



2022 Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

**Arizona UnitedHealthcare Dual Complete and
Dual Complete One (HMO SNP)**

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Chapter 1: Introduction

Welcome

Welcome to the AZ Dual Complete and Dual Complete One (HMO SNP) plan manual. This comprehensive and up-to-date reference PDF manual allows you and your staff to find important information such as processing a claim and prior authorization. This care provider manual explains the policies and procedures of the UnitedHealthcare Dual Complete programs network. This manual also includes important phone numbers and websites. We hope it provides you and your office staff with helpful information and guide you in making the best decisions for your patients.

Operational policy changes and additional electronic tools are available on our website at [UHCprovider.com](https://www.uhcprovider.com).

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual-go to [UHCprovider.com/guides](https://www.uhcprovider.com/guides). Click on Community Plans.

Easily search for a specific topic or word in the manual using the following steps:

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

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

We greatly appreciate your participation in our program and the care you offer our members.

Important information about the use of this manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of 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.

Background

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) are Medicare Advantage Special Needs Plans, serving members who are dually eligible for Medicare and Arizona Health Care Cost Containment System (AHCCCS) (Medicaid) within the UnitedHealthcare Dual Complete programs service area.

In 2015, UnitedHealthcare implemented a second Medicare Advantage Special Needs Plan called UnitedHealthcare Dual Complete One (HMO SNP). This change split the Dual Special Needs Plan into two plans. UnitedHealthcare Dual Complete includes those Qualified Medicare Beneficiaries (QMB) and Dual-eligible members with both Medicare A & B with Medicaid benefits. UnitedHealthcare Dual Complete One includes Qualified Medicare Beneficiaries (QMB) and Dual-eligible members with both Medicare A & B with UnitedHealthcare Community Plan's Long Term Care benefits under Medicaid. Please refer to Chapter 4 for the member ID card changes.

Members of UnitedHealthcare Dual Complete programs have already demonstrated eligibility for and been enrolled in Medicare Part A, Medicare Part B, and AHCCCS Medicaid Title XIX benefits. UnitedHealthcare Dual Complete programs members may be enrolled in UnitedHealthcare Community Plan. UnitedHealthcare

Community Plan Dual Complete is currently available in Apache, Cochise, Coconino, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties. UnitedHealthcare Dual Complete One is available in Apache, Coconino, Maricopa, Mohave, Navajo, Pinal and Yavapai Counties. Dual Complete and Dual Complete One are available in Gila County.

UnitedHealthcare Community Plan provides AHCCCS programs for AHCCCS Complete Care (ACC), Arizona Long Term Care Elderly Physically Disabled (ALTCS EPD) and Developmentally Disabled (DD) as well as all other AHCCCS plans available to eligible members in Arizona.

Contacting UnitedHealthcare Community Plan Dual Complete and Dual Complete One (HMO SNP)

UnitedHealthcare Dual Complete programs manage a comprehensive care provider network of independent practitioners and facilities across Arizona. The network includes health care professionals such as primary care providers (PCPs), specialist care providers, medical facilities, allied health professionals, and ancillary service providers. UnitedHealthcare Dual Complete programs offer several options to support care providers who require assistance.

Online resources

[UHCprovider.com](https://www.uhcprovider.com) is your home for care provider information with access to Electronic Data Interchange (EDI), Provider Portal online services, medical policies, news bulletins. It also includes great 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)

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](https://www.uhcprovider.com/EDI) for more information. Learn how to optimize your use of EDI at [UHCprovider.com/optimizeEDI](https://www.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 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 portal, go to [UHCprovider.com](https://www.uhcprovider.com) and click Sign In on 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](https://www.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 titled “What can I help you find?” on UHCprovider.com, and 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 Document Library. 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.

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 then click Sign In.

* For more instructions, visit UHCprovider.com/Training or [Self Service Tools](https://UHCprovider.com/SelfServiceTools) for online self-service training and information.

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errand claims. This portal can replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.

- Avoid duplicate recoupment and returned checks.
- Decrease resolution timeframes.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

All users will access Direct Connect using the Provider Portal. On-site and online training is available.



Email directconnectsupport@optum.com to get started with Direct Connect.

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Roster

PCPs are given access to a roster of all assigned members. PCPs should use this to determine if they are responsible for providing primary care to a particular member. Rosters can be viewed electronically on UHCprovider.com.

Additional resources

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. All issues received in Provider Services are acknowledged within three business days. You are notified of resolution within 30 business days. Notification of resolution is the action of telling you the issues have been resolved. It states a detailed description of the actions to be taken and when to expect resolution.

- UnitedHealthcare Community Plan Provider Services (ACC/DD): 800-445-1638
- Long-Term Care (ALTCS EPD): 800-293-3740



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.

Office of Individual and Family Affairs

The AHCCCS Office of Individual and Family Affairs (OIFA) works closely with you, our members and their loved ones to help ensure recovery from mental health issues and substance use challenges becomes a reality.



For more information or to set up a meet and greet, please call the OIFA administrator at **602-255-8605**

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) network

UnitedHealthcare Dual Complete programs maintain and monitor a network of participating care providers including physicians, hospitals, skilled nursing facilities (SNFs), ancillary providers and other health care providers through which members obtain covered services.

Members using this UnitedHealthcare Dual Complete (HMO SNP) must choose a PCP to coordinate their care. PCPs are the basis of the managed care philosophy.

UnitedHealthcare Dual Complete programs work with contracted PCPs who manage the health care needs of members and arrange for medically necessary covered medical services. You may, at any time, advocate on behalf of the member without restriction to help ensure the best care possible for the member. In particular, you are not prohibited or otherwise restricted from advising or advocating, on behalf of a member who is your patient, for:

- a. The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- b. Any information the member needs to decide among all relevant treatment options
- c. The risks, benefits, and consequences of treatment or non-treatment; and,

- d. The member's right to participate in decisions regarding their behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

To help ensure continuity of care, members must coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women's routine preventive health services, routine dental, routine vision, and behavioral health). Contracted health care professionals are required to coordinate member care within the care provider network. If possible, all members should be directed to UnitedHealthcare Dual Complete programs contracted care providers.

If a contracted care provider is not available to provide services, referrals outside of the network are permitted. However UnitedHealthcare Dual Complete programs require prior authorization. The services must be a covered benefit and the member must be eligible on the date of service.

All out-of-network services will be denied unless prior authorization has been obtained and services are emergent in nature.

The referral and prior authorization procedures explained in this manual are particularly important to the UnitedHealthcare Dual Complete programs. Understanding and adhering to these procedures are essential for successful participation. A prior authorization list is available online at [UHCprovider.com/azcommunityplan](https://www.uhcprovider.com/azcommunityplan) in the Prior Authorization and Notification section.

Occasionally the Dual Complete programs distribute communication documents on administrative issues and general information to you and your office staff. It is very important that you and/or your office staff read the newsletters and other special mailings and retain them with this care provider manual, so you can incorporate the changes into your practice.

Participating care providers

Primary care providers

UnitedHealthcare Dual Complete programs contract with certain care providers whom members may choose to coordinate their health care needs. These care providers are known as PCPs. With the exception of member self-referral covered services (Chapter 2) the PCP is responsible for providing or coordinating Covered Services for our members. PCPs are generally physicians of internal medicine, pediatrics, family practice or general practice. However, they may also be other provider types who accept and assume PCP roles and responsibilities. All members must select a PCP when they enroll in UnitedHealthcare Dual Complete programs and may change their designated PCP once a month.

Specialists

A specialist is any licensed participating care provider (as defined by Medicare) who provides specialty medical services to members. A PCP may refer a member to a specialist as medically necessary.

Care provider privileges

To help our members get access to appropriate care, you must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services. This includes but is not limited to full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Quick Reference Guide

Resource	Uses	Contact Information
UnitedHealthcare Community Plan Electronic Information	Verify member eligibility, check claim status, submit claims, request adjustment, review remits through the Provider Portal	Provider Portal through UHCprovider.com
UHCprovider.com	Prior Authorization List, Provider Manual, Pharmacy, Clinical Guidelines, Bulletins and Reimbursements Policies and communication and reference materials	UHCprovider.com/AZcommunityplan > Policies and Clinical Guidelines
Provider Service Center	Available 8 a.m. to 5 p.m. Pacific Time, seven days a week claim inquiries, benefit questions, form requests	800-445-1638 TTY: 711
Language Interpretation Line (Including Sign)		866-293-1798 Provide Tax ID and Member IDs - State Code: 03 TTY: 711
Admission Notification	Notify of member admission to a facility at UHCprovider.com/admit .	EDI: Transactions 278 and 278N UHCprovider.com/azcommunityplan > Prior Authorization and Notification UHCprovider.com/paan 800-445-1638
Prior Notification-Medical	Submit prior authorization requests and advanced notifications. Find information about advance notification and the prior authorization lists at UHCprovider.com/azcommunityplan > Prior Authorization and Notification .	EDI: Transactions 278 and 278N UHCprovider.com/azcommunityplan > Prior Authorization and Notification UHCprovider.com/paan 800-445-1638
Prior Notification-Behavioral Health		800-547-2797
Prior Notification-Optum Prescriptions	professionals.optumrx.com	800-711-4555
Dental Benefit Providers	Dental Providers	855-812-9208
Nationwide Vision	Vision Providers	480-961-1865
Epic Hearing Health Care	Hearing Aid Provider	866-956-5400
Member Transportation (Non-Emergent Transportation)	<ul style="list-style-type: none"> Up to 36 one-way trips are covered per calendar year (limited to ground transportation only). Trips must be to or from plan-approved locations within the plan service area, limited to covered routine dental, vision, podiatry or hearing services not covered by Original Medicare. 	888-700-6822
Dual Complete and Dual Complete One (HMO SNP) Member Service Line		877-614-0623

Chapter 2: Covered Services

Summary

Medicare Cost-sharing for Members Enrolled in UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP)[™] (Costs will vary significantly based on the member's category of Medicaid assistance). Dual programs include QMB Plus, FBDE and SLMB Plus.

For Ancillary Benefit Planning	Medicaid Eligibility Status		Does Medicaid cover Part A Premium?	Does Medicaid cover Part B Premium?	Does Medicaid cover Part D Premium?	Does Medicaid cover Medicare Deductibles, Copays, Co-insurance?	Does the member have Full Medicaid Benefits?
Full Dual	QMB Plus (02)	<u>Qualified Medicare Beneficiary w/ Full Medicaid</u>	Yes	Yes	No*	Yes	Yes
Full Dual	FBDE (08)	Full Benefit Dual Eligible	No	Varies by State	No	Varies by State	Yes
Full Dual	SLMB Plus (04)	Specified Low Income Medicare Beneficiary w/ Full Medicaid	No	Yes	No*	Varies by State	Yes
Partial Dual	QMB Only (01)	<u>Qualified Medicare Beneficiary</u>	Yes	Yes	No*	Yes	No
Partial Dual	SLMB Only (03)	Specified Low Income Medicare Beneficiary	No	Yes	No*	No	No
Partial Dual	QDWI (05)	Qualified Disabled Working Individual	Yes	No	No	No	No
Partial Dual	QI (06)	Qualified Individual	No	Yes	No*	No	No

*QMBs, SLMBs and QIs are automatically enrolled in the low income subsidy program to cover Part D premium costs and will not have Part D premiums.

Medicaid (Medicaid contractor) pays the Medicare cost-sharing (coinsurance, deductible, or copayments except Part D), up to the lesser of the Medicare or Medicaid rate, for Medicare-covered benefits except prescription drug copayments (unless institutionalized and then no prescription drug copayments).

Supplemental benefits (dental, vision, product catalog, etc.) are covered by the Medicare Plan. There is no Medicare cost-sharing. Once a supplemental benefit is exhausted, if it's not covered by Medicare, the member is responsible for payment unless otherwise covered by Medicaid.

Excerpt from AHCCCS Medicare Cost-sharing Policy (located in the AHCCCS Contractor Operations Manual, policy 201) – HMO

*Non-QMB Dual

Contractors (Medicaid HMO) are responsible for cost-sharing for AHCCCS-only covered services for Non-QMBs. Contractors (Medicaid HMO) are not responsible for the following services:

- Chiropractic services for adults.
- Inpatient and outpatient occupational therapy coverage for adults.
- Inpatient psychiatric services. (Medicare has a lifetime benefit maximum.)

- Other behavioral health services such as partial hospitalization.
- Any services covered by or added to the Medicare program not covered by AHCCCS.

**Out-of-Network Services

1. Care Provider

If you make an out-of-network referral, and the contractor (Medicaid HMO) specifically prohibits out-of-network referrals in the provider contract, you may be considered in violation of the contract. In this instance, the contractor (Medicaid HMO) has no cost-sharing obligation. The care provider who referred the member to an out-of-network care provider is obligated to pay any cost-sharing. The member shall not be responsible for the Medicare cost-sharing except as stipulated in the member section of azahcccs.gov.

However, if the Medicare HMO and the contractor (Medicaid HMO) have networks for the same service that have no overlapping care providers, and the contractor (Medicaid HMO) chooses not to have the service performed in its own network, the contractor (Medicaid HMO) is responsible for cost-sharing for that service. If the overlapping care providers have closed their panels, and the member goes to an out-of-network care provider, the contractor (Medicaid HMO) is responsible for cost-sharing.

2. Member

If a member has been advised of the contractor's (Medicaid HMO) network, and the member's responsibility is delineated in the member handbook, and the member elects to go out-of-network, the member is responsible for paying the Medicare cost-sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the contractor's (Medicaid HMO) Member Handbook.

Medicaid benefits

Information for members with Medicare and Medicaid

UnitedHealthcare Dual Complete (HMO SNP) is a Full Dual-Eligible Special Needs Plan (D-SNP). It is designed for persons entitled to both Medicare and Medicaid. If

members have both Medicare and Medicaid, services are paid first by Medicare and then by Medicaid. Medicaid coverage depends on income, resources and other factors.

Following are the categories of people who may enroll in UnitedHealthcare Dual Complete (HMO SNP):

- **Qualified Medicare Beneficiary Plus (QMB+).** You get Medicaid coverage of Medicare cost-share and are eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayment amounts.
- **Specified Low-Income Medicare Beneficiary Plus (SLMB+).** Medicaid pays your Part B premium and provides full Medicaid benefits.
- **Full Benefits Dual Eligible (FBDE).** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits.

If SLMB+ or FBDE:

Members may be eligible for full Medicaid benefits. At times, they may also be eligible for limited assistance from the Arizona Health Care Cost Containment System (AHCCCS) in paying Medicare cost share amounts. Generally, cost-share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where members pay cost-sharing when a service or benefit is not covered by Medicaid.

If category of Medicaid eligibility changes, cost-share may also increase or decrease. Members must rectify Medicaid enrollment to continue to receive Medicare coverage.

UnitedHealthcare Dual Complete One

Eligible categories

Qualified Medicare Beneficiary Plus (QMB+)

Medicaid pays the Medicare cost-share. This includes deductibles, coinsurance and copayment amounts. Medicaid also pays for QMB+ Part A and Part B premiums. QMB+ members have full Medicaid benefits. QMB+ beneficiaries have \$0 cost-share except for Part D prescription drug copays.

Full Benefit Dual Eligible (FBDE) members

FBDE members have full Medicaid benefits. Medicaid pays the cost-share for covered services rendered by a participating Medicare care provider. At times, members may be eligible for limited assistance from the AHCCCS in paying Medicare cost-share amounts. Generally, members' cost-share is 0% when both Medicare and Medicaid cover the service. There may be cases where members have to pay a cost-share when Medicaid and Medicare does not cover a service or benefit.

Specified Low-Income Medicare Beneficiary (SLMB+)

Medicaid pays members' Part B premium and provides full Medicaid benefits.

What that means to our members:

If they are a QMB+ beneficiary:

They have 0% cost-share, except for Part D prescription drug copays.

If members are a SLMB+ or FBDE beneficiary:

They are eligible for full Medicaid benefits. At times, they may also be eligible for limited assistance from the AHCCCS in paying Medicare cost-share amounts. Generally, the cost share is 0% when both Medicare and Medicaid cover the service. There may be cases where members have to pay a cost-share when Medicaid does not cover a service or benefit.

How to read the Medicaid Benefit Chart

The following benefits are covered by Medicaid. For each of the following benefits listed, you can see what Arizona Health Care Cost Containment System (AHCCCS) covers and what our plan covers. If a benefit is used or not covered by Medicare, then Medicaid may provide coverage. This depends on the member's type of Medicaid coverage. Additional information regarding benefits can be found online at UHCprovider.com > Resources > Choose a Location > Arizona > Medicare > [**Arizona Dual Complete® Special Needs Plans.**](#)

Benefit	Arizona Health Care Cost Containment System (AHCCCS)		UnitedHealthcare Dual Complete (HMO SNP)
	QMB or QMB+ Members pay:	SLM B+ or FBDE Members pay:	
Nursing Facility	Member contribution determined by Medicaid Agency	Member contribution determined by Medicaid Agency	Covered (up to 100 days).
Home and Community Based Services	Member contribution determined by Medicaid Agency	Member contribution determined by Medicaid Agency	No coverage
Medicare-covered services			
Adult Day Care/ Personal Care Services	\$0	\$0	Covered.
Ambulance		\$0	Covered.
Chiropractic Care	\$0	\$0 for age 20 and younger. Not covered for people age 21 and older.	Covered.
Chiropractic (additional routine) Provided by OptumHealth Physical Health	Members are covered for 18 routine Chiropractic visits every year	Please refer to the Additional Benefits Contact List in the Evidence of Coverage document on UHCCommunityPlan.com	
Dental Services	Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount. For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services	Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount. For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services	Covered.
Diabetes Supplies and Services	\$0	\$0	Covered.
Diagnostic Tests, Lab and Radiology Services, and X-Rays	\$0	\$0	Covered.
Doctor Office Visits	\$0	\$0 to \$5 depending on eligibility* for age 19 and older. \$0 for age 18 and younger.	Covered.
Durable Medical Equipment (DME)	\$0	\$0	Covered.

Benefit	Arizona Health Care Cost Containment System (AHCCCS)		UnitedHealthcare Dual Complete (HMO SNP)
	QMB or QMB+ Member pay:	SLM B+ or FBDE Member pay:	
Emergency Care	\$0	\$30 for Non-Emergency use of the emergency room depending on eligibility* for age 19 and older. \$0 for all others. <i>Emergency Room visits for which presenting problem(s) are usually minor or self-limited indicated by procedure 99281 are not covered for people age 21 and older.</i>	Covered.
Foot Care (podiatry services)	\$0	\$0 for people age 20 and younger, if furnished by a podiatrist	Covered.
Hearing Services	\$0 for people age 20 and younger. Not covered for people age 21 and older.	\$0 for people age 20 and younger. Not covered for people age 21 and older.	Covered.
Home Health Care	\$0	\$0	Covered.
Hospice	Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount. For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services	Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount. For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services	Covered.
Inpatient Hospital Care	\$0	\$0	Covered.
Mental Health Care	\$0	\$0	Covered.
Outpatient Rehabilitation	Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount. For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services	Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount. For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services	Covered.
Outpatient Substance Abuse	\$0	\$0	Covered.

Benefit	Arizona Health Care Cost Containment System (AHCCCS)		UnitedHealthcare Dual Complete (HMO SNP)
	QMB or QMB+ Member pay:	SLM B+ or FBDE Member pay:	
Outpatient Surgery	<p>Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount.</p> <p>For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services</p>	<p>Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount.</p> <p>For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services</p>	Covered.
Prescription Drug Benefits	\$0	<p>Generic</p> <p>\$0 to \$4 depending on eligibility* for age 19 and older</p> <p>\$0 for age 18 and younger</p> <p>Brand</p> <p>\$0 to \$10 depending on eligibility* for age 19 and older</p> <p>\$0 for age 18 and younger</p>	Covered.
Preventive Care	\$0	\$0	Covered.
Prosthetic Devices (braces, artificial limbs, etc.)	\$0	\$0 <i>Lower limb microprocessor controlled limb or joint not covered for adults age 21 and older.</i>	Covered.
Renal Dialysis	\$0	\$0	Covered.
Skilled Nursing Facility (SNF)	\$0	\$0	Covered.
Urgent Care	\$0	<p>\$0 to \$5 depending on eligibility* for age 19 and older.</p> <p>\$0 for age 18 and younger. See page 20 of Medicaid handbook.</p>	Covered.
Vision Services	<p>Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount.</p> <p>For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services</p>	<p>Depending on level of Medicaid eligibility, Medicaid may pay Medicare cost-sharing amount.</p> <p>For services not covered by Medicare, or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost-share amounts: \$0 copay for Medicaid services</p>	Covered.

Benefit	Arizona Health Care Cost Containment System (AHCCCS)		UnitedHealthcare Dual Complete (HMO SNP)
	QMB or QMB+ Member pay:	SLM B+ or FBDE Member pay:	
Additional services available through UnitedHealthcare Dual Complete (HMO SNP)			
Additional Dental Services	No coverage	No coverage	Covered.
Additional Foot Care	No coverage	No coverage	Covered.
Additional Hearing Services	No coverage	No coverage	Covered.
Healthy Food	No coverage	No coverage	Covered.
Over-the-Counter Items	No coverage	No coverage	Covered.
Transportation (routine)	No coverage	No coverage	Covered.
Additional Vision Services	No coverage	No coverage	Covered.

*Refer to the AHCCCS website for additional copay and benefit-related information.

Members who are enrolled in UnitedHealthcare Dual Complete programs may also be covered by UnitedHealthcare Community Plan AHCCCS (Medicaid) benefits. Members should refer to their Medicaid Member Handbook for further details on Medicaid benefits. Members who are enrolled in another AHCCCS (Medicaid) plan must coordinate their benefits with that plan.

Prior authorization

Services requiring prior authorization are available on [UHCprovider.com](https://www.uhcprovider.com) in the Prior Authorization and Notification section (periodically updated). The presence or absence of a procedure or service on the list does not define whether coverage or benefits exist for that procedure or service. A facility or practitioner must contact UnitedHealthcare Dual Complete programs for prior authorization. Submit requests for prior authorizations using the Prior Authorization and Notification tool on the Provider Portal or by calling to the Prior Authorization Department at 800-445-1638.

Referral guidelines

PCPs are generally responsible for initiating and coordinating coverage for medically necessary services beyond the scope of their practice for Dual Complete programs members if a **contracted care provider** is not available. A referral to a non-contracted care provider may be requested, but UnitedHealthcare Community Plan must authorize the referral. PCPs monitor the progress of referred members' care and see that members are returned to the PCP's care as soon as possible.

All referrals to non-contracted care providers require the completion of a referral form.

If a contracted care provider is not available to provide services a referral can be completed. Referrals are to be written on the same UnitedHealthcare Dual Complete programs referral form you use for UnitedHealthcare Community Plan Medicaid members. Prior authorization is required when services are performed by a non-contracted care provider.

The PCP is to complete, date, and sign (a signature stamp is acceptable) the referral form. Forward a copy of the referral form to the non-contracted specialist. Referrals are limited to an initial consultation and up to two follow-up visits. Follow-up visits must be completed

within 180 calendar days from the date the referral is signed and dated.

Referrals for hematology/oncology, radiation oncology, gynecology oncology, allergy, orthopedic services, and nephrology are valid for unlimited visits within the 180 day timeframe.

Emergency and urgent care

Definitions

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a care provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Members with an emergency medical condition should be instructed to go to the nearest emergency care provider.

Members who need urgent (but not emergency) care are advised to call their PCP, if possible, prior to obtaining urgently needed services. However, prior authorization is not required.

Urgently needed services are covered services that are not emergency services provided when:

- The member is temporarily absent from the UnitedHealthcare Dual Complete programs service area, and
- When such services are medically necessary and immediately required 1) as a result of an

unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through a network care provider.

Under unusual and extraordinary circumstances, services may be considered urgently needed when the member is in the service area but a network care provider is temporarily unavailable or inaccessible.

Out-of-area renal dialysis services

A member may obtain medically necessary dialysis services from any qualified care provider the member selects when they are temporarily absent from UnitedHealthcare Dual Complete programs service area and cannot reasonably access network dialysis care providers. No prior authorization or notification is required. However, a member may voluntarily advise UnitedHealthcare Dual Complete programs if they will temporarily be out of the service area. UnitedHealthcare Dual Complete programs may provide medical advice and recommend the member use a qualified dialysis care provider.

Direct access services

Members may access Behavioral Health services without a referral from their PCP as long as they obtain these services from a participating care provider. Those services are discussed in this section. Members requiring Behavioral Health services may call United Behavioral Health at 800-547-2797. Telephonic access is available anytime. Mental Health Inpatient services as well as Detoxification programs are available after coordination for emergency admissions or mental health care provider's evaluation has taken place.

Preventive services

Members may access the following services from a participating care provider without a referral from a PCP:

- Influenza and pneumonia vaccinations.
- Routine and preventive women's health services (such as pap smears, pelvic exams and annual mammograms).
- Routine dental.

- Routine vision.
- Routine hearing.

Members may not be charged a copayment for influenza or pneumonia vaccinations or pap smears.

Annual well-woman visit

An annual well-woman preventive care visit is a covered benefit for women for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits. The well-woman preventive visit should include:

- a. A physical exam (well exam) that assesses overall health.
- b. Clinical breast exam.
- c. Pelvic exam (as necessary, according to current recommendations and best standard of practice).
- d. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. NOTE: Genetic screening and testing is not covered, except as described in AHCCCS Medical Policy Manual Chapter 300, Medical Policy for Covered Services
- e. Screening and counseling is included as part of the well-woman preventive care visit and should address:
 - i. Proper nutrition
 - ii. Physical activity
 - iii. Elevated BMI indicative of obesity
 - iv. Tobacco/substance use, abuse, and/or dependency
 - v. Depression screening
 - vi. Interpersonal and domestic violence screening that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
 - vii. Sexually transmitted infections
 - viii. Human Immunodeficiency Virus (HIV)
 - ix. Family planning counseling
 - x. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
 - a) Reproductive history and sexual practices

- b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
- c) Physical activity or exercise
- d) Oral health care
- e) Chronic disease management
- f) Emotional wellness
- g) Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
- h) Recommended intervals between pregnancies

NOTE: Preconception counseling does not include genetic testing.

- f. Initiation of necessary referrals when the need for further evaluation, diagnosis and/or treatment is identified.

PCPs and primary care obstetricians responsibilities

Network PCPs and primary care obstetricians (PCO) are responsible for the following:

- Physicians and practitioners must follow the American College of Obstetricians and Gynecology (ACOG) standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.
- Female members shall have direct access to contracted GYN care providers, including physicians, physician assistants, nurse practitioners and midwives within the scope of their practice, **without** a referral.
- If a member's pregnancy is confirmed by a PCO, the PCO is required to notify UnitedHealthcare Community Plan Healthy First Steps at 800-599-5985 to initiate a PCO reassignment. The ACOG form needs to be faxed to Healthy First Steps at 877-353-6913 immediately after the initial OB visit.
- The member's PCO effective date is the date the completed ACOG form is received. A PCO's failure to notify UnitedHealthcare Dual Complete programs of this reassignment may result in delay or denial of reimbursement. The date of the PCO assignment

is the effective date of the transfer of care from the PCP to the PCO. PCOs are responsible for coordinating a member's care until the first day of the first month following the 60th day after delivery or termination of pregnancy.

- EPSDT services for pregnant members younger than 21 years are to be performed by the assigned PCO or perinatologist.

Additional PCO responsibilities

- Scheduling medically necessary care appointments for enrolled pregnant members to obtain initial and ongoing prenatal care within the timeframes as stated in this manual under Appointment Standards, Chapter 13
- Coordinating covered services for members
- Counseling members and their families regarding members' medical care needs, including family planning and advance directives
- Initiating medically necessary referrals for specific covered services to contracted health care practitioners or care providers
- Monitoring progress, care and managing utilization of services to facilitate the return of care to the PCP after delivery
- Scheduling time-specific office visits during an uncomplicated pregnancy based upon the recommended standards from the ACOG
- Maintaining responsibility for care until the first day of the first month following the 60th day after delivery with a minimum of one postpartum visit at approximately six weeks postpartum. Patients at high risk shall have a return visit scheduled appropriate to their individual need
- Adhering to reproductive health and wellness guidelines contained within UnitedHealthcare Community Plan Policies and Procedure, such as screening members for perinatal and postpartum depression at least once during the pregnancy and then repeated at the postpartum visit. If a positive screening is obtained, referring the member to the appropriate behavioral health care provider for services. The PCO will share health information about lifestyle habits that promote healthy pregnancies, including spacing of births and smoking cessation

- Educating members regarding potential complications and adverse outcomes related to cesarean sections and elective inductions prior to 39 weeks gestation
- Referring members for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, to support healthy pregnancy outcomes. In the event a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services
- Cooperating with Healthy First Steps, the maternity program and/or other perinatal support programs that may be authorized by UnitedHealthcare Community Plan.
- Faxing the OB clinical record as a referral to UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Healthy First Steps program. Referrals can be made by faxing any of the following forms to the Healthy First Steps at: 877-353-6913
- Completing and sending ACOG prenatal forms pages one and two as well as other prenatal forms that sufficiently document past and present medical, psychosocial and obstetrical history
- Sending any other OB Risk Assessment or OB Notification form to Healthy First Steps referral fax number 877-353-6913

Follow UnitedHealthcare Global Billing Guidelines for obstetrical services, which may be found on [UHCprovider.com](https://www.uhcprovider.com) in the Reimbursement Policies section. A detailed guideline is also available in the Bulletins section, or you may request a copy.

Perinatology referrals

A PCO or PCP may refer a member for a consult to a contracted perinatologist when a high-risk need is identified. The PCO or PCP may transfer the member's care to a perinatologist by calling Provider Customer Service for reassignment.

Once the transfer of care is completed, the perinatologist becomes the member's PCO. They are responsible for the member's care for the duration of the pregnancy and 60 days postpartum.

Licensed midwife services

UnitedHealthcare Dual Complete programs cover maternity care and coordination services provided by contracted licensed midwives. The members must have an uncomplicated prenatal course and an expected low-risk labor and delivery. Members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in the AHCCCS Medical Policy Manual, Chapter 400, Policy 410. Risk status must initially be determined at the time of the first visit. It must be evaluated at each trimester thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies outlined by the ACOG or Mutual Insurance Company of Arizona. A new risk assessment must be completed if a new complication or concern is identified, and a referral will be made to a qualified physician if necessary. Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution.

Licensed midwives must have a plan of action, including the name and address of an AHCCCS-registered care provider and acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event a complication should arise. The licensed midwife must notify UnitedHealthcare Community Plan or the AHCCCS Newborn Reporting Line of the birth no later than three days.

Family planning

Family planning services are covered when provided by contracted physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Family planning services include specified covered medical, surgical, pharmacological and laboratory benefits. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Physicians and other practitioners with members of reproductive age must document in the medical record they have notified the member, either verbally or in writing, of the family planning services available. Members (male and female) eligible to receive full health care coverage and are enrolled with UnitedHealthcare Dual Complete programs may elect to receive family planning services in addition to other covered services. Family planning services for members

eligible to receive full health care coverage may receive the following medical, surgical, pharmacological and laboratory services:

- Contraceptive counseling, medication, supplies, including, but not limited to oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories.
- Associated medical and laboratory examinations including ultrasound studies related to family planning.
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Natural family planning education or referral to qualified health professionals, and postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse. (RU 486 is not postcoital emergency oral contraception.)
- Natural family planning education or referral to qualified health professionals, and postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse. (RU 486 is not postcoital emergency oral contraception.)

Hysteroscopic tubal sterilization (Essure) is a covered service under the UnitedHealthcare Community Plan. The procedure does not render a woman immediately sterile, and another form of birth control will be required minimally for three months. Only report sterilization of SOBRA members who have undergone this procedure for at least three months and only after confirmatory hysterosalpingogram produces satisfactory results. The hysterosalpingogram must be billed on the same claim as the hysteroscopic tubal sterilization to help ensure both services were rendered. If the hysteroscopic tubal sterilization (Essure, procedure code 58565) is billed without the hysterosalpingogram (procedure code 58340), the service will be denied for a lack of documentation.

The following are not covered for the purpose of family planning services:

- Infertility services, including diagnostic testing, treatment services or reversal of surgically induced infertility
- Pregnancy termination counseling

Pregnancy termination services

UnitedHealthcare Dual Complete programs cover pregnancy termination if one of the following conditions is present:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
 - Creating a serious physical or mental health problem for the pregnant member or seriously impairing a bodily function of the pregnant member.
 - Causing dysfunction of a bodily organ or part of the pregnant member or exacerbating a health problem of the pregnant member, or
 - Preventing the pregnant member from obtaining treatment for a health problem.

As the attending care provider, you must acknowledge a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. The certificate can be obtained online at azahcccs.gov, from the AHCCCS Medical Policy Manual, Chapter 400, Exhibit 410-4. The certificate must be submitted via prior authorization to the UnitedHealthcare Dual Complete programs medical director or designee. It must certify that, in the care provider's professional judgment, one or more of these criteria have been met. Additional required documentation includes:

- A written informed consent must be obtained by the care provider and kept in the member's chart for all pregnancy terminations. If the pregnant member is younger than 18 years old, or is 18 years old or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), a dated

signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

- When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities. This includes the name of the agency to which it was reported, the report number if available, and the date the report was filed. Except in cases of medical emergencies, the care provider must obtain prior authorization for all covered pregnancy terminations from the UnitedHealthcare Dual Complete programs medical director or designee. A completed Certificate of Necessity for Pregnancy Termination and Verification of Diagnosis by Contractor for Pregnancy Termination Request must be submitted with the request for prior authorization. The certificates can be obtained online at azahcccs.gov, from the AHCCCS Medical Policy Manual Dual Complete programs, Chapter 400, Exhibit 410-4 and 410-5.

In cases of medical emergencies, you must submit all documentation of medical necessity to UnitedHealthcare Dual Complete programs within two working days of the date on which the pregnancy termination procedure was performed.

Sterilization

You must comply with the following requirements before performing a sterilization procedure. Prior authorization is not required unless the member is younger than 21 years. Sterilization of a member younger than 21 years of age must be medically necessary. A completed Federal Consent Form must be submitted with claims for all voluntary sterilization procedures. Federal consent requirements for voluntary sterilization require:

- The recipient to be at least 21 years at the time of consent is signed.
- The recipient to be mentally competent.
- Consent is to be voluntary and obtained without duress.
- Thirty days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized

at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

- Copy of the signed Federal Consent Form must be submitted by each care provider involved with the hospitalization and/or the sterilization procedure and with a witness present when the consent is obtained.
- Suitable arrangements must be made to help ensure the information in the consent form is effectively communicated to members with limited English proficiency or reading skills and as well as members with visual and/or auditory limitations.

Prior to signing the consent form, the member must first have been offered the following:

- Answers to questions asked regarding the specific procedure to be performed.
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits.
- A description of available alternative methods.
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the advantages or disadvantages that may be expected as a result of the sterilization.
- Notification that sterilization cannot be performed for at least 30 days after consent.
- That sterilization consents may not be obtained when an eligible member:
 - Is in labor or childbirth.
 - Is seeking to obtain or obtaining an abortion.
 - Is under the influence of alcohol or other substances which affect the member's state of awareness.

The Sterilization Consent Form is available online at azahcccs.gov, in the AHCCCS Medical Policy Manual, Chapter 400, exhibit 420-1.

Hysterectomy claims

Claims for hysterectomy procedures are reimbursable if:

- The service was prior authorized per the Prior Authorization List.
- Documentation is provided to show the procedure is consistent with prior authorization information and claim information.
- Documentation is provided to show the patient gave voluntary consent for the hysterectomy. The physician must certify that the procedure was medically necessary by submitting one of the following:
 - AHCCCS Certificate of Medical Necessity: documentation of medical reason for the hysterectomy, type and direction of all medical treatment attempted to avoid surgery, intensity and duration of the symptoms.
 - Pathology Report from the surgery showing the procedure met hysterectomy criteria
 - Operative report.
- The physician must also submit documentation of one of the following:
 - Request for Hysterectomy form signed by the patient showing that she understands the sterilization will be permanent. You may obtain a copy of the Hysterectomy Consent form from the AHCCCS website at azahcccs.gov, Chapter 800 of the Medical Policy Manual, Exhibit 820-1.
 - Documentation of previous sterility, if applicable. If the patient is sterile at the time of the hysterectomy, no consent is required. However, it must be confirmed by a record of the exam on the history and physical, the pathology report, or other documentation.

Prior to signing consent form, the member must first have been offered the following information:

- Answers to questions asked regarding the procedure to be performed.
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits.
- A description of available alternative methods.
- A full description of the discomforts and risks that may accompany or follow the performing of the

procedure. This includes an explanation of the type and possible effects of any anesthetic to be used.

- A full description of the advantages or disadvantages that may be expected as a result of the hysterectomy.
- Notification that a hysterectomy cannot be performed for at least 30 days after consent.
- That hysterectomy consents may not be obtained when an eligible member:
 - Is in labor or childbirth.
 - Is seeking to obtain or obtaining an abortion.
 - Is under the influence of alcohol or other substances which affect the member's state of awareness.

Hospital services

Acute inpatient admissions

All elective inpatient admissions require prior authorization from the UnitedHealthcare Dual Complete programs Prior Notification Service Center.

UnitedHealthcare Dual Complete programs Concurrent Review nurses and staff, in coordination with admitting physicians and hospital-based physicians (hospitalists), will be in charge of coordinating and conducting Continued Stay Reviews. This involves providing appropriate referrals for extended care facilities and coordinating services required for adequate discharge. UnitedHealthcare Dual Complete programs case managers will assist in coordinating services identified as necessary in the discharge planning process as well as coordinating the required follow-up by the corresponding PCPs.

Inpatient concurrent review: clinical information

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, treatment plan, admission order, patient 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 the 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.

Absent superseding state and/or Centers for Medicare and Medicaid Services (CMS)-required guidelines, UnitedHealthcare Community Plan uses InterQual, SAMHSA and American Society of Addiction Medicine (ASAM) clinical criteria to make medical care determinations for members with substance abuse and co-occurring disorders. Then UnitedHealthcare Community Plan applies evidence-based, peer-reviewed concurrent review criteria. Hospital system review criteria are not adopted by UnitedHealthcare Community Plan and are not acceptable.

UnitedHealthcare Community Plan also uses level of care utilization system (LOCUS), child and adolescent level of care/service intensity utilization system (CALOCUS-CASII) and early childhood service intensity instrument (ECSIII) for the evidenced-based clinical care guidelines that support utilization management for behavioral health services.

Peer and recovery support specialist and trainer qualifications

To comply with CMS requirements for delivering peer support services, the OIFA has established training requirements and credentialing standards for peer recovery support specialists (PRSS) and parent family support specialists. Review the AHCCCS Medical Policy Manual (AMPM) Policies 963 and 964 for more information about:

PRSS and CPFSS trainer qualifications

Peer and parent/family support employment training program approval process and curriculum standards
Individuals seeking credentialing and employment as a

peer recovery support specialist or as a parent/family support specialist must pass a competency exam with a minimum score of 80% upon completion of required training. Individuals credentialed in another state must submit their credentials to AHCCCS/OIFA through UnitedHealthcare Community Plan or the employing care provider. Agencies must keep documentation of required qualifications and credentialing for PRSS.

AHCCCS OIFA asks all agencies training peer and parent/family support specialists to complete Attachments B and C in policies 963 and 964. These documents are rosters of individuals who have graduated your peer and/or family training. The documents should be completed immediately after training graduation. Email Attachment C for Peer Support and Attachment B for parent/family support to oifa@azahcccs.gov and our OIFA at [Dawn McReynolds@uhc.com](mailto:DawnMcReynolds@uhc.com).

Our OIFA contacts all agencies employing peer support specialists and parent/family support specialists to complete the attachments. It also requests a contractually required audit of employment records and supervision logs of all employed credentialed peer and family support specialists.

In accordance with the AHCCCS and Division of Developmental Disabilities (DDD) Policies 963 and 964 and UnitedHealthcare Community Plan's contractual obligations, the OIFA conducts audits of agencies that employ or train individuals to become peer and/or family support specialists. The following outlines the information and process in which the audits are performed.

1. OIFA requested a list of all peer and/or family support specialists employed at each care provider site. Once it receives the list, UnitedHealthcare Community Plan and OIFA will conduct the file review. Each employee file must contain the following evidence:
 - At least 2 hours of continuing education requirements annually
 - At least 1 hour per work week of Behavioral Health Professional (BHP) or Behavioral Health Technician (BHT) supervision
 - Employee credential certification
 - Documentation of yearly ongoing peer or family support-focused learning opportunities
2. OIFA requests evidence of inclusion of member and/or family member voice and choice in service

delivery and decision-making procedures. Random samples of how care providers are operationalizing these items may be solicited within the audit notification communication.

Chapter 3: Non-Covered Benefits and Exclusions

Some medical care and services are not covered (“excluded”) or are limited. The following list describes services that are not covered under any conditions and some services that are covered only under specific conditions.

If members receive services that are not covered, they must pay for the services themselves.

UnitedHealthcare Dual Complete programs will not pay for the exclusions that are listed in this section and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered.

Services not covered by UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP)

- Services not covered under Original Medicare, unless such services are specifically listed as covered.
- Services members receive from non-plan care providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services received when members are temporarily outside the plan’s service area, and care from non-plan care providers arranged or approved by a plan provider.
- Services that members receive without prior authorization, when prior authorization is required for getting those services.
- Services that are not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a covered service.
- Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those UnitedHealthcare Dual Complete programs and Original Medicare determines are not generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare.
- Private room in a hospital, unless medically necessary.
- Private-duty nurses.
- Personal convenience items, such as a telephone or television in the member’s room at a hospital or SNF.
- Nursing care on a full-time basis in the member’s home.
- Charges imposed by immediate relatives or members of the household.
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
- Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

- Supportive devices for the feet. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, vision therapy and other low-vision aids and services.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
- Naturopath services (covered under Medicaid for members younger than 21).
- Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under UnitedHealthcare Dual Complete programs, we reimburse veterans for the difference. Members are still responsible for the UnitedHealthcare Dual Complete programs cost-sharing amount.

Chapter 4: Care Provider Responsibilities

General care provider responsibilities

UnitedHealthcare Community Plan Dual Complete programs does not prohibit or otherwise restrict you from advising or advocating on behalf of a member who is your patient for the following:

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

You are responsible for:

- Verifying the enrollment and assignment of the member via UnitedHealthcare Dual Complete programs roster, using the Interactive Voice Response (IVR), UnitedHealthcare Community Plan's care provider portal, or contacting Provider Services prior to the provision of covered services. Failure to verify member enrollment and assignment may result in claim denial.
- Rendering covered services to UnitedHealthcare Dual Complete programs members in an appropriate, timely, and cost-effective manner and in accordance with your specific contract and CMS requirements.
- Maintaining all licenses, certifications, permits, or other prerequisites required by law to provide covered services. You must submit evidence that each is current and in good standing upon the request of UnitedHealthcare Dual Complete programs.
- Rendering services to members diagnosed as being infected with the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) in the same manner and to the

same extent as other members and under the compensation terms set forth in your contract.

- Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility.
- Educating members about the proper utilization of the practitioner's office in lieu of hospital emergency rooms. The practitioner shall not refer members to hospital emergency rooms for non-emergent medical services at any time.
- Abiding by the UnitedHealthcare Dual Complete programs referral and prior authorization guidelines.
- Admitting members in need of hospitalization only to contracted hospitals unless: (1) prior authorization for admission to some other facility has been obtained from UnitedHealthcare Dual Complete programs; or (2) the member's condition is emergent, and the use of a contracted hospital is not feasible for medical reasons. The practitioner agrees to provide covered services to members while in a hospital as determined medically necessary by the practitioner or a medical director.
- Using contracted hospitals, specialists, and ancillary care providers. A member may be referred to a non-contracted practitioner or care provider only if the medical services required are not available through a contracted practitioner or care provider and if prior authorization is obtained.
- Reporting all services provided to UnitedHealthcare Dual Complete programs members in an accurate and timely manner.
- Obtaining authorization from UnitedHealthcare Dual Complete programs for all hospital admissions.
- Providing culturally competent care and services.
- Compliance with the Health Insurance Portability and Accountability Act (HIPAA) provisions.
- Adhering to advance directives (Patient Self-Determination Act). The federal Patient Self-Determination Act requires health professionals and facilities serving those covered by Medicare

and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive.

Advance directives are oral or written statements either outlining a member's choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions. Information about advance directives is included in the UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Member Handbook.

Member eligibility and enrollment

Medicare and AHCCCS (Medicaid) beneficiaries who become members of UnitedHealthcare Dual Complete programs must meet the following qualifications:


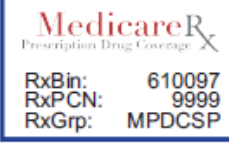
- Members must be entitled to Medicare Part A and be enrolled in Medicare Part B.
- Members must be entitled and enrolled in AHCCCS (Medicaid) Title XIX benefits.
- Members must reside in the Dual Complete programs service area:
 - Dual Complete: Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai and Yuma
 - Dual Complete One: Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal, and Yavapai
- A member must maintain a permanent residence within the service area and must not reside outside the service area for more than six months.
- Members of all ages who have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) that were participating in UnitedHealthcare Community Plan's AHCCCS plan at the time of their enrollment in Dual Complete programs.



Each UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) member will receive an identification (ID) card containing the member's name, member number, PCP name and information about their benefits. The ID membership card does not guarantee eligibility. It is for identification purposes only.


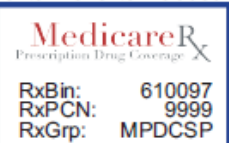
UnitedHealthcare Dual Complete programs members

are assigned a specialist to act as advocates.

Members who lose their AHCCCS eligibility have 180 days to regain certification. If recertification is not obtained, the member may be disenrolled from the plan.

	
Health Plan (80840): 911-87726-04	
Member ID: QA00001-00 Group Number: AZMCARE	
Member: FRANCISCA INDIGO	
Payer ID: 03432	
PCP Name: JIMENEZ, RODOLFO PCP Phone: (520) 762-5200	
Dental Benefits Included	
	
RxBin: 610097 RxPCN: 9999 RxGrp: MPDCSP	
H0321 PBP# 002	
<div style="border: 1px solid red; padding: 2px; display: inline-block;"> UnitedHealthcare Dual Complete (HMO SNP) </div>	

	
Health Plan (80840): 911-87726-04	
Member ID: QA00001-00 Group Number: AZMCARE	
Member: RUTH J INDIGO	
Payer ID: 03432	
PCP Name: NEWCOMB, MICHAEL P. PCP Phone: (602) 996-5595	
Dental Benefits Included	
	
RxBin: 610097 RxPCN: 9999 RxGrp: MPDCSP	
H0321 PBP# 004	
<div style="border: 1px solid red; padding: 2px; display: inline-block;"> UnitedHealthcare Dual Complete ONE (HMO SNP) </div>	

	
Health Plan (80840): 911-87726-04	
Member ID: QA00001-00 Group Number: AZMCARE	
Member: STEFANI K INDIGO	
Payer ID: 03432	
PCP Name: VANDRUFF, JOHN E. PCP Phone: (928) 472-4675	
Dental Benefits Included	
	
RxBin: 610097 RxPCN: 9999 RxGrp: MPDCSP	
H5008 PBP# 012	
<div style="border: 1px solid red; padding: 2px; display: inline-block;"> UnitedHealthcare Dual Complete (HMO SNP) </div>	

PCP member assignment

UnitedHealthcare Dual Complete programs manage the member's care on the date that the member is enrolled with the plan and until the member is dis-enrolled.

Each enrolled member can choose a PCP within the UnitedHealthcare Dual Complete programs care Provider Directory. Medicare members are required to select a PCP at the time of enrollment. If this does not happen, a PCP is then assigned. Members then have opportunity to change the PCP if not satisfied by calling Member Services.

Members receive a letter notifying them of the name of their PCP, office location, telephone number, and the opportunity to select a different PCP should they prefer someone other than the PCP assigned. If the member elects to change the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Dual Complete programs to change their PCP at any other time, the change will be made effective on the date of the request.

Verifying member enrollment

Once a member has been assigned to a PCP, UnitedHealthcare Dual Complete programs documents the assignment and provides each PCP a roster indicating the members assigned to them. PCPs should verify eligibility by using their rosters in conjunction with:

- UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Interactive Voice Response (IVR) 800-445-1638
- MediFAX
- UnitedHealthcare Community Plan Provider Service Center (available 8 a.m. to 5 p.m. local time, Mon - Fri) 800-445-1638
- AHCCCS (Medicaid) web-based eligibility verification system

At each office visit, your office staff should:

- Ask for the member's ID card and have a copy of both sides in the member's office file.
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes.
- Refer to the member's ID card for the

appropriate phone number to verify eligibility in the UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP), deductibles, coinsurance amounts, copayments and other benefit information.

- Check the UnitedHealthcare Dual Complete programs panel listing to be sure the PCP is the member's PCP. If the member's name is not listed, your office staff should contact UnitedHealthcare Dual Complete programs Customer Service to verify PCP selection before the member is seen by the participating care provider.

You should verify member eligibility prior to providing services. All Dual Complete and Dual Complete One (HMO SNP) members received new member ID cards. Verify these member ID cards online at UHCprovider.com.

Coordinating 24-hour coverage

PCPs are expected to provide coverage for UnitedHealthcare Dual Complete programs members anytime. When a PCP is unavailable to provide services, the PCP must help ensure they have coverage from another participating care provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating care providers. Consult your UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Provider Directory, or contact UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Member Services with questions regarding which care providers participate in the UnitedHealthcare Dual Complete programs network.

Behavioral health benefits for members with both Medicare and Medicaid coverage

UnitedHealthcare Community Plan may provide the behavioral health services covered by Medicaid for Dual Complete programs members. These members will be enrolled with AHCCCS for their Medicaid benefit in addition to Medicare A/B benefit coverage. Non-DD/ALTCS members determined to be Seriously Mentally

Ill (SMI) will receive their Medicaid coverage under the Regional Behavioral Health Authority (RBHA) of which they are assigned. Those DD/ALTCS EPD members receiving their Medicaid coverage under UnitedHealthcare Community Plan do not require a referral when contacting a behavioral health care provider for services. Members can call Member Services at 800-348-4058 and ask for the contact information for a behavioral health care provider. Referrals to behavioral health care providers are based on where member resides, member request, care provider specialty and expertise.

Both members and care providers can find the list of behavioral health network care providers by using the Searchable Directory feature on Live and Work Well (Medicaid) or Live and Work Well (Medicare) at provider.liveandworkwell.com. This website provides you a list of participating behavioral health care providers. You and members can also get a copy of the care provider directory by contacting Member Services.

The following behavioral health services are covered for members with Medicare and Medicaid coverage through AHCCCS:

- Behavioral health counseling
 - Medication services
 - Case management
 - Evaluation and assessment
 - Individual, group and family therapy and counseling
 - Inpatient hospital services (The contractor may provide services in alternative inpatient settings licensed by the Arizona Department of Health Services, Division of Assurance and Licensure, the office of Behavioral Health Licensure, in lieu of services in an inpatient hospital. These alternative settings must be lower in cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development.
 - Non-hospital inpatient psychiatric facilities services (level 1 residential treatment centers and sub-acute facilities)
 - Psychotropic medication adjustment and monitoring
 - Respite care (with limitations)
 - Rural substance abuse transitional agency services.
- Behavioral health therapeutic home care

For a complete list of covered services, please refer to the AHCCCS website in the Covered Service Guide section of azahcccs.gov.

Chapter 5: Claims Process, Coordination of Benefits, Claims

Claims submission requirements

UnitedHealthcare Dual Complete programs require that you initially submit your claim within your contracted deadline which may vary from what is documented in this manual. Please consult your contract to determine your initial filing requirement. The standard timely filing limit is set at 90 days after the date of service for participating care providers and 365 days from date of service for non-participating care providers.

A “clean claim” is defined in Arizona Revised Statutes as one processed without obtaining additional information from the care provider of service or from a third party. It does not include a claim from a care provider under investigation for fraud or abuse or a claim selected for medical review by UnitedHealthcare Dual Complete programs.

Please mail your paper claims to:

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP)
P.O. Box 5290
Kingston, NY 12402-5290

For electronic submission of claims, please access the Claims, Billing and Payments section on UHCprovider.com and sign up for electronic claims submission. You can register by going to UHCprovider.com and clicking on New User in the top right hand corner of the screen.

Practitioners

You should submit claims to UnitedHealthcare Dual Complete programs as soon as possible after service is rendered, using the standard HCFA-1500 claim form or electronically as follows.

To expedite claims payment, identify the following items on your claims:

- Prior authorization number, when applicable (on specialist’s referral claims)
- Member name

- Member’s date of birth and sex
- Member’s UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) ID number
- Member’s Group ID Number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-10 Codes
- CPT-4 Procedure Codes
- Place of Service Code
- Date of services
- Charge for each service
- National Provider Identifier (NPI)
- Care provider’s ID number and locater code, if applicable
- Care provider’s Tax Identification Number
- Name/address of care provider
- Signature of care provider rendering services

UnitedHealthcare Dual Complete programs will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to UnitedHealthcare Dual Complete programs should comply with HIPAA requirements.

Hospitals

Hospitals should submit claims to the UnitedHealthcare Dual Complete programs claims address as soon as possible after service is rendered, using the standard UB-04 form.

To expedite claims payment, identify the following items on your claims:

- Member name
- Member’s date of birth and sex
- Member’s UnitedHealthcare Dual Complete programs ID number

- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Care provider's ID number and locator code, if applicable
- Care provider's Tax Identification Number
- Care provider's name/address
- Current principal diagnosis code (highest level of specificity) with the applicable present on admission (POA) indicator on hospital inpatient claims
- Current other diagnosis codes, if applicable (highest level of specificity), with the applicable present on admission (POA) indicator on hospital inpatient claims

UnitedHealthcare Dual Complete programs will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162.

Any electronic claims submitted to UnitedHealthcare Dual Complete programs should comply with HIPAA requirements.

Participating care providers should submit ambulatory surgical center (ASC) claims according to their contract. Non-participating care providers should follow CMS billing guidelines.

Corrected claims and resubmission requirements

UnitedHealthcare Dual Complete participating and non-participating care providers have one year from the date of service to submit a corrected claim unless otherwise stated in the participating care providers' contract. A corrected claim is a claim meant to replace a previously submitted claim with changes or corrections applied.

Claim resubmissions can be submitted by participating care providers up to one year from the date of service for those claims originally denied or rejected due to missing documentation. Non-participating care providers have 60 days from the date of the remittance advice showing the denial to submit necessary medical records or additional information through a claim resubmission.

Corrected claims changing the DRG for a non-participating inpatient facility claim must be submitted within 60 days from the date of remittance. Otherwise, or the correction will be rejected.

How to use:

Use the claims submission 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 the appropriate frequency code or bill type as shown below. Allow up to 30 days to receive payment for initial claims and a response.

For medical claims, mail to:

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Submit corrected dental claims to:

UnitedHealthcare Community Plan
Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

Additional Information:

Enter the appropriate frequency code or bill type to indicate whether the claim is a resubmission of a previously processed claim or a void request of a previously processed claim. Enter the Original Claim Number of the claim being corrected, replaced or voided as shown below.

When submitting a corrected electronic CMS-1500 claim, be sure to:

- **Loop 2300 (Claim Information), Segment CLM**
 - Use CLM05-3- '7' to process as a replacement claim and reverse the original claim on file.
 - Use CLM05-3- '8' to void the original claim on file. Any previous payments will be recouped.
- **REF*F8 ; must include the original claim number ID**
 - Confirm the original claim reference number (CRN) does not have additional characters. This means if the original claim ID is 22A23xxxxxx, additional characters such as CLM 22A23xxxxxx are incorrect.

When submitting a corrected paper CMS-1500 claim, along with the UB-04 information, be sure to include:

- **Box 22 - Claim Resubmission Code**
 - Use the appropriate resubmission code:

1 – Original claim submission

7 or H– Replacement

8 – Void

• **Box 22 – Original Ref. Num. (Claim ID)**

- Include the Original Claim Number. Do not include additional characters. This means if the original claim ID is 22A23xxxxxx, additional characters such as CLM 22A23xxxxxx are incorrect.

Corrected claims submitted without this information are rejected and not processed in the claims system. For a list of rejected claims, refer to the claim rejection report your clearinghouse provides.

If any previously paid lines are blanked out or removed the system will assume that those lines should not be considered for reimbursement and payment will be recouped. When submitting a corrected claim, you must resubmit any documentation that was sent with the denied or previously paid claim.

Reconsiderations

Reconsiderations are the first step in the Medicare appeal process. UnitedHealthcare Dual Complete participating care providers have one year from the date of service to submit a reconsideration request unless otherwise stated in their contract. A reconsideration can be submitted after a care provider has been notified about the claim status (e.g., Provider Remittance Advice [PRA], 835 electronic remittance), and the care provider disagrees with the outcome. This includes a reimbursement rate or denial. When submitting a reconsideration, also send supporting documentation.

Non-participating care providers have 60 days from the date on the PRA to submit a reconsideration request on a zero-pay denied claim. They have 120 days to submit a reconsideration for all other reasons.

Coordination of benefits

If a member has coverage with another plan primary to Medicare, please submit a claim for payment to that plan first. The amount payable by UnitedHealthcare Dual Complete programs will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies.

Medicaid cost-sharing policy

A group of UnitedHealthcare Community Plan members are dually eligible for both Medicaid and Medicare services. Claims for dual-eligible members will be paid according to the Medicare Cost-Sharing policy. UnitedHealthcare Community Plan will not be responsible for cost-sharing should the payment from the primary payer be equal to or greater than what you would have received under Medicaid. Please refer to the Appendix: 2010 UnitedHealthcare Dual Complete programs cost-sharing and prior authorization for contracted care providers.

CMS requires that Special Needs Plans for dual-eligible members (eligible for both Medicare and Medicaid) pay the cost-share for members who temporarily lose their Medicaid coverage. During the first six months of a patient's loss of Medicaid coverage, the Dual-Eligible Special Needs Plan pays the cost-share amount. For example, if a patient has a claim for date of service 8/22/09 with a \$10 copay, and they lose Medicaid eligibility on 8/1/09, the Dual-Eligible Special Needs Plan will pay the \$10 copay since the date of service is within the first six months of Medicaid eligibility loss. However, if this same patient has a claim for date of service 2/15/10 with a \$10 copay, then you may bill the patient for the \$10 copay since their loss of Medicaid coverage was more than six months ago.

Claims for dual-eligible members will be paid according to the AHCCCS Medicare Cost-sharing Policy located at azahcccs.gov (Section 202).

Excerpt from AHCCCS Medicare Cost-sharing Policy – Section 202: Contractors have cost-sharing responsibility for all AHCCCS-covered services provided to members by a Medicare Risk HMO. For those services that have benefit limits, the contractor shall reimburse you for all AHCCCS and Medicare-covered services when the member reaches the Medicare Risk HMO's benefit limits.

Contractors only have cost-sharing responsibility for the amount of the member's coinsurance, deductible or copayment. Total payments to you shall not exceed the Medicare allowable amount which includes Medicare's liability and the member's liability. For those Medicare services which are also covered by AHCCCS, there is no cost-sharing obligation if the contractor has a contract with you as the Medicare care provider, and your contracted rate includes Medicare cost-sharing as specified in the contract.

Contractors shall have no cost-sharing obligation if the Medicare payment exceeds the contractor's contracted rate for the services. The contractor's liability for cost-sharing plus the amount of Medicare's payment shall not exceed the contractor's contracted rate for the service. With respect to copayments, the contractor may pay the lesser of the copayment, or their contracted rate.

The exception to these limits on payments as noted is that the contractor shall pay 100% of the member's copayment amount for any Medicare Part A SNF days (21 through 100) even if the contractor has a Medicaid nursing facility rate less than the amount paid by Medicare for a Part A SNF day.

Qualified Medicare Beneficiaries (QMB) duals

Medicaid pays the cost-sharing for Medicare beneficiaries, including deductibles, coinsurance and copayment amounts for Medicare Part A and B covered services. Once Medicare pays primary, you should bill cost-sharing amounts to UnitedHealthcare Community Plan or the member's Medicaid plan. Members are responsible for payment of their prescription drug copayments.

You may not bill a QMB for either the balance of the Medicare rate or your customary charges for Part A or B services. The QMB is protected from liability for Part A and B charges, even when the amounts you receive from Medicare and Medicaid are less than the Medicare rate or less than your customary charges as specified in the Balanced Budget Act of 1997 (BBA). Billing for QMB amounts the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions. You may not accept QMB patients as "private pay" to bill the patient directly. You must accept Medicare assignment for all Medicaid patients, including a QMB.

Non-QMB duals

Medicaid pays the cost-sharing for Medicare beneficiaries, including copayments, coinsurance and deductibles for Medicaid-covered benefits. Once Medicare pays primary, bill cost-sharing amounts to UnitedHealthcare Community Plan or the member's Medicaid plan. Members are responsible for their prescription drug copayments. Non-QMB dual eligible members may be billed for Medicare cost-sharing amounts for non-covered Medicaid services.

Balance billing

The balance billing amount is the difference between Medicare's allowed charge and your actual charge to the patient.

UnitedHealthcare Community Plan members cannot be billed for covered services based on A.A.C (UFC) R9-22-702 and A.A.C (HCG) R9-27-702. Services to members cannot be denied for failure to pay copayments. If a member requests a service not covered by UnitedHealthcare Community Plan, have the member sign a release form indicating they understand the service is not covered by UnitedHealthcare Community Plan. The member is financially responsible for all applicable charges.

Do not bill a member for a non-covered service unless:

- You have informed the member in advance that the service is not covered, and
- The member has agreed in writing to pay for the services if they are not covered.

Six-month grace period

The "grace period" is the time a member who becomes ineligible for our Special Needs Plan due to loss of their Medicaid eligibility has to regain Medicaid eligibility. Dual-eligible members that lose Medicaid eligibility may remain enrolled in UnitedHealthcare Dual Complete programs for up to six months without Medicaid coverage to allow the member time to regain eligibility. UnitedHealthcare Community Plan no longer covers the members, coinsurance or copays. The member is responsible for covered services that would have been paid by their Medicaid plan.

Care provider appeals

If you are not able to resolve a processed claim through a claim resubmission or adjustment request, communication with Provider Service Center, or the PCSU, you may challenge the claim denial or adjudication by filing a formal appeal with the health plan.

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) policy requires all claim appeals from participating care providers challenging claim payments, denials or recoupments must be filed in writing no later than 12 months from the date of service,

12 months after the date of eligibility posting. Failure to timely request an appeal is deemed as a waiver of all rights to further administrative review.

An appeal must be in writing and state with particularity the factual and legal basis and the relief requested, along with any supporting documents (e.g. claim, remit, medical review sheet, medical records, correspondence). Particularity usually means a chronology of pertinent events and a statement as to why you believe the action by UnitedHealthcare Community Plan was incorrect.

Mail formal written claim appeal to:

**UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP)
Provider Appeals Department
P.O. Box 6103, CA124-0187
Cypress, CA 90630-0023**

Non-submission or incomplete submission may result in a decision that upholds our original claim decision. A formal resolution letter notifying you of our final decision regarding the appeal will be sent within 30 calendar days of appeal receipt. If additional research time is needed, UnitedHealthcare Dual Complete programs have the right to request a 14-day extension. We will notify you in writing if extension is needed.

Non-contracted care providers

All non-contracted care providers must submit written appeals with supporting documentation of the initial claim denial within 120 calendar days from the initial determination date. In addition, non-contracted care providers must submit a signed Medicare Waiver of Liability form. UnitedHealthcare Dual Complete programs will not process any appeals from a non-contracted care provider without this form. The Medicare Waiver of Liability form is located in the appendix of the UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Care Provider Manual. The Waiver of Liability form, may also be accessed at UHCprovider.com in the Provider Forms, Programs and References section. UnitedHealthcare Community Plan will respond within 30 calendar days from the receipt of the appeal or dispute.

Non-contracted care providers claim payment dispute

Claim Payment Dispute – Any decision where a non-contracted Medicare health plan care provider contends the amount paid by the Medicare health plan for a Medicare-covered service is less than the amount that would have been paid under Original Medicare. Non-contracted care provider claim payment disputes also include instances where there is a disagreement between a non-contracted Medicare health plan care provider and the Medicare health plan about the plan's decision to pay for a different service or level than that billed. You have 120 calendar days from the initial determination date to file a claim dispute when either you disagree with the amount paid, or with UnitedHealthcare Community Plan's decision to pay for different services other than what was billed.

Some examples are:

- Bundling issues.
- Disputed rate of payment.
- Diagnostic Related Groups (DRG) payment dispute.
- Downcoding.

Payment appeal

A challenge or an “appeal” related to benefit/payment denials by the Medicare health plan that results in zero payment being made to the non-contracted Medicare health plan care provider. The first level of the Medicare appeal process is referred to as the reconsideration level. The Medicare health plan has 30 calendar days to review and respond to a claim payment dispute.

Valid proof of timely filing attachments

Following is a list of documents accepted as proof of timely filing:

Note: Letters of appeal will not be accepted as valid proof of timely filing. Documents must be computer-generated, not hand-written:

- A. UnitedHealth Group correspondence (data entry send back letter) OR

- B. A computer-generated activity page/print screen listing the date the claim was submitted to UnitedHealthcare Dual Complete programs.
- C. Electronic claims acceptance report
Submission must contain: Member name, identifying information, DOS, billed amount, date submitted to insurance.
- D. Other insurance carrier denial/rejection EOB or letter (e.g. terminated coverage, not their member).

Filing an appeal on behalf of a member

This applies to “Appeals for In-Patient Administrative Denials and Medical Necessity Determinations by Practitioner”.

You may assist members in filing an appeal on their behalf. UnitedHealthcare Dual Complete programs do not restrict or prohibit you from advocating on behalf of a member.

Part C

On Part C appeals, treating physicians, other physicians or the physician’s office staff will not need to complete an Appointment of Representative (AOR) form if they are appealing on behalf of the member. **All requests for pre-service reconsiderations do require a signature of the appealing party on it. If there is not a signature, one must be obtained.**

The following are examples of providers (not otherwise defined as a physician) who require an AOR to be on file:

- Hospitals
- SNFs
- Long-term care facilities
- Durable medical equipment suppliers
- Critical care access hospitals

Part D

If anyone other than the member or the treating physician, other physician or their office staff is appealing on behalf of the member, an AOR must be in the file. (The completion time frame does not start

until this document is received.) To process a member, member representative or treating physicians (including the prescribing physician, other prescriber and their respective office staff) request for redetermination of a denied coverage determination for a medication within seven calendar days from the date of the redetermination request.

The appeal may be filed either verbally or in writing and must be received within 60 calendar days from the date of the notice of action letter. Expedited appeals may also be requested if you feel the member’s health is in jeopardy and must be submitted within 60 calendar days after the occurrence.

Reasons for filing an appeal include:

- A denied authorization.
- A denied payment for a service either in whole or part resulting in member liability.
- UnitedHealthcare Dual Complete programs reducing or terminating services.
- UnitedHealthcare Dual Complete programs failing to provide services to a member in a timely manner.
- UnitedHealthcare Dual Complete programs failing to act within the time frame given for grievances and appeals.

You may send written appeals and documentation of member’s authorization to appeal on behalf of members to:

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP)
Attention: Appeals Department
1 East Washington, Suite 900
Phoenix, AZ 85004

Inquiries about appeals are directed to Provider Services at: 800-445-1638.

Chapter 6: Medical Management, Quality Improvement and Utilization Review

UnitedHealthcare Dual Complete programs seek to improve the quality of care provided to its members. Thus, UnitedHealthcare Dual Complete programs encourage your participation in health promotion and disease-prevention programs. You are encouraged to work with UnitedHealthcare Dual Complete programs in their efforts to promote healthy lifestyles through member education and information sharing. The programs seek to accomplish the following objectives through its Quality Improvement and Medical Management programs.

You must comply and cooperate with all UnitedHealthcare Dual Complete programs medical management policies and procedures and in our quality assurance and performance-improvement programs.

Referrals and prior authorization

Contracted health care professionals are required to coordinate member care within the care provider network. If possible, all UnitedHealthcare Dual Complete programs members should be seen by contracted care providers. Services provided outside of the network are permitted, but only with prior authorization from UnitedHealthcare Dual Complete programs. Referrals are not required for Dual Complete programs members when they are seeing a network care provider.

The prior authorization procedures are particularly important to the UnitedHealthcare Dual Complete programs managed care program. Prior authorization is one of the tools we use to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other care providers are required to comply with UnitedHealthcare Dual Complete programs' prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the PCP coordinates most services provided to a member, it is typically the

PCP who initiates requests prior authorization. However, specialists and ancillary care providers also request prior authorization for services within their specialty areas.

Unless another department or unit has been specially designated to authorize a service, requests for prior authorization are routed through UnitedHealthcare Dual Complete programs Prior Authorization department where nurses and medical directors are available at any time.

Requests are made by calling Prior Authorization at 800-445-1638.

PCP referral responsibilities

If a member self-refers, or the PCP is coordinating with the member a referral to a specialist, the PCP should check the UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) Provider Directory to help ensure the specialist is a contracted care provider.

The PCP should provide the specialist with the following clinical information:

- Member's name.
- Referring PCP.
- Reason for the consultation.

Chapter 7: Dental

UnitedHealthcare Dual Complete welcomes you as a participating dental provider in providing dental services for our members. We are committed to providing accessible quality, comprehensive dental services in the most cost-effective and efficient manner possible. We realize strong partnerships with our providers are critical, and we value you as an important part of our program.

See the following quick reference grid. For more information, please call 855-812-9208. You may also access our website (UHCprovider.com) and register as a participating care provider. Once registered, you may conduct a claim history search by surfaced tooth, verify eligibility and check benefits. The full Dental Provider Manual and Dental Training are also available on the website.

Resource: You want to:	Provider services line – dedicated service representatives. Phone: 855-812-9208 Hours: 9 a.m. - 5 p.m. Monday – Friday, Eastern time	Online UHCprovider.com	Interactive voice response
Inquire about a claim	√	√	√
Ask a benefit/plan question including prior authorization requirements	√	√	
Inquire about eligibility	√	√	√
Request an EOB	√	√	
Request a Fee Schedule	√	√	
Request a copy of your contract	√		
Ask a question about your contract	√		
Inquire about the in-Network Practitioner Listing	√	√	√
Nominate a care provider for participation	√	√	
Request a participation status change	√		
Request an office visit (e.g., staff training)	√		
Request documents	√	√	
Request benefit information	√	√	

Chapter 8: Care Provider Performance Standards and Compliance Obligation

Care provider evaluation

When evaluating the performance of a care provider, UnitedHealthcare Dual Complete will review at a minimum the following areas:

- **Quality of Care** - measured by clinical data related to the appropriateness of member care and outcomes.
- **Efficiency of Care** - measured by clinical and financial data related to a member's health care costs.
- **Member Satisfaction** - measured by the members' reports regarding accessibility, quality of health care, member-participating care provider relations, and the comfort of the practice setting.
- **Administrative Requirements** - measured by the participating care provider's methods and systems for keeping records and transmitting information.
- **Participation in Clinical Standards** - measured by the participating care provider's involvement with panels used to monitor quality of care standards.

Care provider compliance to standards of care

You must comply with all applicable laws and licensing requirements. In addition, you must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. You must also comply with UnitedHealthcare Dual Complete standards, which include, but are not limited to:

- Guidelines established by the federal Center for Disease Control (or any successor entity).
- All federal, state, and local laws regarding the conduct of their profession.

You must also comply with UnitedHealthcare Dual Complete policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care.
- Prior authorization requirements and timeframes.
- Participating care provider credentialing requirements.
- Referral policies.
- Case management program referrals.
- Appropriate release of inpatient and outpatient utilization and outcomes information.
- Accessibility of member medical record information to fulfill the business and clinical needs of UnitedHealthcare Dual Complete.
- Cooperating with efforts to assure appropriate levels of care.
- Maintaining a collegial and professional relationship with UnitedHealthcare Dual Complete personnel and fellow participating care providers.
- Providing equal access and treatment to all Medicare members.

Compliance process

The following types of non-compliance issues are key areas of concern:

- Out-of-network referrals/utilization without prior authorization by UnitedHealthcare Dual Complete.
- Failure to pre-notify UnitedHealthcare Dual Complete of admissions.
- Member complaints/grievances that are determined against the care provider.
- Underutilization, overutilization, or inappropriate referrals.

- Inappropriate billing practices.
- Non-supportive actions and/or attitude participating care provider noncompliance is tracked, on a calendar year basis. Using an educational approach, the compliance process is composed of four phases, each with a documented educational component. Corrective actions will be taken.

You, acting within the lawful scope of practice, are encouraged to advise patients who are members of UnitedHealthcare Dual Complete about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options.
2. The risks, benefits, and consequences of treatment or non-treatment.
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.
4. The importance of preventive changes at no cost to the member.

Such actions shall not be considered non-supportive of UnitedHealthcare Dual Complete.

Laws regarding federal funds

Payments you receive for furnishing services to UnitedHealthcare Dual Complete members are, in whole or part, from federal funds. Therefore, as a participating care provider, you, and any subcontractors must comply with certain laws that are applicable to individuals and entities receiving federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84, the Age Discrimination Act of 1975 as implemented by 45 CFR part 91, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

Marketing

You may not develop and use any materials that market UnitedHealthcare Dual Complete without the prior approval of UnitedHealthcare Dual Complete in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS and not disapproved within 45 days.

Sanctions under federal health programs and state law

You must ensure you do not employ or subcontract management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other federal health care programs.

You must disclose to UnitedHealthcare Dual Complete whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws, the rules or regulations of Arizona, the federal government, or any public insurer. You must notify UnitedHealthcare Dual Complete immediately if any such sanction is imposed on a participating care provider, a staff member or subcontractor.

Selection and retention of participating care providers

UnitedHealthcare Dual Complete is responsible for arranging covered services provided to thousands of members through a comprehensive care provider network of independent practitioners and facilities. The network includes health care professionals such as PCPs, specialist physicians, medical facilities, allied health professionals, and ancillary service providers.

UnitedHealthcare Dual Complete's network has been carefully developed to include those contracted health care professionals who meet certain criteria such as availability, geographic service area, specialty,

hospital privileges, quality of care, and acceptance of UnitedHealthcare Dual Complete managed care principles and financial considerations.

UnitedHealthcare Dual Complete continuously reviews and evaluates participating care provider information and recredentials every three years. The credentialing guidelines are subject to change based on industry requirements and UnitedHealthcare Dual Complete standards.

Termination of participating care provider privileges

Termination without cause

UnitedHealthcare Dual Complete and a contracting care provider must provide at least 60 days' written notice to each other before terminating a contract without cause.

Appeal process for care provider participation decisions

Physicians - If UnitedHealthcare Dual Complete decides to suspend, terminate or non-renew a physician's participation status, UnitedHealthcare Dual Complete must:

- Give the affected physician written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by UnitedHealthcare Dual Complete.
- UnitedHealthcare Dual Complete will allow the physician to appeal the action to a hearing panel, and give the physician written notice their right to a hearing and the process and timing for requesting a hearing.
- UnitedHealthcare Dual Complete will help ensure the majority of the hearing panel members are peers of the affected care provider.

If a suspension or termination is the result of quality of care deficiencies, UnitedHealthcare Dual Complete must give written notice of that action to the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician groups must provide that these procedures apply equally to physicians within those subcontracted groups.

Other Care Providers

UnitedHealthcare Dual Complete decisions subject to appeal include decisions regarding reduction, suspension, or termination of a participating care provider's participation resulting from quality deficiencies. UnitedHealthcare Dual Complete will notify the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law. Written communication to the participating care provider will detail the limitations and inform them of their rights to appeal.

Notification of members of care provider termination

You should make every effort to provide as much advance notice as possible when preparing to terminate participation with the UnitedHealthcare Dual Complete provider network. CMS requires the notification of members affected by termination a minimum of 30 days' notice prior to the termination effective date. Advance notice is tantamount to a safe and orderly transition of care.

Chapter 9: Medical Records

Medical record review

A UnitedHealthcare Dual Complete programs representative may visit the participating care provider's office to review the medical records of UnitedHealthcare Dual Complete programs members to obtain information regarding medical necessity and quality of care. Medical records and clinical documentation will be evaluated based on the following Standards for Medical Records. The Quality and Utilization Management subcommittee, the Provider Affairs Subcommittee and the Quality Management Oversight Committee review the medical record results quarterly. The results will be used in the re-credentialing process.

Standards for medical records

You must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter, whether direct or indirect, must be comprehensively documented in the member's medical chart. Each medical record chart must have documented at a minimum:

- Member name.
- Member identification number.
- Member age.
- Member sex.
- Member date of birth.
- Date of service.
- Allergies and any adverse reaction.
- Past medical history.
- Chief complaint/purpose of visit.
- Subjective findings.
- Objective findings, including diagnostic test results.
- Diagnosis/assessment/ impression.

- Plan, including services, treatments, procedures and/or medications ordered, recommendation and rationale.
- Name of care provider including signature and initials.
- Instructions to member.
- Evidence of follow-up with indication that test results and/or consultation was reviewed by PCP and abnormal findings discussed with member/legal guardian.
- Health risk assessment and preventive measures.

You are required to participate in and cooperate with the UnitedHealthcare Quality Management program. The UnitedHealthcare Community Plan Quality Management program is allowed to use your performance data to conduct quality activities.

Proper documentation and medical review

Medical review is performed to determine if services were provided according to policy, particularly related issues of medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided.

The following are scenarios where the appropriate documentation is required to process the claim:

- Out-of-state care providers who submit corrected claims must include itemization of charges.
- Inpatient claims with extraordinary cost-per-day thresholds may qualify for an outlier reimbursement. For an inpatient claim to be paid the outlier payment, the facility must bill a Condition Code 61 in any of the Condition Code fields (24-30) on the UB-04. If the inpatient claims is an interim bill, only the last bill (e.g. bill type 114) will be considered for outlier reimbursement.

- All Medicare inpatient claims require medical records. Please be sure to include them with your claim submission.
- All care providers when unlisted procedures are being billed, including any documentation, including: the name of the medication, the dosage given, the National Drug Code (NDC) number from the vial(s) used, the number of vials used that details what service was provided.
- Medicare services:
 - Cardiology services.
 - Radiological service interpretation.
 - Home health visits.
 - Injectable drugs.
 - Home IV therapy.
 - Surgical procedures with Modifier 22 indicating unusual procedural service.
- Itemized bill for claims where member is eligible for part of the date span but not the entire date span.

In addition, you must document in a prominent part of the member's current medical record whether the member has executed an advance directive.

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of Arizona and signed by a patient. They explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Confidentiality of member information

You must comply with all state and federal laws concerning confidentiality of health and other information about members. You must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Member record retention

You must retain the original or copies of patient's medical records as follows:

- Keep records for at least 10 years after last medical or health care service for all patients. You must comply with all state (A.R.S. 12-2297) and federal laws on record retention.

Chapter 10: Reporting Obligations

CMS requirements

UnitedHealthcare Dual Complete programs must provide to CMS information that is necessary for CMS to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates, information on member satisfaction and information on health outcomes. You must cooperate with UnitedHealthcare Dual Complete programs in its data-reporting obligations by providing any information that they need to meet obligations.

Certification of diagnostic data

UnitedHealthcare Dual Complete programs are specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a care provider, supplier, physician, or other practitioner (encounter data). You must certify (based on best knowledge, information and belief) the accuracy, completeness and truthfulness of the data you submit.

Risk adjustment data

You are encouraged to comprehensively code all members' diagnoses to the highest level of specificity possible. All members' medical encounters must be submitted to UnitedHealthcare Dual Complete programs.

Chapter 11: Initials Decisions, Appeals and Grievances

Initial decisions

The “initial decision” is the first decision UnitedHealthcare Dual Complete programs makes regarding coverage or payment for care. In some instances, you acting on behalf of UnitedHealthcare Dual Complete programs may make an initial decision regarding whether a service will be covered.

- If a member asks us to pay for medical care the member has already received, this is a request for an “initial decision” about payment for care.
- If a member or care provider acting on behalf of a member, asks for preauthorization for treatment, this is a request for an “initial decision” about whether the treatment is covered by UnitedHealthcare Dual Complete programs.
- If a member asks for a specific type of medical treatment from a care provider, this is a request for an “initial decision” about whether the treatment the member wants is covered by UnitedHealthcare Dual Complete programs.

UnitedHealthcare Dual Complete programs will generally make decisions regarding payment for care that members have already received within 30 days.

A decision about whether UnitedHealthcare Dual Complete programs will cover medical care can be a “standard initial decision” that is made within the standard time frame (typically within 14 days). The decision can also be expedited (typically within 72 hours).

A member can ask for an expedited initial decision only if the member or care provider believes waiting for a standard initial decision could seriously harm the member’s health or ability to function. The member or you can request an expedited initial decision. If you request an expedited initial decision, or supports a member in asking for one, and you indicate waiting for a standard initial decision could seriously harm the member’s health or ability to function, UnitedHealthcare Dual Complete programs will automatically provide an expedited initial decision.

At each patient encounter with a UnitedHealthcare Dual Complete programs member, the care provider must notify the member of their right to receive, upon request, a detailed written notice from UnitedHealthcare Dual Complete programs regarding the member’s services. The care provider’s notification must provide the member with the information necessary to contact UnitedHealthcare Dual Complete programs and must comply with any other requirements specified by CMS. If a member requests UnitedHealthcare Dual Complete programs to provide a detailed notice of a care provider’s decision to deny a service in whole or part, UnitedHealthcare Dual Complete programs must give the member a written notice of the initial determination.

If UnitedHealthcare Dual Complete programs do not make a decision within the time frame and do not notify the member regarding why the time frame must be extended, the member can treat the failure to respond as a denial. They may appeal.

Appeals and grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints they can make. You must cooperate in the Medicare appeals and grievances process.

- An appeal is the type of complaint a member makes when the member wants UnitedHealthcare Dual Complete programs to reconsider and change an initial decision (by UnitedHealthcare Dual Complete programs or a care provider) about what services are necessary or covered or what UnitedHealthcare Dual Complete programs will pay for a service.
- A grievance is the type of complaint a member makes regarding any other type of problem with UnitedHealthcare Dual Complete programs or a care provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating care provider’s facilities are

grievances. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (refer to appeal).

Resolving appeals

A member may appeal an adverse initial decision by UnitedHealthcare Dual Complete programs or a care provider concerning authorization for, or termination of coverage of a health care service. A member may also appeal an adverse initial decision concerning payment for a health care service. A member's appeal of an initial decision about authorizing health care or terminating coverage of a service within 30 calendar days or sooner, if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

You must also cooperate with UnitedHealthcare Dual Complete programs and members in providing necessary information to resolve the appeals within the required time frames. Provide the pertinent medical records and any other relevant information to UnitedHealthcare Dual Complete programs. In some instances, you must provide the records and information very quickly to allow UnitedHealthcare Dual Complete programs to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's care provider may request an expedited appeal. Such an appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time. If you request the expedited appeal and indicate the normal time for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

Special types

A special type of appeal applies only to hospital discharges. If the member thinks UnitedHealthcare Dual Complete programs coverage of a hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Professional Research Organization (QIPRO). In Arizona that organization is the [Health Services Advisory Group \(HSAG\)](#). However, such an appeal must be requested no later than noon on the first working day after the day

the member gets notice that UnitedHealthcare Dual Complete programs coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal.

Another special type of appeal applies only to a member dispute regarding when coverage will end for a SNF, home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). SNFs, HHAs and CORFs are responsible for providing members with a written notice at least two days before their services are scheduled to end. If the member thinks the coverage is ending too soon, the member can appeal directly and immediately to the QIPRO. The QIPRO in Arizona is [HSAG](#). If the member gets the notice two days before coverage ends, the member must request an appeal to QIPRO, Inc., no later than noon of the day after the member gets the notice. If the member gets the notice more than two days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to QIPRO the member can request an expedited appeal.

Resolving member grievances

If a UnitedHealthcare Dual Complete programs member has a grievance about UnitedHealthcare Dual Complete programs, you or any other issue, you should instruct the member to contact Member Services at 877-614-0623. (TTY/TDD users should call 711.) Mail a written grievance to:

Member Grievance Part C:
Appeals and Grievance Department
P.O. Box 6103 CA124-0187
Cypress, CA 90630-0023

Fax: 844-226-0356

Member Grievance Part D:
Part D Appeal and Grievance Department
P.O. Box 6103 CA124-0197
Cypress, CA 90630-0023

Fax: 877-960-8235

UnitedHealthcare Dual Complete programs will send a received letter within five days of receiving your grievance request. A final decision will be made as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving

your complaint. We may extend the time frame by up to 14 calendar days if you request the extension or if we justify a need for additional information, and the delay is in your best interest.

UnitedHealthcare Dual Complete programs members may ask for an expedited grievance upon initial request. We will respond to “expedited” or “fast” grievance requests within 24 hours.

Further appeal rights

If UnitedHealthcare Dual Complete programs denies the member’s appeal in whole or part, except for Part D claims, we will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not a part of UnitedHealthcare Dual Complete programs. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision.

If the IRE issues an adverse decision, and the amount at issue meets a specified dollar threshold, the member may appeal to an administrative law judge (ALJ). If the member is not satisfied with the ALJ’s decision, the member may request review by the Department Appeal Board (DAB). If the DAB refuses to hear the case or issues an adverse decision, the member may appeal to a district court of the United States.

Chapter 12: Member Rights and Responsibilities

UnitedHealthcare Dual Complete programs members have the right to timely, high-quality care and treatment with dignity and respect. You must respect the rights of all UnitedHealthcare Dual Complete programs members. Specifically, UnitedHealthcare Dual Complete programs members have been informed that they have the following rights:

Timely quality care

- Choice of a qualified contracting PCP and contracting hospital.
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Timely access to their PCP and referrals and recommendations to specialists when medically necessary.
- To receive emergency services when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists.
- To actively participate in decisions regarding their health and treatment options.
- To receive urgently needed services when traveling outside UnitedHealthcare Dual Complete's (HMO SNP) service area or in UnitedHealthcare Dual Complete's (HMO SNP) service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating care provider.
- To request the number of grievances and appeals and dispositions in aggregate.
- To request information regarding physician compensation.
- To request information regarding the financial condition of UnitedHealthcare Dual Complete programs.

Treatment with dignity and respect

- To be treated with dignity and respect and to have their right to privacy recognized.
- To exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To confidential treatment of all communications and records pertaining to the member's care.
- To access, copy and/or request amendment to the member's medical records consistent with the terms of HIPAA.
- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care.
- To refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision).
- To complete an advance directive, living will or other directive to the member's medical care providers.

Member satisfaction

UnitedHealthcare Dual Complete programs periodically survey members to measure overall customer satisfaction as well as satisfaction with the care received from participating care providers. Survey information is reviewed by UnitedHealthcare Dual Complete programs and results are shared with the participating care providers.

CMS conducts annual surveys of members to measure their overall customer satisfaction as well as satisfaction with the care received from you. Survey results are available upon request.

Member responsibilities

Member responsibilities include:

- Reading and following the Evidence of Coverage (EOC).
- Treating all UnitedHealthcare Dual Complete programs staff and health care providers with respect and dignity.
- Protecting their AHCCCS or DDD ID card and showing it before obtaining services.
- Knowing the name of their PCP.
- Seeing their PCP for their health care needs.
- Using the emergency room for life-threatening care only and going to their PCP or urgent care center for all other treatment.
- Following their doctor's instructions and treatment plan and telling the doctor if the explanations are not clear.
- Bringing the appropriate records to the appointment, including their immunization records until the child is 18 years old.
- Making an appointment before they visit their PCP or any other UnitedHealthcare Dual Complete programs care provider.
- Arriving on time for appointments.
- Calling the office at least one day in advance if they must cancel an appointment.
- Being honest and direct with their PCP, including giving the PCP the member's health history as well as their child's.
- Telling their AHCCCS, UnitedHealthcare Dual Complete programs, and their DDD support coordinator if they have changes in address, family size, or eligibility for enrollment.
- Tell UnitedHealthcare Dual Complete programs if they have other insurance.
- Give a copy of their living will to their PCP.

Services provided in a culturally competent manner

UnitedHealthcare Dual Complete programs help ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating care providers must cooperate with UnitedHealthcare Dual Complete programs in meeting this obligation.

Member complaints/grievances

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) tracks all complaints and grievances to identify areas of improvement. This information is reviewed in the Quality Improvement Committee, Service Improvement Subcommittee and reported to the UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) board of directors. Please refer to Chapter 11 for members' appeal and grievances rights.

Chapter 13: Access to Care/Appointment Availability

Member access to health care guidelines

UnitedHealthcare Dual Complete programs monitor the adequacy of appointment processes and help ensure a member's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 15 minutes, except when you are unavailable due to an emergency. For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health.

You must meet the following appointment standards:

- Urgent care PCP appointments – within 2 business days of request.
- Routine care PCP appointments – within 21 calendar days of request.

For specialty referrals, the following standards must be met:

- Urgent care appointments – within 2 business days of referral.
- Routine care appointments – within 45 calendar days of referral.

For dental appointments, you must meet the following standards:

- Urgent care appointments – within three business days of request.
- Routine care appointments – within 45 calendar days of referral.

General behavioral health appointment standards:

1. Urgent need: as immediately as the member's health condition requires but no later than 24 hours from identification of need
2. Routine care
 - Initial assessment: 7 calendar days of referral or request for service
 - First behavioral health service: as immediately as the member's health condition requires but no later than 23 calendar days after initial assessment
 - Subsequent behavioral health services: as immediately as the member's health condition requires but no later than 45 calendar days from identification of need.

3. Referrals for psychotropic medications:
 - Assess the urgency of the need immediately
 - Provide an appointment within the time frame indicated by clinical need, no later than 30 calendar days from identification of need.

You must offer a range of appointment availability per the appointment timeliness standards for intakes and ongoing services based upon the clinical need of the member. Exclusive use of "same-day only" appointment scheduling and/or "open access" is prohibited within our network.

Adherence to member access guidelines will be monitored through the office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination.

Variations from the policy will be reviewed by network management for educational and/or counseling opportunities and tracked for participating care provider re-credentialing.

All providers and hospitals will treat all UnitedHealthcare Dual Complete programs members with equal dignity and consideration as their other patients.

Care provider availability

PCPs shall provide coverage 24 hours a day, seven days a week. When a participating care provider is unavailable to provide services, they must help ensure another participating care provider is available.

The member should normally be seen within 45 minutes of a scheduled appointment or be informed

of the reason for delay (e.g. emergency cases) and be provided with an alternative appointment.

After-hours access shall be provided to assure a response to emergency phone calls within 30 minutes, with response to urgent phone calls within one hour. Individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services.

Physician office confidentiality statement

UnitedHealthcare Dual Complete programs members have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage Program. Participating care providers and each staff member will sign an employee confidentiality statement to be placed in the staff member's personnel file.

Transfer and termination of members from participating physician's panel

UnitedHealthcare Dual Complete programs will determine reasonable cause for a transfer based on written documentation submitted by the participating care provider. Participating care providers may not transfer a member to another participating care provider due to the costs associated with the member's covered services. Participating care providers may request termination of a member due to fraud, disruption of medical services, or repeated failure to make the required reimbursements for services.

Closing of care provider panel

When closing a practice to new UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) members or other new patients, participating care providers are expected to:

- Give UnitedHealthcare Dual Complete programs prior written notice that the practice will be closing to new members as of the specified date.

- Keep the practice open to UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) members who were members before the practice closed.
- Close the practice to all new patients, including private payers, commercial or governmental insurers.
- Give UnitedHealthcare Dual Complete programs prior written notice of the reopening of the practice, including a specified effective date.

Prohibition against discrimination

Neither UnitedHealthcare Dual Complete programs or participating care providers may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability including conditions arising out of acts of domestic violence
- Disability

Chapter 14: Prescription Benefits

Network pharmacies

With a few exceptions, UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) members must use network pharmacies to get their outpatient prescription drugs covered. A network pharmacy is a pharmacy where members can get their outpatient prescription drugs through their prescription drug coverage. We call them “network pharmacies” because they contract with our plan. In most cases, prescriptions are covered only if they are filled at one of our network pharmacies. Once a member goes to one, they are not required to continue going to the same pharmacy to fill their prescription; they can go to any of our network pharmacies.

Covered Drugs is the general term we use to describe all of the outpatient prescription drugs that are covered by our plan. Covered drugs are listed in the Prescription Drug List (PDL).

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before a prescription is filled at an out-of-network pharmacy, please contact Member Services to see if there is a network pharmacy available.

- We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, members will have to pay the full cost (rather than paying just the copayment) when they fill their prescription. They can ask us for reimbursement for their share of the cost by submitting a paper claim form.
- If our member is traveling within the U.S., but outside of the plan’s service area and becomes ill, loses or runs out of their prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. In this situation, the member will have to pay the full cost (rather than paying just their copayment) when they fill their prescription. The member can ask us to reimburse them for

our share of the cost by submitting a claim form. Remember, prior to filling a prescription at an out-of-network pharmacy, call Member Services to find out if there is a network pharmacy in the member’s area where they are traveling. If there are no network pharmacies in that area, our Member Services may make arrangements for the member to get their prescriptions from an out-of-network pharmacy.

- If our member is unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If a member is trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail store. (These drugs include orphan drugs or other specialty pharmaceuticals.)

Paper claim submission

When our members go to a network pharmacy, their claims are automatically submitted to us by the pharmacy. However, if they go to an out-of-network pharmacy for one of the reasons listed, the pharmacy may not submit the claim directly to us. When that happens, members will have to pay the full cost of their prescription. Call Member Services at 877-614-0623 (TTY/TDD users should call 711) for a direct member reimbursement claim form and instructions on how to obtain reimbursement for covered prescriptions. Mail the claim form and receipts to:

OptumRx
P.O. Box 29044
Hot Springs, AR 71903

Prescription Drug List (PDL)

A PDL is a list of all the drugs we cover. We will generally cover the drugs listed in our PDL as long as the drug is medically necessary, the prescription is filled at a network pharmacy, or through our network

mail order pharmacy service, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the PDL are selected by our plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the PDL. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the PDL. In some cases, the law prohibits coverage of certain types of drugs. In other cases, we have decided not to include a particular drug. We may also add or remove drugs from the PDL during the year. If we change the PDL we will notify you of the change at least 60 days before the effective date of change. If we don't notify you of the change in advance, the member will get a 60-day supply of the drug when they request a refill. However, if a drug is removed from our PDL because the drug has been recalled from the market, we will NOT give a 60-day notice before removing the drug from the PDL. Instead, we will remove the drug from our PDL immediately and notify members about the change as soon as possible.

To find out what drugs are on the PDL or to request a copy of our PDL, please call Member Services at 877-614-0623. (TTY/TDD users should call 711.)

You can also get updated information about the drugs covered by us by visiting our website at UHCCommunityPlan.com.

Exception request

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make:

- A. You can ask us to cover your drug even if it is not on our PDL.
- B. You can ask us to waive coverage restrictions or limits on your drugs. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's PDL would not be as effective in treating the member's

condition and/or would cause them to have adverse medical effects.

Please call our Member Services at 877-614-0623 (TTY/TDD users should call 711) to request a PDL exception. If we approve your exception request, our approval is valid for the remainder of the plan year, as long as the physician continues to prescribe the drug and it continues to be safe and effective for treating the patient's condition.

All new Dual Complete programs members may receive a 30-day transition supply of a non-PDL/non-covered drug when a prescription is presented to a network pharmacy. The pharmacist will fill the script. A letter will be automatically generated to you and the member advising that either a PDL alternative should be chosen or a request for exception should be submitted.

- A. You may request an exception for coverage (or continuation of coverage post-transition fill) of a non-formulary drug, or you may ask to waive quantity limits or restrictions. Exception requests require you to provide documentation that the patient has unsuccessfully tried a regimen of a PDL medication or that such medication would not be as effective as the non-formulary alternative. Exception requests will be evaluated based on the information you provide. Please call 800-711-4555 to initiate the exception process.

Drug management programs (utilization management)

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

These requirements and limits help ensure our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our plan to help us provide quality coverage to our members. Examples of utilization management tools include:

- 1. Prior Authorization:** We require our members to get prior authorization for certain drugs. This means that a participating physician or pharmacist will need to get approval from us before a member fills their prescription. If they don't get approval, we may not cover the drug.

- 2. Quantity Limits:** For certain drugs, we limit the amount of the drug that we cover per prescription or for a defined period of time. For example, we will provide up to 90 tablets per prescription for ALTOPREV. This quantity limit may be in addition to a standard 30-day supply limit.
- 3. Step Therapy:** In some cases, we require members to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
- 4. Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the member the generic version, unless their doctor has told us that they must take the brand-name drug.

You can find out if the drugs you prescribe are subject to these additional requirements or limits by looking in the PDL. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules.

Find medical policies and coverage determination guidelines at UHCprovider.com/AZcommunityplan >

[Policies and Clinical Guidelines.](#)

Chapter 15: Fraud, Waste and Abuse

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs. If any such actions, activities, or behaviors come to your attention, please contact UnitedHealthcare Dual Complete immediately at 877-614-0623 (TTY 711), 8 a.m. - 8 p.m. local time, seven days a week.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 877-7SafeRx (877-722-3379) or to the Medicare program directly at 1-800-Medicare (800-633-4427). TTY users can call 877-486-2048. The website is [medicare.gov](https://www.medicare.gov).

This hotline allows you to report cases anonymously and confidentially. All information provided to UnitedHealthcare Dual Complete regarding potential fraud or abuse occurrence will be maintained in the strictest confidence in accordance with the terms and conditions of UnitedHealthcare Community Plan Dual Complete's Confidentiality Policy. A copy of this policy is available upon request. Any information developed, obtained or shared among participants in an investigation of a potential fraud and abuse occurrence is maintained specifically for this purpose and no other. Any questions or concerns a care provider may have regarding confidentiality should be addressed to the attention of the UnitedHealthcare Dual Complete compliance officer.

UnitedHealthcare Community Plan members are instructed through the Member Handbook to safeguard their member ID cards as they would any other private and personal identification information, such as a driver license or checkbook. If you have any concerns regarding a member's enrollment when they present for non-emergent or non-urgent services:

- Ask for another form of identification, preferably one with a photograph.
- Use the Provider Portal located on [UHCprovider.com](https://www.uhcprovider.com) or the IVR phone line to confirm enrollment.
- Contact the Member Services Department for verification.

Federal False Claims Act

The federal False Claims Act prohibits knowingly submitting (or causing to be submitted) to the federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by a state Medicaid program, the federal government or its agents, such as a carrier or other claims processor. Civil penalties can be imposed on any person or entity that violates the federal False Claims Act, including monetary penalties of \$5,500 to \$11,000 as well as damages of up to three times the federal government's damages for each false claim.

Federal fraud civil remedies

The Program Fraud Civil Remedies Act of 1986 also allows the government to impose civil penalties against any person who makes, submits or presents false, fictitious or fraudulent claims or written statements to designated federal agencies, including the U.S. Department of Health and Human Services, which is the federal agency that oversees the Medicare and Medicaid programs.

State false claims acts

Several states, including Arizona, have enacted broad false claims laws modeled after the federal False Claims Act or have legislation pending that is similar to the federal False Claims Act. Other states have enacted false claims laws that have provisions limited to health care fraud.

Whistleblower and whistleblower protections

The federal False Claims Act and some state false claims acts permit private citizens with knowledge of fraud against the U.S. government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are known as a “qui tam” plaintiff or “whistleblower.” The federal False Claims Act and some state false claims acts also prohibit retaliation against an employee for investigating, filing or participating in a whistleblower action. You must establish an effective training program for all staff on the following aspects of the federal False Claims Act provisions:

- The administrative remedies for false claims and statements.
- Any state laws relating to civil or criminal penalties for false claims and statements.
- The whistleblower protections under such laws.

All training must be appropriately documented and may be requested at any time by UnitedHealthcare Dual Complete.

Waiver of Liability Statement



Waiver of Liability Statement

Member / HIC Number
Enrollee's Name
Provider
Date of Service
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600

Signature _____ Date: _____

Case Management Referral Form



UnitedHealthcare Community Plan Dual Complete Health Services Case Management Referral Form

Member Name:	Member ID:
Date of Birth:	Address:
City:	Zip:
Phone:	Cell:
PCP:	Phone:
Referred By:	Phone:
Language: English Spanish Other:	
MSR:	Date:
Ext/Phone:	

Check Appropriate CM Request:

ASTHAM CM	BEHAVIORAL HEALTH CM	DIABETES CM	PSYCHO/SOCIAL CM
CHF CM	PAIN CM	GENERAL CM	ER DIVERSION
TRANSPLANT/HEMOPHILIA CM	HIV CM	MOMS CM	MISSED APPOINTMENTS
BENEFIT EXPLANATION	OTHER:		

Reason for Case Management: _____

Goal: _____

Glossary

Appeal

Any of the procedures that deal with the review of adverse organization determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by UnitedHealthcare Dual Complete programs, an independent review entity, hearings before an ALJ, review by the Medicare Appeals Council, and judicial review.

Basic Benefits

All health and medical services that are covered under Medicare Part A and Part B, except hospice services and additional benefits. All members of UnitedHealthcare Dual Complete programs receive all basic benefits.

CMS

The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Contracting Hospital

A hospital that has a contract to provide services and/or supplies to UnitedHealthcare Dual Complete programs members.

Contracting Medical Group

Physicians organized as a legal entity for the purpose of providing medical care. The contracting medical group has an agreement to provide medical services to UnitedHealthcare Dual Complete programs members.

Contracting Pharmacy

A pharmacy that has an agreement to provide UnitedHealthcare Dual Complete programs members with medication(s) prescribed by the members' participating care providers in accordance with UnitedHealthcare Dual Complete programs.

Cost-Sharing

Refers to UnitedHealthcare Community Plan's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

Covered Services

Those benefits, services or supplies which are:

- Provided or furnished by participating care providers or authorized by UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP) or its participating care providers.
- Emergency services and urgently needed services that may be provided by non-participating care providers.
- Renal dialysis services provided while you are temporarily outside the service area.
- Basic and supplemental benefits.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention result in 1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency Services

Covered inpatient or outpatient services 1) Furnished by a care provider qualified to furnish emergency services; and 2) Needed to evaluate or stabilize an emergency medical condition.

Experimental Procedures and Items

Items and procedures determined by UnitedHealthcare Dual Complete programs and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, UnitedHealthcare Dual Complete programs will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

Fee-for-Service Medicare

A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or Original Medicare).

Grievance

Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeals process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Home Health Agency

A Medicare-certified agency which provides intermittent skilled nursing care and other therapeutic services in your home when medically necessary, when members are confined to their home and when authorized by their PCP.

Hospice

An organization or agency certified by Medicare, which is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed in Arizona, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Hospitalist

A hospitalist is a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists must complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient’s PCP.

Independent Physicians Association (IPA)

A group of physicians who function as a contracting medical provider/group yet work out of their own independent medical offices.

Medically Necessary

Medical services or hospital services that are determined by UnitedHealthcare Dual Complete programs to be:

- Rendered for the diagnosis or treatment of an injury or illness; and

- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the member, the attending participating care provider or other service provider.

UnitedHealthcare Dual Complete programs will make determinations of medical necessity based on peer reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by UnitedHealthcare Dual Complete programs.

Medicare

The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

Hospital insurance benefits including inpatient hospital care, SNF care, home health agency care and hospice care offered through Medicare.

Medicare Part A Premium

Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island, or local government employment to be insured, members do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, they may buy the coverage from Social Security if members are at least 65 years old and meet certain other requirements.

Medicare Part B

Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Medicare Part B Premium

A monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services whether members are covered by an MA Plan or by Original Medicare.

Medicare Advantage (MA) Plan

A policy or benefit package offered by a Medicare Advantage Organization (MAO) under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by UnitedHealthcare Dual Complete programs. An MAO may offer more than one benefit plan in the same service area. UnitedHealthcare Dual Complete programs are MA plans.

Member

The Medicare beneficiary entitled to receive covered services, who has voluntarily elected to enroll in the UnitedHealthcare Dual Complete programs and whose enrollment has been confirmed by CMS.

Non-Contracting Medical Provider or Facility

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by Arizona or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract to deliver covered services to UnitedHealthcare Dual Complete programs members.

Non-QMB Dual

An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB benefits.

Participating Care Provider

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by Arizona or Medicare to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to UnitedHealthcare Dual Complete programs members pursuant to the terms of the agreement.

Primary Care Provider (PCP)

The participating care provider who a member chooses to coordinate their health care. The PCP is responsible for providing covered services for UnitedHealthcare Dual Complete programs members and coordinating referrals to specialists. PCPs are generally participating care providers of internal medicine, family practice or general practice.

Qualified Medicare Beneficiary (QMB) Dual

An individual who is eligible for QMB Benefits as well as Medicaid benefits.

Please contact UnitedHealthcare Dual Complete programs if you have any questions regarding the definitions listed or any other information listed in the manual. Our representatives are available anytime at 800-445-1638.

Comments and Suggestions

UnitedHealthcare Dual Complete programs welcome your comments and suggestions about this care provider manual. Please complete this form if you would like to see additional information, or expansions on topics, or if you find inaccurate information. Please mail this form to:

Phone:

UnitedHealthcare Dual Complete and Dual Complete One (HMO SNP)
Attn: Medicare Vice President of Operations
1 E. Washington, Suite 900
Phoenix, AZ 85004-2582

Comments and Suggestions:

Submitted by

Name:

Address:

