the California Health Plan at **866-260-5785**. Ask for a referral to case management.

Enhanced care management

Enhanced Care Management is part of the UnitedHealthcare Community Plan benefits for eligible members. We connect members with complex health issues to care management services through California's Medicaid program. Enhanced Care Management offers care management services through a network of care coordination and community-based organizations. These care providers form a virtual support network for patients who have medical, mental health, substance abuse and social service needs. Care managers oversee Enhanced Care Management to provide care management, care coordination, care transition, individual and family support and social service supports.

Services are available at no cost to qualified members. Members who qualify are:

- Individuals and families who both:
  - Are experiencing homelessness
  - Have at least one complex physical, behavioral or developmental health need and cannot take care of themselves, for whom coordination of services would likely result in improved health outcomes and/or lower utilization of high-cost services.
- Adults with:
  - 1. 5 or more ER visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or
  - 3 or more unplanned hospital and/or short-term SNF stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
- Adults who:
  - Meet the eligibility criteria for participation in or obtaining services through:
    - the County Specialty Mental Health (SMH) System and/or
    - The Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program. And
  - Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of ACEs, former foster youth, history of recent contacts with law enforcement related to mental health, substance use symptoms or associated behaviors); And
  - Meet one or more of the following criteria:
    - High risk for institutionalization, overdose and/or suicide;
    - Use crisis services, ERs, urgent care or inpatient stays as the sole source of care;
    - 2 or more ED visits or hospitalizations due to SMI or SUD in the past 12 months;
    - Pregnant and post-partum women (12 months from delivery)

Community Supports

Community Supports are flexible wrap-around services the Medi-Cal managed care plan will integrate into the population health management program. These services act as a substitute or help avoid utilization of other services, such as hospital or SNF admissions, discharge delays or ER use. Community Supports should be integrated with case management for members at medium-to-high levels of risk. They may fill gaps to address medical or other needs that may arise due to

social determinants of health.

As of Jan. 1, 2022, Community Supports includes:

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Respite
- Recuperative care (medical respite)
- Meals/medically tailored meals
- Sobering centers

Case management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Medical Case Management Department assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for case management by calling Provider Services at **866-270-5785**. Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps** program, which manages women with high-risk pregnancies.

Cardiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for cardiology procedures.

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures (including inpatient)
- Stress echocardiograms

Cardiology procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay (except for electrophysiology implants).

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone:

- Online: **UHCprovider.com/cardiology**. Select the Go to Prior Authorization and Notification Tool.
- Phone: **866-889-8054** from 7 a.m. - 7 p.m., Monday through Friday.

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, go to **UHCprovider.com/cardiology** > Specific Cardiology Programs.

Durable medical equipment

Durable medical equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

See our Coverage Determination Guidelines at **UHCprovider.com** Policies and Protocols > For Community Plans > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

Emergency/urgent care services

Emergency services do not require authorization. While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate ER use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, coughs, colds and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and care provider service by in and out-of-network care providers.
- Medical examination.
- Stabilization services.
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services.
- Emergency ground and air transportation.
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal.

We pay out-of-network care providers for emergency services at the current Medi-Cal Program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Emergency room care

UnitedHealthcare Community Plan members who visit an ER should be screened to determine whether a medical emergency exists. Prior authorization is not required for the medical screening. We provide coverage for these services without regard to the emergency care provider's contractual relationship with us. Emergency services, i.e. care provider and outpatient services furnished by a qualified provider necessary to treat an emergency condition, are covered both within and outside our service area.

An emergency is defined as a medical or behavioral condition, which manifests itself by acute symptoms of sufficient severity, including severe pain, that a reasonable layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), or in the case of a behavioral condition, perceived as placing the health of the person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Deliver emergency care without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the Provider Portal at **UHCprovider.com/paan**, EDI 278N transaction at **UHCprovider.com/edi**, or call Provider Services.

Nurses in the Health Services Department review emergency admissions within one business day of notification.

UnitedHealthcare Community Plan makes UM determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting Provider Services (UM Department, etc.).

The criteria are available in writing upon request or by calling **Provider Services**.

If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

Facility notification requirements

Facilities are responsible for Admission Notification for the following inpatient admissions (even if an advanced notification was provided prior to the actual admission date):

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- SNF admissions
- Admissions following outpatient surgery
- Admissions following observation

Admissions when UnitedHealthcare Community Plan pays claims

Contracted facilities are accountable to provide timely notification to both the delegate and UnitedHealthcare Community Plan within 24 hours of admission for all inpatient and observation status cases. This information is needed to verify eligibility, authorize care, and initiate concurrent review and discharge planning.

In maternity cases, notify vaginal delivery or C-section delivery on or before the end of the mandated period 48 hours or 96 hours, respectively. We require notification if the baby stays longer than the mother. In all cases, separate notification is required immediately when a baby is admitted to the neonatal intensive care unit.

For emergency admissions, notification occurs once the member has been stabilized in the emergency department.

Family planning

Family planning services are covered when provided by care provider or practitioners to members who voluntarily choose to delay or prevent pregnancy. Covered services include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available.

Members can choose to receive services from their PCP, specialist or clinic. Members can also choose to obtain the family planning services described through out-of-network care providers.

Members do not need a referral for in-network or out-of-network care providers for these services:

- Family planning services and birth control
- Pregnancy testing and counseling
- Tubal ligation and vasectomies (see Sterilization section)
- Immunizations
- HIV and AIDS testing
- TB screening and follow-up care
- Sexually transmitted disease treatment and follow-up care
- Self-Administered Hormonal Contraceptives
  - Refer to **Family Planning Services** in Chapter 3 for more information.

Voluntary sterilization

You must comply with the procedures below prior to obtaining an authorization and performing the sterilization service. A completed Consent Form (PM 330) must be submitted with claims for all voluntary sterilization procedures. The PM 330 form is available for download from **medi-cal.ca.gov**.

Voluntary sterilization consent requires:

- The recipient to be at least 21 years of age at the time consent is signed.
- The recipient to be mentally competent.
- It to be voluntary and obtained without duress.
- 30 days, but not more than 180 days, to pass between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- At least 72 hours must have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery.
- The informed consent must be given at least 30 days before the expected date of delivery in the case of premature delivery.
- The person securing the informed consent and the care provider performing the sterilization procedure are required to sign and date the consent form.
- Copy of the signed Federal Consent Form must be submitted by each provider involved with the hospitalization and/or the sterilization procedure.

- That sterilization consents may not be obtained when an eligible recipient:
  - is in labor or childbirth.
  - is seeking to obtain or obtaining an abortion.
  - is under the influence of alcohol or other substances that affect that recipient's state of awareness.

Health education

Our Medi-Cal health education program is led by our qualified health educator. You are encouraged to collaborate with the health plan to ensure health education services are provided to members. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their health, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making to effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the health education program.

Programs are based upon the findings from our Population Needs Assessment and will identify the health education, cultural and linguistic needs of our members.

Hospice

UnitedHealthcare Community Plan provides the hospice benefit in accordance with the Medi-Cal Program.

Respite hospice

Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, SNF or hospice facility.

Inpatient hospice

Short-term inpatient care for pain control or symptom management in a hospital, SF or hospice facility.

Laboratory

LabCorp and Quest are the preferred lab providers. Contact **laboratories** directly.

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

For more information on our in-network labs, go to UHCprovider.com > Find Dr > **Preferred Lab Network**.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services.

See the **Billing and Encounter Submission** chapter for more information.

Maternity care

Pregnancy Notification Risk Screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

Access the digital Notification of Pregnancy form through the Provider Portal at **UHCprovider.com**. You may also call Healthy First Steps at 800-599-5985 or fax the notification form to 877-353-6913.

Healthy First Steps strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment.
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care.
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it.
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
- Increase the member's understanding of pregnancy and newborn care.
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making.
- Encourage appropriate pregnancy, postpartum and infant care provider visits.
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings.
- Encourage members to stop smoking with our Quit for Life tobacco program.
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs.

Program staff act as a liaison between members, care providers, and United Healthcare Community Plan for care coordination.

Pregnancy care

Pregnant members should receive care from participating providers only. We consider exceptions to this policy if:

1. The woman was pregnant when she became an UnitedHealthcare Community Plan member, and
2. She has an established relationship with a non-participating obstetrician.

Notify us promptly of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the UnitedHealthcare Healthy First Steps coordinator.

Contact Healthy First Steps by submitting an American College of Gynecology or any initial prenatal visit form to Healthy First Steps. Call **866-270-5785** for more information.

The following information must be provided to UnitedHealthcare within one business day of the visit when the pregnancy is confirmed:

- Patient's name and member ID number
- Obstetrician's name, phone number, and member ID number
- Facility name
- Expected date of confinement (EDC)
- Planned vaginal or Cesarean delivery
- Any concomitant diagnoses that could affect pregnancy or delivery
- Obstetrical risk factors
- Gravida
- Parity
- Number of living children
- Previous care for this pregnancy

An obstetrician does not need approval from the member's provider for prenatal care, testing or obstetrical procedures.

Obstetricians may give the pregnant member a written prescription to present at any of the UnitedHealthcare Community Plan participating radiology and imaging facilities listed in the provider directory. Midwives, doulas, birthing centers and home deliveries are a covered benefit. Maternity services provided by

midwives and home delivery are a covered benefit without authorization.

For additional pregnant member and baby resources, see Healthy First Steps in Chapter 6.

Pregnancy termination services

Abortion services are covered. Additional information on this service is available at dhcs.ca.gov.

Minor consent services

Some services are available for members under the age of 18 without permission or consent from their parent or guardian. Minor Consent Services are services related to:

- Sexual assault, including rape.
- Drug or alcohol abuse for children 12 years of age or older.
- Pregnancy.
- Family planning.
- Sexually transmitted diseases (STD) for children 12 years of age or older.
- Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.

Eligible members can receive these services from any qualified Medi-Cal care provider, including care providers who are not in the network.

Neonatal Intensive Care Unit (NICU) case management

The NICU Management program manages inpatient and post-discharge neonatal intensive care unit (NICU) cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

The NICU Case Management program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. High risk newborns placed in the NICU are eligible upon birth for NICU Case Management services.

The NICU Case Management team works closely with Neonatal Resource Services (NRS) team neonatologist and Utilization Management nurses, health plan registered nurses and social worker care managers to support and coordinate needed care for NICU infants and their families, as appropriate.

Inhaled nitric oxide

Use the NRS guideline for inhaled nitric oxide (iNO) therapy at UHCprovider.com > Menu > Policies and Protocols > Clinical Guidelines.

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to UHCprovider.com > Prior Authorization > Oncology or call Optum at 888-397-8129 Monday -Friday 7am – 7pm CT.

Palliative care

Palliative care consists of patient- and family-centered care that improves quality of life by anticipating, preventing and treating suffering. Receiving palliative care does not mean members lose coverage for any covered benefits or services, including home health services.

Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less. Palliative care may be provided along with curative care. A member with a serious illness who is receiving palliative care may transition to hospice if they meet the hospice eligibility criteria:

- A member 21 years or older may not be concurrently enrolled in hospice care and palliative care.
- A member younger than 21 years may be eligible for palliative care and hospice services concurrently with curative care.

Members of any age may receive palliative care services as defined by DHCS. We allow palliative care services for other conditions when Case Management determines them to be medically necessary or when treating care providers refer the member.

Disease-specific criteria are:

- **Congestive heart failure (CHF):**
  - The member is hospitalized due to CHF as the primary diagnosis, with no further invasive interventions planned, or they meet criteria for the New York Heart Association's (NYHA) heart failure classification III or higher.
  - They also have an ejection fraction of less than 30% for systolic failure or significant co-morbidities.
- **Chronic obstructive pulmonary disease:**
  - The member has a forced expiratory volume (FEV) of less than 35% of predicted and a 24-hour oxygen requirement of less than 3 liters per minute; or
  - The member has a 24-hour oxygen requirement of greater than or equal to 3 liters per minute.
- **Advanced cancer:**
  - The member has a stage III or IV solid organ cancer, lymphom or leukemia; and
  - The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
- **Liver disease** (Must meet the first two requirements or just the third):
  - The member has irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
  - The member has irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

Pediatric palliative care eligibility criteria:

- Members younger than 21 years may be eligible for palliative care and hospice services concurrently with curative care.
- The family and member agree to the provision of pediatric palliative care services; and
- There is documentation of a life-threatening diagnosis. This can include conditions for which curative treatment is possible (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
- Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
- Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
- Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).
- For children who have an approved CCS-eligible condition, CCS remains responsible (in non-Whole Child Model counties) for medical treatment for the CCS-eligible condition. We then provide palliative care services related to the CCS-eligible condition.

To make a palliative care referral, call Case Management at **866-270-5785**.

Radiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain prior authorization for the following advanced imaging procedures if you provide them in an office or outpatient setting:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Advanced imaging procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care

- Inpatient stay

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- Online: **UHCprovider.com/radiology** > Go to Prior Authorization and Notification Tool
- Phone: **866-889-8054** from 8 a.m. - 5 p.m. Pacific Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code.

For a current list of CPT codes that require prior authorization, a prior authorization crosswalk table, and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Specific Radiology Programs.

Pharmacy

Preferred Drug List

Magellan Medicaid Administration Inc. determines and maintains the Contract Drug List (CDL) of covered medications. Find the CDL on the Medi-Cal Rx website, **medi-calrx.dhcs.ca.gov/home/cdl.**

You must prescribe Medicaid members drugs listed on the CDL. If a member requires a non-preferred medication, submit a prior authorization through the provider portal on the Medi-Cal Rx website at **medi-calrx.dhcs.ca.gov**.

Prior authorization

Medications can be dispensed as an emergency 72-hour supply when drug therapy must start before prior authorization is secured and the prescriber cannot be reached. The rules apply to non-preferred PDL drugs and those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, visit the Medi-Cal Rx secure provider portal at **medi-calrx.dhcs.ca.gov**, submit through CoverMyMeds (CMM). Or fax 800-869-4325.

Specialty medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has one or more of the following characteristics:

- Used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable, or inhaled

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community partnerships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

- Prevention:
  - Prevent opioid use disorders (OUDs) before they occur through pharmacy management, provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support case management and referral to person-centered recovery resources.
- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.

- Strategic community partnerships and approaches:
  - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/ OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Prescribing opioids

Go to medi-calrx.dhcs.ca.gov/home/cdl to learn more about which opioids require prior authorization and if prescription limits apply.

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

SABIRT

You must annually provide Alcohol and Drug SABIRT to patients ages 11 and older, including pregnant women. Additional screenings must be provided when medically necessary. Medical necessity must be documented by the PCP or primary care team.

Conduct an alcohol and drug use screening using validated tools. Validated screening tools include:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults. The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

Maternal mental health screening

Conduct a mental health screening using the designated screening tool during the second and/or third trimester and/or at the postpartum visit.

We recommend using the Patient Health Questionnaire 9 (PHQ-9) and the Edinburgh Postnatal Depression Screening (EPDS) tools. The PHQ-9 tool can be administered during the second or third trimester and/or during postpartum periods. The EPDS tool may only be used for postpartum screening.

The screening helps you either begin medical therapy or refer patients to appropriate behavioral health resources

when needed. Refer the member to Optum Behavioral Health Services (OBHS) or other behavioral health entity for further evaluation. The OB and/or PCP monitor the referral process to help ensure the member successfully connects with OBHS. OBHS determines the best course of action to treat any mental health concerns.

To make sure you are complying with the screening requirements, complete the PHQ-9 tool training at UHCprovider.com/training > Maternal Mental Health Screening Training > Screening Requirements for Maternal Mental Health.

Adverse childhood experiences screening

An Adverse Childhood Experiences (ACEs) screening evaluates children and adults for trauma that occurred during the first 18 years of life. The ACEs questionnaire for adults (18 years and older) and Pediatric ACEs and Related Life-events Screener (PEARLS) tools for children (0 to 19 years) are both forms of ACEs screening. Both the ACEs questionnaire and the PEARLS tool are acceptable for members aged 18 or 19 years. You may also use the ACEs screening portion (Part 1) of the PEARLS tool to screen adults 20 years and older.

Screen members as often as deemed appropriate and medically necessary.

Network care providers must attest to completing certified ACEs training on the DHCS website to continue receiving directed payments. The training is now available on acesaware.org. You will be prompted to create an account and provide Board Certification details and NPI. The training takes up to 2 hours to complete and includes a 12-minute video and multiple case studies. DHCS maintains a list of care providers who have self-attested to their completion of the training.

We will use as the list to verify your attestation before processing your claims.

Behavioral counseling interventions for alcohol misuse

When a screening is positive, use a validated assessment tool to determine if unhealthy alcohol use or substance use disorder (SUD) is present. Validated assessment tools include:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

For recipients with brief assessments that reveal unhealthy alcohol use, offer brief misuse counseling. You must offer appropriate referral for additional evaluation and treatment, including medications for addiction treatment, to recipients whose brief assessment demonstrates probable Alcohol Use Disorder (AUD) or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals or services. Brief interventions must include the following:

1. Providing feedback regarding screening and assessment results;
2. Discussing negative consequences that have occurred and the overall severity of the problem;
3. Supporting the patient in making behavioral changes; and
4. Discussing and agreeing on plans for follow-up, including referral to other treatment if indicated.

Transplant services

Major organ transplants are a covered benefit of the Medi-Cal program.

PCP Responsibility – Identification and Referral - The PCP is responsible for identifying and coordinating care for members who are potential candidates for a major organ transplant. The PCP initiates the referral to the appropriate specialist and/or UnitedHealthcare Community Plan-approved transplant center.

Authorization Request – If the transplant center physician considers the member a suitable candidate, the transplant coordinator submits a Prior Authorization Request to either UnitedHealthcare Community Plan (for adults) or the California Children Services Program (for children) for approval.

Disenrollment – Once each of the above steps is completed and the member is approved for transplant, UnitedHealthcare Community Plan initiate the disenrollment process.

Continuity of Care – UnitedHealthcare Community Plan continues to provide all medically necessary covered services until the member has been disenrolled from the plan.

If it is determined the member is not a candidate for a major organ transplant or DHCS denies authorization for a transplant, the member is not disenrolled and UnitedHealthcare Community Plan covers the cost of

the evaluation performed by the Medi-Cal approved transplant center.

Tuberculosis (TB) screening and treatment; direct observation therapy (DOT)

Guidelines for TB screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with LHDs for TB screening, diagnosis, treatment, compliance, and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within one day of identification.

Waiver programs

Human immunodeficiency virus (HIV)/ Acquired immune deficiency syndrome (AIDS) HCBS waiver program

The HIV/AIDS in-home waiver services program is available to members who would otherwise require long-term institutional services.

Identification – Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or PCP may identify members potentially eligible for the waiver program. They may also inform the member of the waiver program services.

Referral – If the member agrees to participation, provide the waiver agency with supportive documentation including history and physical, any relevant labs or other diagnostic study results and current treatment plan.

Continuity of Care – The HIV/AIDS waiver program will coordinate in-home HCBS services in collaboration with the PCP and care coordinator. If the member does not meet criteria for the waiver program, or declines participation, the health plan will continue care coordination as needed to support the member.

For more information on waiver programs go to AIDS Medi-Cal Waiver Program.

Other federal waiver programs

Other waiver services including the Nursing Facility Acute Hospital Waiver may be appropriate for members who can benefit from HCBS services. These members are referred to the Long Term Care Division/HCBS Branch to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services unless/until member is disenrolled from the Medi-Cal Program.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional and TIN/NPI.
- ICD clinical modifications (CM).
- Anticipated date(s) of service.
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable.
- Service setting.
- Facility name and TIN/NPI, when applicable.

If you have questions, please go to your state's prior authorization page: UHCprovider.com/CAcommunityplan > Prior Authorization and Notification Resources.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within two business days of the decision
Urgent/Expedited Pre-service	Based on the member's condition, not to exceed 72 hours	Notified within 24 hours of determination	Practitioner notified within 24 hours of determination and member notification within two business days
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Practitioner notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Practitioner within 24 hours of determination and member notification within two business days

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities. We perform a record review or phone review for each day's stay using InterQual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Concurrent review details

Concurrent Review is notification within 24 hours or one business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries

from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare Community Plan uses Interqual, CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition.
- Maintain health.
- Prevent the onset of an illness, condition or disability.
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity.
- Prevent the deterioration of a condition.
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age.
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member.
- Not experimental treatments.

Determination process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws. You may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Medical and drug policies and coverage determination guidelines

Find medical policies and coverage determination guidelines at UHCprovider.com > Menu > Policies and Protocols > For Community Plans > **Medical and Drug Policies and Coverage Determination Guidelines for Community Plan.**

Referral guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization of all out of-network referrals. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for, but not limited to, the following:

- Continuity of care issues
- Necessary services are not available within network

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using the Provider Portal on **UHCprovider.com**, contacting UnitedHealthcare

Community Plan's Provider Services, or the Medi-Cal Point of Service Network.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:
- Services UnitedHealthcare Community Plan decides are not medically necessary.
- Non-covered services.
- Services provided to members not enrolled on the date(s) of service.

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the CA DHCS. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:
- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **866-270-5785**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services not covered by UnitedHealthcare Community Plan

The following services are not included in the UnitedHealthcare Community Plan program:
- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs.
  - Long-term care services in a nursing home.
  - NF services.
  - ICFs for members with developmental delay
  - Home- and community-based waiver services.
  - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
  - Residential inpatient hospice services.
- Experimental procedures
- Investigational services are not covered except when it is clearly documented that all the following apply:
  - Conventional therapy will not adequately treat the intended patient's condition;
  - Conventional therapy will not prevent progressive disability or premature death;
  - The care provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service;
  - The investigational service is the lowest-cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives;
  - The service is not being performed as a part of a research study protocol;
  - There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.
  - All investigational services require prior authorization. Payment will not be authorized for investigational services that do not meet the

stated criteria, or for associated inpatient care when a beneficiary needs to be in the hospital primarily because they are receiving such nonapproved investigational services.

- Mental health and substance abuse care. This service is covered by OptumHealth Behavioral Solutions of California.
- Phones and TVs used when in the hospital.
- Personal comfort items used in the hospital such as a barber.
- Contact lenses, unless used to treat eye disease.
- Sunglasses and photo-gray lenses.
- Ambulances, unless medically necessary.
- Infertility services.

Services requiring prior authorization

For a list of services that require prior authorization, go to UHCprovider.com/cacommunityplan > **Prior Authorization and Notification**.

Direct access services – Native Americans

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization.

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** one business day.
- **Inpatient Admissions; After Ambulatory Surgery:** one business day.
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.

Utilization management guidelines

Call **Provider Services** to discuss the guidelines and utilization management.

Utilization Management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service (FFS) or capitated basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a FFS basis or capitated plan. The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention

Key contacts

Topic	Link	Phone Number
EPSDT	dhcs.ca.gov/services/Pages/EPSDT.aspx	855-347-9227
Vaccines for Children	eziz.org/vfc/overview/	877-243-8832

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

The **Early and Periodic Screening, Diagnostic and Treatment** (EPSDT) benefit provides comprehensive and preventive health care services for children younger than 21 who are enrolled in Medi-Cal.

For any EPSDT, perform baseline health assessments and diagnostic evaluations to verify a member has a California Children's Services (CCS) eligible medical condition; work with the Local Education Agency (LEA) or Regional Center (RC) to develop an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP); determine the appropriate strategies and services required based on the child's unique identified needs.

Referral – Refer eligible members to the CCS program for comprehensive case management. Referral may be made by phone or same-day mail, if available. Follow the initial referral by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

Only make referrals to CCS paneled providers and CCS-approved hospitals within the contracted network effective from the date of referral.

Contact Information:

San Diego County CCS: **619-528-4000**

California Children's Services (CCS)

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children younger than 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

Identification – A child may qualify for services if all four CCS eligibility criteria are met:

- Age eligible: younger than 21 years old
- Medically eligible: Physical disability or medical condition that is covered by CCS.
  - A detailed list of covered medical conditions is available through the following link: dhcs.ca.gov
- Residentially eligible: Child lives with a parent or guardian in covered service area
- Financially eligible: Medi-Cal with full benefits

Continuity of care – UnitedHealthcare Community Plan continues to provide all Medically Necessary Covered Services for the member's CCS-eligible condition until CCS eligibility is confirmed. Once eligibility for the CCS program is established for a member, we continue to provide all medically necessary covered services unrelated to the CCS eligible condition and monitor and help ensure coordination of services and joint case

management between its PCPs, the CCS specialty providers and the local CCS program. If the local CCS program does not approve eligibility, the health plan remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, we remain responsible for obtaining the service, if it is medically necessary, and paying for the service if it has been provided.

Development disability services and coordination with regional centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment. The Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, autism and disabling conditions closely related to intellectual disability or requiring similar treatment.

Referral – If you determine supportive services would benefit the member, refer the member to the Regional Center for approval and assignment of a Regional Center Case Manager who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the Regional Center Interdisciplinary Team. While the Regional Center does not provide overall case management for their clients, they must assure access to health, developmental, social and educational services from birth throughout the lifespan of an individual who has a developmental disability.

Continuity of Care – The Regional Center will determine the most appropriate setting for eligible HCBS services and will coordinate these services for the member in collaboration with the PCP and health plan coordinator. The Care Coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary, and therapeutic covered services.

First Steps program

The First Steps Program is handled by the state of California and provides early intervention services to infants and toddlers with disabilities or developmental delays from birth to age 3 and their families.

Referring a child

Refer a child to First Step services if the child has a visual, hearing, or severe orthopedic impairment, or any combination of these impairments, or if the child potentially requires other developmental intervention services.

The First Steps team will evaluate your request to determine eligibility, then a service coordinator will be assigned to help the child's parents through the process. The assigned coordinator from First Steps, who is employed by the state, will contact you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the Individualized Family Service Plan (IFSP). UnitedHealthcare Community Plan provides member case management and care coordination for the IFSP. If the child has complex needs, a care manager from UnitedHealthcare Community Plan will be assigned as well if we are aware of the situation.

Full screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead assessment
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Mental health (Autism Spectrum Disorder Screening)
- Vision
- Dental
- Other necessary health care, diagnostic services, treatment, and measures as described on dhcs.ca.gov

Without all these components, you cannot bill for a full screen. You may only bill for a partial screen.

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Use this screen to start expanded CCS services. Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

Interperiodic screens are often used for school and athletic physicals. A physical exam may be needed for a certificate stating a child is physically able to take part in school athletics. This also applies for other school physicals when required as conditions for educational purposes.

Lead screening/treatment

United Healthcare Community Plan members shall receive Blood Lead Level (BLL) Testing at the ages of 6 months to 6 years old (i.e., 72 months). The California Department of Public Health's California Childhood Lead Poisoning Prevention Branch (CLPPB) issues guidance for all California providers based on these regulations and required blood lead standards of care, including guidance related to children enrolled in Medi-Cal.

i. Provide oral, anticipatory or written guidance to the parent(s) or guardian(s) of a child that includes information that children can be harmed by exposure to lead. This includes deteriorating or disturbed lead-based paint and the dust from it, which are particularly at risk of lead poisoning from the time the child begins to crawl until age 6 (72 months of age). This information must be shared at each periodic health assessment, starting at six months of age and continuing until 6 years, or 72 months of age.

ii. Order or perform BLL testing on all children based on the following: a) 12 months to 2 years (or 24 months) of age. b) When the health care provider performing a periodic health assessment becomes aware that a child 12 months to 2 years (or 24 months) of age has no documented evidence of BLL test results taken at 12 months of age or thereafter. c) When the health care provider performing a periodic health assessment becomes aware that a child 12 months to 2 years (or 24 months) of age has no documented evidence of BLL test results taken when the child was 2 years (or 24 months) of age or thereafter.

iii. Whenever the health care provider performing a periodic health assessment of a child one year (or 12 months) to 6 years (or 72 months) of age becomes aware that a change in circumstances has placed the child at increased risk of lead poisoning, in the professional judgment of the provider.

iv. Follow the CDC recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

v. When requested by the parent or guardian.

vi. You are not required to perform BLL testing if:
    1. A parent or guardian of the child, or other person with legal authority to withhold consent, refuses to consent to the screening.
    2. If in your professional opinion, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.
    3. You must document the reasons for not screening in the child's medical record.

vii. Document in the children's medical record the reasons for not screening. You must help ensure to list the reason(s) for not performing the blood lead screening test in the child member's medical record. In cases where consent has been withheld, you must document this in the child member's medical record by obtaining a signed statement of voluntary refusal

    If the care provider cannot get a signed statement of voluntary refusal because the party that withheld consent declines to sign or is unable to sign (e.g., when services are provided through telehealth), document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.

    If you cannot get a signed statement of voluntary refusal because the party that withheld consent declines to sign or is unable to sign (e.g., when services are provided through telehealth), document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.

    We will identify, on at least a quarterly basis, all child members younger than 6 years who have no record of receiving a blood lead screening test

    Review the list of members in need, coordinate a visit to conduct the lead screening, and document required written or oral anticipatory guidance to the parent/guardian of that child.

We will continuously monitor the Lead Screening in Children HEDIS® measure specifically reporting rates of compliance with lead screening per practice, as applicable.

Screenings may be conducted using either the capillary (finger stick) or venous blood sampling methods. The venous method is preferred. All confirmatory and follow-up BLL testing must be performed using the venous blood sampling method.

Children identified with blood lead levels greater than (≥) 10 micrograms per deciliter of whole blood (µg/dL) are targeted for outreach and follow-up treatment in collaboration with the CA Department of Health Care Services (DHCS) and the member's PCP to ensure the member is receiving follow-up and treatment.

Follow-up activities could include referral, case management and reporting as set forth in the CLPPB guidelines. However, a provider may determine additional services that fall within the EPSDT benefit are medically necessary.

Coding and reporting requirements

When reporting BLL results and submitting claims, care providers must:

- Report EPSDT data to DHCS and the local children's preventive services using the CMS1500/UB-04 claim forms or their electronic equivalents (837-P/837-I). This must be done within 30 calendar days of the end of each month for all encounters during that month.
- Help ensure that blood lead screening encounters are identified using the appropriate CPT(R) codes.
- Electronically report all results to CLPPB.

Targeted case management

Targeted case management (TCM) consists of case management services for specified targeted groups to access medical, social, educational, and other services provided by a Regional Center or local governmental health program as appropriate.

Identification – The five target populations include:

- Children younger than 21 years at risk for medical compromise
- Medically fragile individuals
- Individuals in frail health, older than 18 years and at risk of institutionalization
- Members in jeopardy of negative health or psychosocial outcomes
- Members infected with a communicable disease, including tuberculosis and HIV/AIDS, or who have been exposed to communicable diseases, until the risk of exposure has passed

Referral – Members who are eligible for TCM services are referred to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

Continuity of Care – UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM provider that are covered services under the contract.

Vaccines for Children program (VFC)

The Vaccines for Children program provides immunizations. Immunizations offered in the state VFC program must be ordered from your office. We do not reimburse for the vaccine ordered from the VFC Program, but we reimburse for administering the vaccine.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. We cannot reimburse for private stock vaccines when they are available through VFC.

Contact **VFC** if you have questions.

Any child through 18 years of age who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for Medi-Cal.
- American Indian or Alaska Native, as defined by the Indian Health Services Act.
- Uninsured.
- Underinsured. (These children have health insurance, but the benefit plan does not cover immunizations. Children in this category may only receive vaccinations from an FQHC or RHC.

They may also receive one under an approved deputization agreement. They cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine.)

Child Health and Disability Prevention Program

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low-income children and youth in California 21 years of age and younger. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private care providers, local health departments, community clinics, managed care plans, and some local school districts. Care providers who are non-CHDP-certified may contact the state directly or call Provider Services at **866-270-5785**.

The CHDP Health Assessment includes:

- Health and developmental history
- Age appropriate behavioral assessment
- Unclothed physical examination, including assessment of physical growth
- Inspection of ears, nose, mouth, throat, teeth and gums
- Nutritional and dental status assessment
- Hearing and vision screening, as appropriate
- Immunizations and TB testing appropriate to age and health history necessary to make status current
- Lab tests appropriate to age and/or sex, including anemia, diabetes, lead levels, sickle cell trait and urinary tract infections
- Health education and anticipatory guidance appropriate to age and health status

The CHDP provider should also coordinate referrals to other programs/services as needed. This includes the following:

- WIC
- Dental care for preventive and restorative care
- Specialty health care providers as necessary
- Mental health care

When billing for services rendered to CHDP-eligible children and youth, use national CPT-4 or HCPCS codes on an appropriate HIPAA-compliant national claim form. Follow Medi-Cal billing practices. For more information, please visit **medi-cal.ca.gov**.

Bright Futures assessment

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The *Bright Futures Guidelines* provide guidance for all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visiting, child care, school-based health clinics, and many others. Materials developed for families are also available.

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care based on *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Settings for Bright Futures implementation include private practices, hospital-based or hospital-affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, community health centers, Indian Health Service clinics, and other primary care facilities. A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*. This objective will help ensure that patients receive information and support that is consistent from family and youth perspectives.

Chapter 6: Value-Added Services

Key contacts

Topic	Link	Phone Number
Provider Services	UHCprovider.com	866-270-5785
Healthy First Steps Rewards	uhchealthyfirststeps.com	800-599-5985
Value-Added Services	UHCCommunityPlan.com/CA > View plan details	866-270-5785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call **Provider Services** unless otherwise noted under the specific topic.

Community based adult services (CBAS)

These are services for eligible older adults and/or adults with disabilities. They focus on restoring or maintaining optimal capacity for self-care. They also help delay or prevent unnecessary (or unwanted) admission to a facility. These services include:

- Individual assessment
- Professional nursing services
- Physical, occupational and speech therapies
- Mental health services
- Therapeutic activities
- Social services
- Personal care
- Meals
- Nutritional counseling
- Transportation to and from the CBAS center.

Identification – Current SPD or family members, care providers and case managers may identify members potentially eligible. SPD members/family or the PCP may contact the case manager to determine eligibility.

Eligibility – These services may be available to current SPD members who meet additional requirements. Eligibility is based on the results of the CBAS Eligibility Determination Tool (CEDT) completed by the health plan RN Case Manager. Once approved, the member is referred to CBAS center for evaluation and development of a plan of care. Referrals are based on member choice of center and the ability of the center to meet the member needs.

Continuity of Care – We are responsible for providing primary care and prevention services including CBAS-eligible services. The case manager works with the PCP and CBAS case manager to ensure the member gets the eligible services.

Diabetes Prevention Program

This is a Medi-Cal covered benefit. The Diabetes Prevention Program (DPP) benefit is consistent with the federal Centers for Disease Control and Prevention's (CDC's) National DPP and national standards and guidelines, also known as the CDC Diabetes Prevention Recognition Program (DPRP).

The DPP is an evidence-based, lifestyle change program designed to assist Medi-Cal beneficiaries diagnosed with prediabetes in preventing or delaying the onset of Type 2 Diabetes. DPP services are provided through trained peer coaches who use a CDC-approved curriculum.

The DPP includes a core benefit consisting of at least 22 peer-coaching sessions over 12 months, which are provided regardless of weight loss. In addition, beneficiaries who achieve and maintain a required

minimum weight loss of 5% from the first core session will also be eligible to receive ongoing maintenance sessions, after the 12-month core services period, to help them continue healthy lifestyle behaviors. The CDC's DPP curriculum promotes realistic lifestyle changes, emphasizing weight loss through exercise, healthy eating and behavior modification.

Access the Diabetes Prevention Program and referral information at **UHCprovider.com**.

Doctor Chat— virtual visits

Members will have access to UnitedHealthcare Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for non-emergent care. A board-certified emergency medicine physician will assess the severity of the enrollee's situation, provide treatment (including prescriptions) and recommend additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to bring forward looking solutions to expand and deliver access to care.

Health4Me

The Health4Me mobile app is available at no charge to our members. Health4Me enables users to review health benefits, access claims information and locate in-network providers.

Healthy First Steps Rewards

Healthy First Steps™ (HFS) is a specialized case management program designed to provide assistance to all pregnant members, those experiencing an uncomplicated pregnancy, as well as additional medical, behavioral, and social risks. The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant members. Care management staff are board-certified in maternal and neonatal medicine.

Members self-enroll on a smartphone or computer. They can go to **UHCHealthyFirstSteps.com** and click on "Register" or call **800-599-5985**.

How It Works

Care providers and UnitedHealthcare Community Plan reach out to members to enroll them.

Members enter information about their pregnancy and upcoming appointments online. Members get reminders of upcoming appointments and record completed visits.

How You Can Help

- Identify UnitedHealthcare Community Plan members during prenatal visits.
- Share the information with the member to talk about the program
- Encourage the member to enroll in Healthy First Steps Rewards.

Keeping members healthy

We use educational materials and newsletters to remind members to follow positive health actions such as immunizations, wellness and EPSDT screenings. For members with chronic conditions, we provide specific information, including recommended routine appointment frequency, necessary testing, monitoring, and self-care through our disease management (DM) program. All materials are based upon evidence-based guidelines or standards. All printed materials are written at a sixth-grade reading level. They are available in English as well as other languages and in alternative formats (e.g., braille, large-size print, [1]audio format) upon request. The materials support members as they begin to take responsibility for their health. They provide information necessary to successfully manage their condition and live a healthy lifestyle.

Members at highest risk with conditions such as asthma, CHF, diabetes, COPD and CAD receive more intense health coaching. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

Identification – The health plan uses claims data (e.g. hospital admissions, ER visits, and pharmacy claims) to identify members with gaps in care and/or chronic conditions.

Referral – PCPs may make referrals to support practice-based interventions by calling the Health Services team at **866-270-5785**.

uhclatino.com, our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

Kick It California

Kick It California is a free program that helps Californians kick smoking, vaping and smokeless tobacco. Kick It California has trained, caring professionals who will work with the member to create a plan and stick to it.

Members can self-enroll on a smartphone or computer. They can go to kickitca.org or call 800-300-8086 to connect with a Quit Coach.

Long term support services

In-Home Supportive Services (IHSS) is a state mandated, county-administered program. It is an alternative to out-of-home care (such as nursing homes). It helps pay for services provided to members so that they can remain safely in their own home. The types of services that can be authorized through IHSS are:

- Housecleaning
- Meal preparation
- Laundry
- Grocery shopping
- Personal care services (such as bowel and bladder care, bathing, grooming and paramedical services)
- Accompaniment to medical appointments
- Protective supervision for the mentally impaired

IHSS allows members to self-direct care through selection, hiring, supervising, training and terminating caregivers(s).

Eligibility Requirements:

- California resident physically residing in the United States
- Meet Medi-Cal recipient eligibility criteria
- Reside in own home or abode (acute care hospital, long-term care facilities, and licensed community care facilities are not considered “own home”)
- Submit a completed Health Care Certification form completed by a licensed health care professional indicating that the member is: Unable to perform more than one activity of daily living independently, and is at risk of out-of-home care placement without IHSS services

Referral – Anyone may initiate an IHSS application on behalf of a member. Adult members are encouraged to self-refer. Referrals can be made using the AIS Aging and Disability Resource Connection (ADRC) Call Center, or the AIS Web Referral process. A completed Health Care Certification (SOC 873) must be received by the county prior to authorization of services.

Contact information for referrals

Phone Number: **800-510-2020.** Representatives are available Monday through Friday, 8 a.m. – 5 p.m. Calls received after hours are returned the next business day.

AIS Web Referral (Attachment C): aiswebreferral.org/ Available 24 hours a day, seven days a week

Assessment and Approval – The County Social Worker schedules a face-to-face assessment with the member to determine need. They authorize the service hours. The member is notified by the county if services are approved or denied. If denied, they are told the reason for denial. We pay for eligible IHSS hours that are approved by the county IHSS agency.

Mindfulness: be here now

We deliver this program to social worker and community partners. The focus is caregiver well-being. It provides mindfulness techniques to reduce burnout, raise performance and improve quality of care.

Multipurposes Services Program

This provides Home and Community-Based Services (HCBS) to Medi-Cal-eligible individuals who are 65 years or older and disabled. This is an alternative to NF placement that lets these individuals to remain safely in their homes. Local MSSP sites provide social and health care management for frail elderly clients who could be in an NF but who wish to remain in the community. The program goal is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for NF care.

Eligibility – MSSP site staff makes this certification determination based upon Medi-Cal criteria for placement. Individuals can only be enrolled in one HCBS waiver at any a time. The services may not exceed the cost of care within an NF. Eligibility requirements include:

- Aged 65 years or older and currently eligible for Medi-Cal
- Without the provision of these services would require the NF level of care (certified or certifiable for placement in an NF)
- Must reside in a county with an MSSP Site
- Be appropriate for care management services

Eligible services include:

- Adult day care
- Housing assistance
- Chore and personal care assistance
- Protective supervision
- Care management
- Respite
- Transportation
- Meal services
- Social services
- Communications

Referral and Coordination of Services – The member's family, PCP or the case managers may make a referral to the MSSP program. The Case Manager and PCP collaborate with the MSSP Waiver Case Management Team to coordinate services. The MSSP Case Management Team conducts a case conference if MSSP services are indicated.

Contact information for the local MSSP sites:

- San Diego County – Aging and Independent Services:
  sandiegocounty.gov/hhsa/programs/ais/
  800-510-2020

NurseLine

NurseLine is available anytime at no cost to our members. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **866-351-6827** to reach a nurse.

OB Homecare

OB Homecare services provide skilled nursing care at home to reduce costs and improve clinical outcomes for mother and infant. The goals are to reduce:

- maternal ER/hospital utilization
- preterm births
- NICU stays

OB Homecare services include:

1. Preterm Birth Prevention Program for preterm labor and history of spontaneous preterm birth: 17HPC/Makena® Administration Nursing and Care Management service is designed to improve weekly injection adherence and reduce preterm delivery
2. Nausea and Vomiting of Pregnancy program: continuous antiemetic therapy utilizing micro-infusion pump with pharmacist and nursing support to reduce complications for mother and fetus, and to avoid hospitalizations and ER visits
3. Diabetes in Pregnancy – Insulin pump only for members with gestational diabetes or existing Type 1 or Type 2. Home-based assessment, counseling, and monitoring of insulin via pump managed care by RN and CDE including visits as needed to assure stable glycaemia thereby improving outcomes and reducing NICU admissions

Women, Infants and Children supplemental nutrition program (WIC)

State-funded program

The state also has programs, such as Women, Infants, and Children Supplemental Nutrition programs (WIC) to help with nutritional needs for low-income families.

Contact information

- San Diego
  - sdsuwic.org

Chapter 7: Mental Health and Substance Use

Key contacts

Topic	Link	Phone Number
Behavioral Health/Provider Express	providerexpress.com	800-888-2998
Provider Services	UHCprovider.com	866-270-5785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

U.S. Behavioral Health Plan, California, doing business as OptumHealth Behavioral Solutions of California (OHBS-CA) provides UnitedHealthcare Community Plan of California members with the mental health provider network. The OHBS-CA Network Manual generally applies to all types of business.

This chapter does not replace the OHBS-CA Network Manual. Rather, it supplements the Manual by focusing on Medi-Cal specific services and procedures.

You must have a National Provider Identification (NPI) number and be enrolled with the Department of Health Care Services to see Medi-Cal members and receive payment from UnitedHealthcare Community Plan.

To request an NPI number, go to the National Plan and Provider Enumeration System (NPPES), developed by the Center for Medicare and Medicaid Services (CMS). Apply online at nppes.cms.hhs.gov.

Please view the OptumHealth Behavioral Solutions of California (OHBS-CA) Network Manual at providerexpress.com.

Joining the behavioral health network

If you are interested in joining the network, go to providerexpress.com > Our Network. Follow the instructions for California providers.

How to Join Our Network: Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental and emotional disorders. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health diagnoses, symptoms, treatments, prevention and other resources in one place.

liveandworkwell.com, accessed through a link on myuhc.com, includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

For member resources, go to providerexpress.com. Under the Clinical Resources tab, locate the Live and Work Well (LAWW) Clinician Center and find information under Mental health centers. In addition, the Provider Express Recovery and Resiliency page includes tools to help members addressing mental health and substance use issues.

Outpatient mental health services

We offer these services to members who meet medical necessity or Early Periodic Screening Diagnosis and Treatment (EPSDT) and/ or members with mild to moderate distress or impairment of mental, emotional, or behavioral functioning:

- Individual and group mental health evaluation and treatment (psychotherapy)*
- Psychological testing when clinically indicated to evaluate a mental health condition*
- Psychiatric consultation for medication management*
- Applied Behavioral Analysis (BHT) for children younger than 21 years old*
- Screening, Brief Intervention Referral and Treatment (SBIRT)
- Outpatient laboratory, supplies and supplements
- Drugs (excluding drugs which are covered by Medi-Cal Fee-For-Service)

Services one through four (*) above are provided through Optum Behavioral Health by care providers contracted with OptumHealth Behavioral Solutions of California. Certain mental health services require prior authorization. Call us at **866-270-5785** for information on referring patients for these behavioral health services. Have members call the health plan at **866-270-5785** to access behavioral health care services.

PCPs perform SBIRT evaluations needed to develop a diagnosis before referring the member to Optum Behavioral Health, County Mental Health or other programs. Outpatient laboratory, supplies, supplements and eligible drugs are administered through the member's medical benefits. Screening tools are available on the DHCS website and our provider website.

The following services for members with Serious Mental Illness (SMI) and/or Severe Emotional Disturbance (SED) condition(s) are covered through the County Mental Health system.

Outpatient services for members with SMI/SED

- Mental health services, including assessments, plan development, therapy and rehabilitation, and collateral
- Medication support
- Day treatment services and day rehabilitation
- Crisis intervention and stabilization
- Targeted case management
- Therapeutic behavior services
- Residential services
- Adult residential treatment services
- Crisis residential treatment services

Inpatient services for members with SMI/SED

- Acute psychiatric inpatient hospital services
- Psychiatric inpatient hospital professional services
- Psychiatric health facility services

Alcohol and drug treatment services are not covered. However, coverage may be available through County Alcohol and Other Drug (AOD) programs.

Eligibility

Verify the UnitedHealthcare Community Plan member's Medi-Cal eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on the Provider Portal at **UHCprovider.com**.

Authorizations

Members may access most mental health outpatient services without a referral. Prior authorization may be required for more intensive services. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by calling **866-270-5785**.

Portal access

UnitedHealthcare Community Plan Website: **UHCprovider.com**

Access the Provider Portal, the gateway to UnitedHealthcare Community Plan's online services, on this site. Use the services to verify eligibility, review electronic claim submission, view claim status, and submit notifications/prior authorizations.

View the Prior Authorization list, find forms and access the care provider manual. Or call the Customer Service

Center at **866-270-5785** to verify eligibility and benefit information (available 8 a.m. – 5 p.m. Central Time, Monday through Friday).

Optum Health Behavioral Solutions of California (OHBS-CA) Website: **providerexpress.com**

Update provider practice information, review guidelines and policies, and view the OHBS-CA Network Manual. Or call **877-614-0484**.

Claims

Submit claims using the CMS 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in Chapter 11.

Monitoring audits

We conduct routine care provider on-site audits. These audits focus on the physical environment, policies and procedures, and quality record documentation.

For more details about contacting Behavioral Solutions of California, see the following table.

Behavioral Solutions of California Contacts

Beneficiaries	UnitedHealthcare Community Plan of CA, Inc. Medi-Cal Managed Care Members	
Provider is Responsible for:	• Verifying enrollee eligibility & benefits • Obtaining authorization as necessary • Being familiar with the Network Manual located on our website, providerexpress.com > Guidelines/Policies	
How to Verify Benefits and Obtain Authorizations:	Call the number on the member's ID card and, after verification of behavioral health benefits, an Optum Care Advocate will provide appropriate authorizations, if needed	
Contact Information		
UHC Community Plan of CA, Inc. Members & Providers	• Phones are answered 7am-7pm PST (After Hours - County Crisis Line*) • Claims, Eligibility & Coordination of Care Issues	866-270-5785
Language Assistance Program	800-999-9585	
Hearing & Speech Impaired Line	800-842-9489 (TTY)	
Wellness Assessment Forms (ALERT®)	Wellness Assessments PO Box 27430 Houston, TX 77277	877-369-2198 Fax: 800-985-6894
Behavioral Network Services	877-614-0484	
Provider Website: providerexpress.com Support Line: (866) 209-9320	Features include: • Available 24/7 • Secure Transactions & Communications • Level of Care, Best Practice & Coverage Determination Guidelines • OHBS-CA Network Manual • Provider Newsletters • Forms • Claim tips	
Claim Submission	Electronic claims (preferred):	providerexpress.com
	Paper claims:	Optum PO Box 30884 Salt Lake City, UT 84130-0884
Medi-Cal Specialty Mental Health Services		
County Behavioral Health Services & Substance Use Treatment Referrals	San Diego Access & Crisis Line 888-724-7240 optumsandiego.com	

Chapter 8: Member Rights and Responsibilities

Key contacts

Topic	Link	Phone Number
Member Services	UHCCommunityPlan.com/ca	866-270-5785
Member Handbook	UHCCommunityPlan.com/ca > Community Plan > Member benefits	866-270-5785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Our Member Handbook has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy.

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to protected health information

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of PHI

Our members have the right to ask that you or we change information they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days, or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during six years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means.

You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: UHCCommunityPlan.com.

Native American access to care

Native American members can access care to tribal clinics and Indian hospitals without approval.

Member rights

Members have the right to:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
- Receive courtesy and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures.
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Choose a PCP in our network.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review the medical records you keep and request changes and/or additions to any area they feel is needed.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care.
- Get a second opinion with an in-network care provider.
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.
- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them.
- Show their Medicaid member ID card.
- Prevent others from using their ID card.
- Understand their health problems and give you true and complete information.
- Ask questions about treatment.
- Work with you to set treatment goals.
- Follow the agreed-upon treatment plan.
- Get to know you before they are sick.
- Keep appointments or tell you when they cannot keep them.
- Treat your staff and our staff with respect and courtesy.
- Get any approvals needed before receiving treatment.
- Use the ER only when they feel it is necessary or when told by their doctor.

- Notify us of any change in address or family status.
- Make sure you are in-network.
- Follow your advice and understand what may happen if they do not follow it.

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

- Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care.
- Follow care to which they have agreed.
- Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible.

Chapter 9: Medical Records

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

You are responsible for securing and maintaining medical records at each site. You must help ensure a complete medical record is maintained for each member in paper or electronic format. It must reflect all aspects of patient care, including ancillary services. This includes:

- Member identification on each page; personal/biographical data in the record.
- Initial Health Assessment within 120 days of enrollment.
- Member’s preferred language (if other than English) prominently noted, as well as the request or refusal of language/interpretation services.
- All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.
- The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
- Allergies and adverse reactions are prominently noted in the record.
- All informed consent documentation, including the human sterilization consent procedures.
- Reports of emergency care provided (directly by the contracted Provider or through an ER) and the hospital discharge summaries for all hospital admissions.
- Consultations, referrals, specialists, pathology and laboratory reports. Any abnormal results shall have an explicit notation.
- For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
- Health education behavioral assessment and referrals to health education services.

A member or their representative is entitled to one copy of their medical record at no cost. Medical records are generally kept for a minimum of five years unless federal requirement mandate a longer time frame (i.e., immunization and TB records required for lifetime).

Quality audits

We coordinate with your office to conduct Quality Audits including the Facility Site Review (FSR) and Medical Record Review (MRR).

These Quality Audits are comprehensive evaluations of the facility, administration, and medical records. For an overview and forms related to these audits, go to **UHCprovider.com/cacommunityplan** > **Quality Facility Site Review Resources**.

Initial medical record review (MRR)

We review medical records of a new provider within 90 calendar days of the date we first assign members. We may defer that review an additional 90 calendar days only if the new care provider does not have enough assigned members to complete a review of the ten medical records. At the end of six months, if the provider still has fewer than ten assigned member records, we complete an MRR on the total number of records available and adjust the scoring based on the number of records reviewed.

We conduct subsequent site reviews no later than three years after the initial MRR.

- We review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issues.
- Care providers will notify us of a provider site relocation at least 30 days prior to the move so that

we can conduct a site review on the new location. However, if the provider notifies us after the move:
  - We complete the review within 30 days of notification of the move.
  - We allow assigned members to continue to see the care provider, however, new members will not be assigned to the provider until the site review is completed
- We review medical records to assess for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
- The medical record serves as legal proof that the patient received care. Incomplete records or lack of documentation implies the provider's failure to provide care.
- We review medical records using the most recent MRR Survey Tool at each provider site as part of the site review and every three years thereafter.
  - During any MRR, reviewers must have the option to request additional records for review. If we review additional records, we must calculate the scores accordingly.
- The medical record score is based on a survey standard of the ten randomly selected records per provider, consisting of five pediatric and five adult and/or obstetric records. For sites with only pediatric, only adult, or only obstetric patients, all ten records surveyed must be only in that preventive car
- The MRR compliance levels are as follows:
  - Exempted Pass: 90% or above
  - Conditional Pass: 80-90%
  - Not Pass: below 80%

Facility site review

A site review is required as part of the credentialing process when both the facility and the care provider are added to our network. If a care provider is added to the network, and the facility has a current passing site review survey score, a site survey is not needed for credentialing or recredentialing.

Facility site audit types

1. Initial Site Review
- All PCP sites serving our members must have an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. We may waive the initial site review for a pre-contracted care provider site if the care provider has documented proof that we completed a site review with a passing score within the past three years.

2. Subsequent Periodic Facility Site Review
- We conduct subsequent site reviews no later than three years after the initial reviews.
- We may review sites more frequently based on monitoring, evaluation, or CAP follow-up issues.

3. Medical Record Review
- See the Medical Record Review section.

4. Interim/Focused Facility Site Review
- This is a targeted audit of one or more specific areas of the FSR or MRR.
- We use focused reviews to monitor providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions.

5. Physical Accessibility Review Survey (PARS)
- This reviews the physical accessibility of provider facilities that serve a high volume of seniors and Persons with Disabilities (SPDs).
- These results are available to members through our websites and provider directories.

FSR critical elements

Sites must meet the nine critical elements:
- A PCP facility must correct any critical element deficiency identified during a site review, focused survey, or monitoring visit within 10 business days of the survey date. We verify the corrective actions within 30 calendar days of the survey date.
- The nine critical elements are:
  1. Exit doors and aisles are unobstructed and escape is accessible;
  2. Airway management equipment is onsite;
  3. Only qualified/trained personnel retrieve, prepare or administer medications;
  4. Office practice procedures are used onsite that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results;

5. Only lawfully authorized persons dispense drugs;
6. Personal protective equipment is readily available for staff;
7. Needlestick safety precautions are practiced;
8. Blood, other potentially infectious materials and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping; and
9. Spore testing of each autoclave/steam sterilizer is completed at least monthly, with documented results.

Corrective action plan

A CAP is required on all cited deficiencies for sites with a Conditional Pass score on the FSR or MRR Survey Tool, on a focused review or for deficiencies identified through oversight and monitoring activities.

A CAP is required under the following conditions identified by us, or the state, through oversight and monitoring activities. They must be corrected to 100%:

- Deficiencies on any Critical Element(s) on the FSR
- Conditional Passing or Failing scores on FSR or MRR survey tools
- Deficiencies found on Focused or Interim review(s)
- A total MRR score below 90%
- Any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score

Chapter 10: Quality Management (QM) Program and Compliance

Key contacts

Topic	Link	Phone Number
Credentialing	Medical: Network Management Resource Team at Networkhelp@uhc.com Chiropractic: myoptumphysicalhealth.com	877-842-3210
Fraud, Waste and Abuse (Payment Integrity)	uhc.com/fraud	800-455-4521

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

What is the Quality Improvement Program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement program falls under the leadership of the CEO and the Chief Medical Officer. A copy of our Quality Improvement program is available upon request.

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhance patient safety
- Tracking member and provider satisfaction and take actions as appropriate

As a participating care provider, you may offer input through representation on our Provider Advisory Committees and your provider services representative/ provider advocate.

We require your cooperation and compliance to:

- Provide requested timely medical records.
- Cooperate with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participate in quality audits, such as site visits and medical record reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Provide requested medical records for quality activities at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Respond timely to practitioner appointment access and availability surveys and subsequent requests for CAPs.
- Allow the plan to use your performance data.
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

Cooperation with quality improvement activities

You must comply with all quality improvement activities. These include:

- Providing requested timely medical records.

- Cooperation with quality of care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participation in quality audits, such as site visits and medical record standard reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Participation in practitioner appointment access and availability surveys.

Care provider satisfaction

Every year, we conduct care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys.
- Regular visits.
- Town hall meetings.

Our chief concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to collect data.

Survey results are reported to our Quality Management Committee. We compare the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. We respect our network care providers. We appreciate the collaboration to promote better health, improve health outcomes and lower overall costs to offer our members. You are encouraged to visit the following website to view the guidelines, as they are an important resource to guide clinical decision-making.

UHCprovider.com/cpg

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you based on applicable CA statutes and the National Committee of Quality Assurance (NCQA). These are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or

- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider.

Health facilities

Facility providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and NPI number.
- Have a current unrestricted license to operate.
- Have been reviewed and approved by an accrediting body.
- Have malpractice coverage/liability insurance that meets contract minimums.
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency.
- Have no Medicare/Medicaid sanctions

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/ national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center completes these reviews. You can find applications on the Council for Affordable Quality Healthcare (CAQH) website.

First-time applicants must call the **National Credentialing Center (VETTS line)** to get a CAQH number and complete the application online.

For chiropractic credentialing, call **800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 Form

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every three years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have three chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NMRT finds erroneous information,

a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NMRT representative provided.

You also have the right to receive the status of your credentialing application, please email us at networkhelp@uhc.com. Include your full name, NPI, TIN and brief description of the request. A UnitedHealthcare Community Plan representative will be in touch with you within two business days from when we receive your request.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, send a letter to:

UnitedHealthcare Community Plan Central Escalation Unit
P.O. Box 5032
Kingston, NY, 12402-5032

A representative will work to resolve the issue with you. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your Provider Agreement.

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or Care Coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Provider Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Provider Agreement.

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member Handbook and Chapter 12 of this manual.

HIPAA compliance – your responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care providers who conduct business electronically.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA. Otherwise, submit claims using a Clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, health care providers, health plans and individuals for use in standard transactions.

National Provider Identifier

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on FFS claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and

Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates,
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations, and
- Help ensure compliance with the security regulations by the covered entity's staff.

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

UnitedHealthcare Community Plan has a compliance officer. The UnitedHealthcare Community Plan Compliance program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program.
- Development and implementation of ethical standards and business conduct policies.
- Creating awareness of the standards and policies by educating employees.
- Assessing compliance by monitoring and auditing.
- Responding to allegations of violations.
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.

To facilitate the reporting process of questionable incidents involving members or care providers, call our Fraud and Abuse line or go to uhc.com/fraud.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the

UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the State of CA to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the CA Department of Health and Human Services.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the CA program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until one year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state or designee. During these reviews, the state will address your capability to meet CA program standards.

You must cooperate with the state or any of its authorized representatives, the CA Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

- Any referral request where the medical necessity or the proposed treatment is not clear will be discussed with the care provider. Complex cases may be brought to the UMC/medical director for further discussion.
- Individual(s) who can hold financial ownership interest in the organization may not influence the clinical or payment decisions.

Possible request for authorization determinations include:

- Approved as requested – No changes.
- Approved as modified – Referral approved, but changed the requested care provider or treatment plan. (e.g., requested chiropractic, approved physical therapy).

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for Quality of Care/Services (QOC)

concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance.
- Available handicapped parking.
- Handicapped accessible facility.
- Available adequate waiting room space
- Adequate exam room(s) for providing member care.
- Privacy in exam room(s).
- Clearly marked exits.
- Accessible fire extinguishers.
- Post file inspection record in the last year.

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit based on UnitedHealthcare Community Plan policy.

QOC Issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	One complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	Two complaints in six months
Other	All other complaints concerning the office facilities	Three complaints in six months

Chapter 11: Billing and Submission

Key contacts

Topic	Link	Phone Number
Claims	UHCprovider.com/claims	866-633-4449
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	800-465-3203
EDI	UHCprovider.com/EDI	866-633-4449

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Our claims process

For claims, billing and payment questions, go to UHCprovider.com.

We follow the same claims process as UnitedHealthcare. See Chapter 10 of the Administrative Guide for Commercial, Medicare Advantage and DSNP on UHCprovider.com/guides.

Claims: From submission to payment

1. **You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.**
2. All claims are checked for compliance and validated.
3. Claims are routed to the correct claims system and loaded.
4. Claims with errors are manually reviewed.
5. Claims are processed based on edits, pricing and member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

Claims reconsideration and appeals
If you think we processed your claim incorrectly, please see the Claims Reconsiderations, Appeals and Grievances chapter in this manual for next steps.

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions.

If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call the VETTS line or Provider Services.

Your clean claims must include your NPI and federal TIN. Also include the Clinical Laboratory Improvement Amendments Number (CLIA) laboratory claims.

General billing guidelines

We only consider reimbursing claims if you meet billing and coverage requirements. Submitting an authorization does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek

reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

Reimbursements also depend on your contract, the fee schedule and the procedure performed.

Member ID card for billing

The member ID card has the UnitedHealthcare Community Plan member ID number. Please use the member ID number for billing.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500 and UB-04 claim forms.

Clean claims and submission requirements

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Clean claims have:

- A health service provided by an eligible health care provider to a covered UnitedHealthcare Community Plan member.
- All the required documentation, including correct diagnosis and procedure codes.
- The correct billed amount.

We may require additional information for some services, situations or state requirements.

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians'.

Claims and encounter data submissions

You must submit a claim and/or encounter for your services. Professional and institutional encounter data is an itemized list of services provided to our Community Plan members.

We encourage you to submit your encounter data at least weekly. Frequent encounter submissions allow us to support various state and federal regulatory requirements for reporting.

Send encounter data using current ASC X12 format to Payer ID 87726 or check with your clearinghouse.

We continuously monitor encounter data submissions for quality and quantity. Submission levels below the monthly threshold of 100% are considered non-compliant. The capitated medical group/IPA/FQHC or other submitting entity must correct any encounter errors identified by a clearinghouse or trading partner. As you are processing claims on our behalf, we expect all encounter submissions to be an accurate reflection of the original claim, paid or denied, without exception. All encounter data submitted to us is subject to state and/or federal chart assessments on any or all of the medical group's/ IPA/FQHC's network care providers. We may review the completeness and accuracy of encounter data and ICD-10-CM and CPT coding. We notify the medical group/IPA/FQHC, in writing, of those audit results.

The delegate may be subject to financial consequences if it, or another submitting entity, fails to submit or meet encounter data element requirements. In addition, they may be required to perform a complete medical record chart review of its network care providers with notice from UnitedHealthcare Community Plan.

Community Plan encounter data requirements

We require capitated medical group/IPA/FQHCs and capitated facilities to submit timely and compliant encounter data. The capitated medical group/IPA/FQHC, or other submitting entity, must certify the completeness and truthfulness of its encounter data submissions, as required by the state regulatory agency. The medical group/IPA/FQHC, or other submitting entity, must submit all professional and institutional encounter data for our members.

Each submission must be in a HIPAA compliant format and contain the complete, accurate and valid diagnosis and procedure coding reported to the highest level

of specificity utilizing industry standard code sets as required by CMS and as outlined in the technical report document for ANSI ASC X12N 837 Health Care Claims transaction implementation guide, for each date of service. Your clearinghouse provides the Payer ID for the submissions.

Contact the Encounter Data Collection Team with any questions: encountercollection@uhc.com.

Care provider coding

UnitedHealthcare Community Plan complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-10 code.

Electronic claims submission and billing

You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- All claims are set up as "commercial" through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for CMS 1500 and UB-04 forms.

For more information, see EDI Claims.

EDI companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted.

UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices.
- Provide values the health plan will return in outbound transactions.
- Outline which situational elements the health plan requires.

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

The companion documents are located on UHCprovider.com/edi > Go to companion guides

Additional claim submission requirements for professional claims

Follow these tips for 837 claim formats:

- Use the 2010AA Billing Provider loop when the billing and rendering provider are the same.
- Use the 2310B Rendering Provider loop when the rendering and billing provider are NOT the same.
- Use one rendering provider per claim. Claims with multiple rendering providers will have to be formatted as separate claims using only the 2310B loop. Do not use 2420A.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, use our EDI at UHCprovider.com > Menu > Resource Library > Electronic Data Interchange > Clearinghouse.

e-Business support

Call Provider Services for help with online billing, claims, Electronic Remittance Advices (ERAs), and Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, go to Chapter 1 under Online Services.

To find more information about EDI online, go to UHCprovider.com > Menu > Resource Library to find Electronic Data Interchange menu.

Electronic payment solutions

UnitedHealthcare has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for provider payment. You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to UHCprovider.com/payment.
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take.
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library.
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to UHCprovider.com/payment.

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 Claim Form

Companion documents for 837 transactions are on UHCprovider.com/cacommunityplan. Look under Healthcare Providers in the EDI section.

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form.

Completing the UB-04 Form

Bill all hospital inpatient, outpatient and ER services using revenue codes and the UB-04 claim form:

- Include ICD CM diagnosis codes.
- Identify other services by the CPT/HCPCS and modifiers.

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims.
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims.

Subrogation and coordination of benefit

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules:

- **Subrogation:** DHCS may recover benefits paid for a member's treatment when a third party causes the injury or illness.
- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

Skilled nursing facility billing

Follow these SNF billing guidelines for custodial care:

- Type of bill 021X
- Revenue code 0160
- Value code 23 to show the share of cost
- Value code 24 to show the accommodation code
- Bill accommodation codes with a Value Code 24 and billed as a cent amount. If billing a single Accommodation Code on row 1 of the claim, the dollar amount should be 0. When billing multiple accommodation codes on a single claim, the dollar amount should be associated with the line number
- Use value code 66 in field 41a, and enter the non-covered service (NCS) in the amount field
- Consistent with Johnson v. Rank, Medi-Cal recipients, not their care providers, may use their SOC funds to pay for non-covered services.
- If hospice is being performed in a SNF, the hospice provider should follow SNF billing guidelines.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services on a CMS 1500. The servicing provider's name is placed in box 31, and the servicing provider's group NPI number is placed in box 33a.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on UHCprovider.com > Menu > Policies and Protocols > For Community Plans > Reimbursement Policies for Community Plan > **Global Days Policy, Professional - Reimbursement Policy - UnitedHealthcare Community Plan**.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures:** Only report these codes when performed independently:
- **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services:** Don't report combinations where one code includes and the other excludes certain services.
- **Medical practice standards:** Services part of a larger procedure are bundled.
- **Laboratory panels:** Don't report individual components of panels or multichannel tests separately.

Use of HIPAA compliant codes vs. local codes

We require HIPAA compliant codes for billing of all physician and provider claims billed using the CMS 1500 format. We do not accept local codes for services billed on a CMS 1500.

Payment for outpatient hospital services

For consistent, accurate and compliant submissions, all participating and non-participating hospitals are encouraged to use only HIPAA compliant codes when billing for outpatient hospital services using the UB 04 format. Use of non-compliant codes may result in rejection by clearinghouses and other partners during claim submissions.

For all participating hospitals with Medi-Cal based rates and for all non-participating hospitals, the following applies based on current DHCS outpatient payment methodology:

- Emergency Services Claims – Emergency services are defined as claims with a place of service 23 or revenue code 450. For any facility claims including a visit, the Medi-Cal rates for use of ER will apply.
- Other outpatient services – any local codes used by providers will be paid at Medi-Cal rates.
- For submission of encounters to the Department of Healthcare services, UnitedHealthcare will leverage HIPAA standard codes billed by providers. For local codes billed by providers, we will leverage diagnosis and procedure code mapping to provide HIPAA compliant codes to submit encounters to DHCS.
- The payment policy became effective July 31, 2019.

Clinical Laboratory Improvements Amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 410-786-3531 or go to the cms.gov.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units.
- The total bill charge is the unit charge multiplied by the number of units.

Billing guidelines for obstetrical services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we will deny the claim:

- If billing for both delivery and prenatal care, use the date of delivery.
- Use one unit with the appropriate charge in the charge column.

Billing guidelines for transplants

The fee-for-service medical program provides authorizations and payment for all medically necessary transplants. The exceptions are kidney and cornea transplants, which are the plan's responsibility. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Claims payment requires

prior authorization for the transplant evaluation. Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Ambulance claims (emergency)

Ambulance claims must include the point of origin, destination address, city, state, and ZIP.

National Drug Code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed.
- HCPCS/CPT code and units of service for the drug billed.
- Actual metric decimal quantity administered.

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11–digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See **Chapter 4** for more information about medical necessity.

Place of Service codes

Go to **CMS.gov** for Place of Service codes.

Asking about a claim

You can ask about claims through UnitedHealthcare Community Plan Provider Services and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to **UHCprovider.com**. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern.

UnitedHealthcare Community Plan Provider Portal

You can view your online transactions with the Provider Portal by signing in at **UHCprovider.com** with your One Healthcare ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

UnitedHealthcare Provider Portal: your gateway to UnitedHealthcare Community Plan online provider tools and resources

The Provider Portal lets you move quickly between applications. This helps you:

- Check member eligibility.
- Submit claims reconsiderations.
- Review coordination of benefits information.
- Use the integrated applications to complete multiple transactions at once.
- Reduce phone calls and paperwork.

You can even customize the screen to put these common tasks just one click away.

Find Provider Portal training at **UHCprovider.com/training** and Self Service Tool training at UHCprovider.com > Menu > Resource Library > **Training**.

Provider Portal training course is available using the **Community Care Provider Portal User Guide**.

Resolving claim issues

To resolve claim issues, contact **Provider Services**, use the Provider Portal or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 30884
Salt Lake City, UT 84130-0884

For Behavioral Health Paper Claims:

OptumHealth Behavioral Health Paper Claims
P.O. Box 30760
Salt Lake City, UT 84130-076

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier.
- Another carrier's explanation of benefits.
- A letter from another insurance carrier or employer group saying the member either has no coverage or had their coverage terminated before the date of service.
- The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.
- To be timely, we must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria. You must submit within 90 calendar days of primary carrier's paid date.
- Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

All the above must include documentation the claim is for the correct member and the correct date of service.

Electronic claims

A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

Paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:

- Member name.
- Date of service.
- Claim date submission (within the timely filing period).

Balance billing

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ.
- UnitedHealthcare Community Plan denies a claim for late submission, unauthorized service or as not medically necessary.
- UnitedHealthcare Community Plan is reviewing a claim.

You may balance bill the member for non-covered services if the member provides written consent prior to getting the service. If you have questions, please contact your provider advocate.

Chapter 12: Claim Reconsiderations, Appeals and Grievances

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

There are a number of ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider contract. Non-network care providers should refer to applicable care provider appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com**. We no longer use fax numbers. Please use our online options or phone number.

The following grid lists the types of disputes and processes that apply:

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR MAIL	CONTACT PHONE NUMBER	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESOLUTION TIMEFRAME
Care Provider Dispute Resolution	A claim outcome with which you do not agree. This could be an overpayment, underpayment or a payment denial of an original or corrected claim.	Care Provider	UnitedHealthcare Attention: Provider Dispute P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com/CAcommunityplan > Provider Dispute Resolution (PDR) Form	866-270-5785	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.	Cannot impose a deadline of less than 365 days after the most recent action or, in the case of inaction, 365 days after time for contesting or denying claim has expired. A provider may submit within 30 working days of the date of receipt of a returned provider dispute for purposes of requesting missing information.	45 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR MAIL**	**CONTACT PHONE NUMBER**	**WEBSITE (Care Providers Only) for Online Submissions**	**CARE PROVIDER FILING TIMEFRAME**	**UnitedHealthcare Community Plan RESOLUTION TIMEFRAME**
Care Provider Claim Resubmission Please note: For disputed claims in California, please use the Provider Dispute Resolution Process described above. PDRs cannot be submitted using the Provider Portal.	Use when submitting a corrected claim – Corrections may include additional information such as medical records, EOB for coordination of benefits or proof of timely filing. Creating a new claim – If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission	Care Provider	UnitedHealthcare P.O. Box 31341 Salt Lake City, UT 84131	UHCprovider.com/claims	866-270-5785	Use the Claims Management or Claims on the Provider Portal. Click Sign in to the Provider Portal in the top right corner of UHCprovider.com, then click Claims.	within 45 business days	30 business days
Member Appeal	A request to change an adverse benefit determination that we made.	• Member • Care provider on behalf of a member with member's written consent • Member's Authorized Representative (such as friend or family member) with written member consent.	UnitedHealthcare Community Plan of California, Inc. Attention: Grievance and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHCprovider.com/claims *AOR Consent Form on this site for member appeals	866-270-5785	N/A	60 calendar days from the date on the determination letter	30 calendar days and 72 hours for urgent
Member Complaint or Grievance	A member's expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns. A complaint is the same as a grievance.	• Member • Care provider on behalf of a member with member's written consent • Member's Authorized Representative (such as friend or family member) with written member consent.	UnitedHealthcare Community Plan of California, Inc. Attention: Grievance and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	N/A	866-270-5785	N/A	No limit	30 calendar days (standard) 72 hours (expedited)

These definitions and process requirements are subject to modification by state contract or regulations. The State may impose more stringent requirements.

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider contracts than described in the standard process.

Care provider dispute resolution process (PDR)

What is it?

The PDR process is available to provide a fair, fast and cost-effective resolution of care provider disputes, in accordance with state and federal regulations. We do not discriminate, retaliate against or charge you for submitting a care provider dispute. The PDR process is not a substitution for arbitration and is not deemed an arbitration. PDRs must be submitted in writing to:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364

When to use:

If you disagree with our claim determination, you may initiate a care provider dispute. You must submit a care provider dispute, in writing, and with additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement or state law dictates otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

What to submit:

As the care provider of service, submit the PDR request form with the following information:

- Provider's name
- Provider's identification number
- Provider's contact information
- Member's name and health care ID number
- Claim number
- Item in dispute, detailed explanation of the issue, dates of service, procedure codes, amounts, etc.
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved

Disputes are not reviewed if the supporting documentation is not submitted with the request.

Provider Dispute Resolution Form:

We recommend you use the Provider Dispute Resolution Form when submitting a PDR. The form is **UHCprovider.com/cacommunityplan** under the Provider Dispute Resolution and Member Grievance and Appeals section.

Where to submit:

Mail related documents with your PDR. These may include a cover letter, medical records and additional information. In your PDR, please include any supporting information not included with your previous request. Send the PDR to:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364

Notes: We acknowledge receipt of paper disputes by mail within 15 business days. A written determination is issued within 45 business days.

If we need more information, we return the dispute within 45 business days. We identify the information we need, in writing to resolve the dispute. You may submit an amended provider dispute within 30 working days from when you receive the returned provider dispute.

Exclusions

The following are examples of issues excluded from the PDR process:

- A member has filed an appeal, and you have filed a dispute about the same issue. In these cases, we review the member's appeal first. You can submit a care provider dispute after we make a decision on the member's appeal. If you are appealing on the member's behalf, we treat the appeal as a member appeal.
- An Independent Medical Review initiated by a member through the member appeal process.
- Any dispute you file beyond the timely filing limit applicable to you, and you fail to give "good cause" for the delay.
- Any delegated claim issue that has not been reviewed through the delegated payer's claim resolution mechanism.
- Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or

capitated hospital/care provider and does not involve medical necessity or medical management.

Claim management tips

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you are unable to verify that a claim is on file.
- To avoid duplicate denials, do not resubmit claims on file unless submitting a corrected claim.
- File corrected claims and PDRs within contractual time requirements.
- If it is medically necessary to exceed the maximum daily frequency for a procedure, submit the required medical records. If you have questions, call **Provider Services**.
- As a Medi-Cal plan, UnitedHealthcare Community Plan is the payer of last resort. This means we can only make payment after you bill the primary insurance and provide their EOB showing the outstanding balance. Attach the EOB to the claim when submitting to UnitedHealthcare Community Plan.

Denial

Your claim may be denied for administrative or medical necessity reasons.

An **administrative denial** is when we didn't get notification before the service, or the notification came in too late. Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary. If a claim is denied for these reasons, you may dispute through the PDR Process.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or incorrect information, such as spelling of a name. You can resubmit this type of claim as a corrected claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Benefit denials occur when a service or procedure is not covered under the member's benefit plan.

Time limit expired. This is when you don't send the claim in time.

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected.

Common Reasons for Rejected Claims:

Some claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131

Corrected claim

What is it?

A corrected claim replaces a previously submitted claim.

When to use:

Submit a corrected claim to fix or void one that has already been submitted and/or processed.

How to use:

Use the claims reconsideration application on the Provider Portal. To access the Provider Portal, sign in to UHCprovider.com using your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form in selecting corrected claim as the reason for the submission. Allow up to 30 days to receive payment or response.

UnitedHealthcare Community Plan
P.O. Box 31341
Salt Lake City, UT 84131

Additional Information:

When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim. To void a claim, use bill type xx8.

Timely filing considerations

What is it?

Sometimes a member gives incorrect coverage information at the time of service. You have an opportunity to submit proof of timely filing after receiving a denial from a different insurance plan. This includes:

- A denial or rejection letter from another insurance plan.
- Another insurance plan's explanation of benefits.
- Letter from another insurance plan indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a corrected claim request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a corrected claim electronically, phone or mail with the following information:

- **Electronic claims:** Include the EDI acceptance report stating your claim was received timely by us or another plan.
- **Mail corrected claims:** Submit any of the documentation listed above that includes submission and acceptance of your original claim to us or another plan. Please ensure that your submission includes:
  - Correct member name.
  - Correct date of service.
  - Claim submission date.

Additional Information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Questions about your appeal or need a status update? Call Provider Services. If you filed your appeal online, you should receive a confirmation email.

Overpayment

What is it?

An overpayment happens when we overpay a claim that you do not dispute or contest.

How to use:

If you find an overpaid claim, send us the overpayment within the time specified in your contract. If we find an overpaid claim, we send you a written notice no later than 365 days from the date of the overpaid claim. If your payment is not received by that time, we may apply the overpayment against future claim payments based on Agreement and applicable law. If you prefer we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, use the Overpayment Refund/Notification Form available at UHCprovider.com > Claims, Billing and Payments > Need a Paper Form.

You can choose to send a letter with the following information:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.

- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on UHCprovider.com/claims.

If you do not agree with the overpayment findings, submit a dispute through the PDR Process within the required timeframe as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can dispute through the PDR Process. See the PDR section in this chapter.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Sample overpayment report

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances. Detailed information on member procedures are available in the Member Handbook.

Member appeals

What is it?

An appeal is a formal way to share dissatisfaction with a benefit determination.

You (with a member's written consent) or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame the state or CMS requires to resolve a grievance.
- Denies or limits authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- For a resident of a rural area with only one MCP, denies the member's request to obtain services outside the network.
- Denies a member's request to dispute financial liability.

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and certification of the appeal as appropriate.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364

Phone: **866-270-5785** (TTY **711**)

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan. Expedited appeals don't need to be in writing.

How to use:

Whenever we deny a service, you must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision.
- Present evidence, and allegations of fact or law, in person and in writing.
- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member's health.
- Ask for continuation of services during the appeal.

We resolve a standard appeal 30 calendar days from the day we receive it.

We resolve an expedited appeal within 72 hours from when we receive it.

We may extend the response up to 14 calendar days if the following conditions apply:

1. Member requests we take longer.
2. We request additional information and explain how the delay is in the member's interest.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at UHCprovider.com.

Member grievance

What is it?

A grievance is an expression of dissatisfaction about UnitedHealthcare Community Plan and/or a care provider about any matter other than an adverse benefit determination. This includes quality of care or service concerns and aspects of interpersonal relationships, such as a care provider or employee's rudeness.

When to use:

You may act on the member's behalf with their written consent.

Where to send:

You or the member may call or mail the information anytime to:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364

Phone: **866-270-5785** (TTY **711**)

We will send an answer no longer than 30 calendar days (or 72 hours for urgent requests) from when you filed the complaint/grievance or as quickly as the member's health condition requires.

Find additional resources for care providers from DMHC at dmhc.ca.gov.

Fair hearings

What is it?

A Fair Hearing lets members share why they think CA Medi-Cal services should not have been denied, reduced or terminated.

When to use:

Members have 240 calendar days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by submitting a request online at cdss.ca.gov/Hearing-Requests.

- The member may ask UnitedHealthcare Community Plan Member Services for help.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

Request for Independent Medical Review (IMR)

The member may request an IMR of a disputed healthcare service. A "disputed healthcare service" is any service eligible for coverage where payment has been denied, modified, or delayed by us or one of our contracted care providers because the service is not medically necessary. We provide the member with an IMR application form with any disposition letter that denies, modifies, or delays healthcare services.

The following requirements are reviewed by the Department of Managed Health Care (DHMC) to determine if the request for an IMR is appropriate:

- You recommended a health care service because it is medically necessary and it is denied
- The member received urgent or emergency services determined to be necessary and it was denied
- The member was seen by a network care provider for the diagnosis or treatment of the medical condition (even if the health care service was not recommended by a network care provider)
- The disputed health care service is denied, changed or delayed by us based in whole or in part on a decision that the health care service is not medically necessary
- The member filed an appeal with us and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 days
- It has been six months from the date of appeal decision

The DMHC submits the dispute to an IMR organization. The DMHC must provide a determination within 30 days of receipt of the application, or less or an urgent case.

Processes related to reversal of our initial decision

If the State Fair Hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

1. As quickly as the member's health condition requires or
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the Fair Hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Managed care ombudsman program

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman Program assists in the mediation of disputes between Medi-Cal Managed Care members and their health plans as well as care providers. They attempt to resolve these disputes informally outside of the formal grievance and appeal processes. If you wish to use the services of the DHCS, please call the Medi-Cal Managed Care Ombudsman program at **888-452-8609**, Monday through Friday, between the hours of 8 a.m. and 5 p.m. Pacific Time. You can also call the DMHC HMO Consumer Service toll free telephone number at **800-400-0815**.

Fraud, waste and abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies based on state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find out how we follow federal and state regulations around false claims at UHCprovider.com/CAcommunityplan > **Integrity of Claims, Reports, and Representations to the Government.**

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors.

They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws.

As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every

month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management** > Data Access

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Chapter 13: Care Provider Communications and Outreach

Key contacts

Topic	Link	Phone Number
Provider Education	UHCprovider.com > Menu > Resource Library	866-270-5785
News and Bulletins	UHCprovider.com > News and Network Bulletin	866-270-5785
Provider Manuals	UHCprovider.com/guides	866-270-5785

Looking for something else?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the "what can we help you find?" search bar.

Connect with us on social media:

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and California (CA)'s managed care program. It includes the following care provider components:

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual

Care provider websites

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. The UHCprovider.com portal facilitates care provider communications related to administrative functions. Our interactive website empowers you to electronically determine member eligibility, submit claims, and view claim status.

We have also implemented an internet-based prior authorization system. This site lets you request medical and advanced outpatient imaging procedures online rather than by phone. The website also has:

- An online version of this manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (e.g., PreCheck MyScript)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is UHCCommunityPlan.com > select Member.

You can find California Department of Health Care Services (DHCS) manual at files.medi-cal.ca.gov > Publications > Provider Manuals.

Care provider office visits

Care Provider Advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a care provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care provider newsletters and network bulletins

UnitedHealthcare Community Plan produces Practice Matters, a care provider newsletter to the entire CA network at least three times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

Network Bulletin

The Network Bulletin is a monthly publication that features important protocol and policy changes, administrative information and clinical resources.

View the latest news or sign up to receive the monthly bulletin at UHCprovider.com > News and Network Bulletin.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, a removable quick reference guide and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

Find these forms on the state's website at **medi-cal.ca.gov**:

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)

Chapter 14: Additional Information for Capitated/ Delegated Care Providers

Looking for something?

- In PDF view, click CTRL+F, then type the keyword.
- In web view, type your keyword in the “what can we help you find?” search bar.

Capitated care providers

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

The plan uses the term ‘medical group/IPA’ interchangeably with the term ‘capitated care providers’. Capitation payment arrangements apply to participating physicians, health care providers, facilities and ancillary care providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, and
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this manual.

Capitation reporting

We provide monthly capitation reporting of the assigned/attributed members to our participating, capitated care providers.

Delegated medical management

Purpose of medical management program

The Medical Management Program helps determine if medical services are:

- Medically necessary.
- Covered under the UnitedHealthcare Community Plan benefit.
- Performed at both the appropriate place and level of care.

Delegation oversight

We may assign medical management to a medical group/ Independent Practice Association (IPA) with established medical management standards. We refer to the medical group/IPA as a “delegate”. Care providers associated with these delegates may use the delegate’s office and protocols for authorizations. The delegate’s medical management protocols and procedures must comply with UnitedHealthcare Community Plan as well as all applicable state and federal regulatory requirements.

Before assigning medical management functions, we assess the delegate. Within 90 calendar days of the

contract effective date, we assess it again to measure compliance with UnitedHealthcare Community Plan standards. We assess the delegate annually thereafter. We may also conduct an off-cycle assessment if needed.

Based on the assessment findings, we may have the delegate develop and implement a corrective action plan to bring the medical group/IPA back into compliance. Delegates who do not achieve compliance within the established timeframes may undergo further corrective action. If the action is not successful, the medical management function will be withdrawn.

Appeals

When we review a member or care provider's adverse determination appeal from a delegate, we use Interqual as the externally licensed medical management guidelines. This happens even if the delegate used different externally licensed medical management guidelines to make the determination.

Semi-annual reporting

The delegate provides us with semi-annual reports as outlined in the delegation agreement. Reports must meet applicable requirements and accreditation standards.

Determining medical necessity

Delegates review nationally recognized criteria to determine medical necessity and appropriate level of care for services. This includes Medi-Cal coverage guidelines.

For services not addressed in Medicaid coverage guidelines, delegates use our medical policies. If other nationally recognized criteria disagree with Medi-Cal coverage guidelines, delegates follow Medi-Cal coverage guidelines.

Members may call the delegate's general number (or the number listed in the denial letters) to request individual eligibility and benefit criteria. They may also call our Member Services department.

NCQA Accreditation standards require all health care organizations, health plans and delegates distribute a statement to members, care providers and employees who make utilization management (UM) decisions. The statement must note the following:

- UM decision-making is based only on appropriateness of care, service and coverage.
- You or others are not rewarded for issuing denials or encouraging decisions that result in under-utilization

Care provider requirements

Render covered services at the most appropriate level of care based on nationally recognized criteria. With few exceptions, we do not reimburse for non-covered services and those not medically necessary. We do not reimburse for the wrong procedures (e.g., notification requirements, preauthorization, verification guarantee process). Authorization receipts do not affect how payment policies determine reimbursement.

We nor the member are responsible for reimbursing medical services, admissions, inappropriate facility days, and/or medically necessary services if you did not obtain required prior authorization. Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and you, as the attending care provider. If you and the member decide to go forward with the medical services after UnitedHealthcare Community Plan or the delegate deny preauthorization, no care provider, facility or ancillary services will be reimbursed. The delegate's medical director can discuss the decisions and criteria with the member. The delegate also makes the medical policy decisions available upon request.

Delegate training attestation

UnitedHealthcare Community Plan delegates are required to provide attestation of the completion of new DHCS-required provider training.

Attestation of new provider training form is available. Please contact your assigned physician advocate for the form or additional information.

Second opinion

Members have the right to second opinions. The delegate will provide a second opinion when either the member or a qualified health care professional requests it. Qualified health care professionals must provide the member with second opinions at no cost. There is no limitation for additional opinions.

Medical management denials/adverse determinations

UnitedHealthcare Community Plan or a delegate may issue a denial when a non-covered benefit is requested but deemed not medically necessary. This may also happen when we receive insufficient information.

Denials, delays and modifications

UnitedHealthcare Community Plan or the delegate must make and communicate timely approvals, modifications or denials. We or the delegate must also state the decision to delay a service based on medical necessity or benefit coverage appropriate to the member's medical condition, in accordance with the applicable state and federal law.

The plan and delegates base all authorization decisions on sound clinical evidence, including medical record review, consultation with the treating care providers, and review of nationally recognized criteria. You must clearly document the medical appropriateness with your authorization request. State and federal law applies to criteria disclosure.

The medical director, Utilization Management Committee (UMC) or you must review referral requests not meeting the authorization criteria. Otherwise, you must present the information to UMC or the subcommittee for discussion and a determination. Only a care provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may delay, modify or deny services for medical necessity reasons. Board-certified, licensed care providers from appropriate specialties must help make medical necessity decisions, as appropriate. Determination rules include:

- You may not review your own referrals.
- Care providers qualified to make an appropriate determination will review referral requests considered for denial.
- Any referral request where the medical necessity or the proposed treatment is not clear will be discussed with the care provider. Complex cases may be brought to the UMC/medical director for further discussion.
- Individual(s) who can hold financial ownership interest in the organization may not influence the clinical or payment decisions.

Possible request for authorization determinations include:

- Approved as requested — No changes.
- Approved as modified — Referral approved, but changed the requested care provider or treatment plan. (e.g., requested chiropractic, approved physical therapy).
- Extension — Delay of decision (e.g., need additional information, require consultation). DHCS allows an extension when a Medi-Cal member requests one.
- Denied – Non-authorization request for health care services.

Reasons for denials of requests for services include:

- Not a covered benefit — The requested service(s) is excluded under the member's benefit plan.
- Not medically necessary or benefit coverage limitation — Specify criteria or guidelines used to make the determination.
- Member not eligible at the time of service.
- Benefit exhausted — Include what benefit was exhausted and when.
- Not a participating care provider — A participating care provider/service is available within the medical group/ IPA in-network.
- Experimental procedure.
- Investigational procedure when coverage requirements are not met.
- Self-referred/no prior authorization (for non-emergent post-service).
- PCP can provide requested services.

Written denial notice

The written denial is an important part of the member's chart and the delegate's records. Regardless of the form used, the denial letter documents member and care provider notification of:

- The denial, delay, partial approval or modification of requested services.
- The reason for the decision, including medical necessity, benefits limitation or benefit exclusion.
- Member-specific information about how the member did not meet criteria.
- Appeal rights.
- An alternative treatment plan, if applicable.

- Benefit exhaustion or planned discharge date.

Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare Community Plan will provide appropriate and approved templates to the delegates.

Minimum content of written or electronic notification

Written or electronic notices to deny, delay or modify a health care services authorization request must include:

- The requested service(s)
- A reference to the benefit plan provisions to support the decision
- The reason for denial, delay, modification, or partial approval, including:
  - Clear, understandable explanation of the decision
  - Name and description of the criteria used
  - How those criteria were applied to the member's condition
- Notification the member can get a free copy of the benefit provision, guideline, protocol or other criterion used to make the denial decision
- Contractual rationale for benefit denials
- Alternative treatments offered, if applicable
- A description of additional information needed to complete that request and why it is necessary
- Appeal and grievance processes, including:
  - When, how and where to submit a standard or expedited appeal
  - The member's right to appoint a representative to file the appeal
  - The right to submit written comments, documents or other additional relevant information
  - The right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable
- The name and phone number of the health care professional responsible for the decision

Medical group/IPA's responsibilities related to member grievance and appeals

Occasionally, a member may contact the delegate instead of the plan. In such cases, delegates must:

- Within one hour of receipt, forward all member grievances and appeals to UnitedHealthcare Community Plan for processing.
- Respond to UnitedHealthcare Community Plan requests for appeal or grievance information within the designated timeframe (standard appeals with 24 hours, expedited appeals within two hours). Timeframes apply to every calendar day.
- Comply with all final UnitedHealthcare Community Plan determinations.
- Cooperate with UnitedHealthcare Community Plan and the external independent medical review organization or State Fair Hearing. This includes promptly forwarding all medical records and information related to the disputed health care service.
- Provide UnitedHealthcare Community Plan with the authorization (pre-service) within the requested timeframes on adverse determinations reversals.
- Respond to requests for proof of overturned appeals.

Referrals

Referral authorization procedure

The delegate may initiate a member referral. Refer to the delegated group's pre- authorization list, as applicable. A referral authorization may be needed for these capitated medical services (not an inclusive list):

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA's facility)
- Specialty consultation/treatment

The delegate, PCP and/or other referring care provider must verify the care provider participates in UnitedHealthcare Community Plan.

You must also comply with the following procedures:

- Review the service request for medical necessity.
- If the treatment is not medically necessary, discuss an alternative treatment plan with the member.
- If the treatment requires referral or prior authorization, submit the request to the delegate UMC for determination.

If the request is not approved, the delegate must issue the member a denial letter.

Referral authorization form

The delegate must use the state mandated authorization form for pharmacy services.

The delegate may design its own authorization form for medical services, without approval from UnitedHealthcare Community Plan. The form should include all the following:

- Member identification (e.g., Member ID number and birth date)
- Services requested (including appropriate ICD-10-CM and/or CPT codes)
- Authorized services (including appropriate ICD-10-CM and/or CPT codes)
- Proper billing procedures (including the medical group/IPA address)
- Verification of member eligibility

The delegate provides this form to the following:

- Referral care provider
- Member
- Member's medical record
- Managed care administrative office

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within two business days of the decision
Urgent/Expedited Pre-service	Based on the member's condition, not to exceed 72 hours	Notified within 24 hours of determination	Practitioner notified within 24 hours of determination and member notification within two business days
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Practitioner notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Practitioner within 24 hours of determination and member notification within two business days

If UnitedHealthcare Community Plan is financially responsible for the services, the provider directly submits the authorization information to the plan, or the delegated entity may submit to the plan on behalf of the provider.

Continuity of care

Continuity of care lets members temporarily continue receiving services from a non-participating care provider. It is intended to last a short period.

The delegate facilitates continuity of care for medically necessary covered services. If a member entering the health plan is receiving medically necessary services (in addition to or other than prenatal services) the day before enrollment, the health plan covers the continued costs of such services without prior approval. This is regardless of whether in-network or out-of-network care providers grant these services.

- The health plan provides continuation of such services for the lesser of (1) 60 calendar days or (2) until the member has transferred without disruption of care to an in-network care provider.
- For members eligible for care management, the new health plan provides service continuation authorized by the prior health plan for up to 60 calendar days after the member's enrollment in the new health plan. Services will not be reduced until the new health plan assesses the situation.

Pregnant members may receive services from their prenatal care provider (whether in-network or out-of-network) under the continuity of care policy without prior authorization through the postpartum period (defined as 60 calendar days from date of birth).

A member should not continue care with a nonparticipating care provider without formal approval by UnitedHealthcare Community Plan or the delegate. Except for emergent or urgent out-of-area (OOA) care, payment for services performed by a non-participating medical group/IPA become the member's responsibility.

UnitedHealthcare Community Plan (or the delegate) reviews all requests for continuity of care. We consider the member's condition and the potential effect on the member's treatment. We also consider how changing the care provider can affect the health outcome.

A member may request to continue covered services with a care provider who has terminated from UnitedHealthcare Community Plan for reasons other than cause or disciplinary action. As the care provider, you must agree in writing:

- To agree to the same contractual terms and conditions imposed on participating care providers, including credentialing, facility privileging, utilization review, peer review and quality assurance requirements; and
- To be compensated at rates and payment methods similar to those used by UnitedHealthcare Community Plan and participating care providers granting similar services that are not capitated and are practicing in the same geographic area.

Authorization log and denial log submission

Authorization logs for all inpatient acute, observation status and SNF cases must be accurately submitted to clinicaloperations@uhc.com.

When no inpatient acute, observation statuses or SNF cases are active, the delegate must submit its weekly authorization log indicating either "no activity" or "no admissions" for each designated admission service type specified in this section and for the applicable reporting time.

Authorization logs covering facility and SNF daily information includes:

- Member ID
- Member name
- Member date of birth
- Attending care provider: (Name and address, with TIN if available)
- Facility care provider: (Name and address, with TIN if available)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Planned and actual admission dates
- Planned and actual discharge dates
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Service type
- Authorization number (if available)

The delegate must clearly define medical necessity and authorizing outpatient services paid as either shared risk or plan risk per the medical group/IPA contract. It must submit authorization or denials for services the group authorized or denied care on behalf of UnitedHealthcare Community Plan.

For more information, please contact your provider advocate.

Glossary

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Adverse Benefit Determination
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the state.

(5) The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.

(6) For a resident of a rural area,the denial of an member's request to exercise their right, to obtain services outside the network.

(7) The denial of an member's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Advance directive
Legal papers that list a member's wishes about their end-of-life health care.

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care". Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services
Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Appeal
A member request that their health insurer or plan review an adverse benefit determination.

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned members made to a care provider for providing covered services for a specific period.

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's Primary Care Provider (PCP).

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

CHIP
Children's Health Insurance Program.

Clean Claim
A claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Contracted Health Professionals
Primary care providers, care provider specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of two or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered Services
The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.**Current Procedural Terminology (CPT) Codes**
A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

Dispute
Provider claim reconsideration: Step 1 when a provider disagreewith the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and

the care they have received.

Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency (see definition below).

Encounter
A record of health care-related services by care providers registered with Medi-Cal to an patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to Medi-Cal. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

FQHC
Federally Qualified Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute).

Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes an member's right to dispute an extension of time proposed to make an authorization decision.

Healthcare Effectiveness Data and Information Set (HEDIS)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding personal health information.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

IHS
Indian Health Services

In-Network Provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. In California, it's known as Medi-Cal.

Medical Emergency
A medical condition manifesting itself by acute

symptoms of sufficient severity (including severe pain) 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 the following:

- 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.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventative Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs and/or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by CA DHCS.

SPD
Seniors and Persons with Disabilities

Specialist
A care provider licensed in the state of CA and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time

limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.