2018
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Arizona Health Care Cost Containment System (AHCCCS) Complete Care (ACC) — Arizona Long Term Care Elderly Physically Disabled (ALTCS EPD) — Developmentally Disabled Children's Rehabilitative Services (DD-CRS)

UnitedHealthcare®
Community Plan

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Welcome

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

CLICK THE FOLLOWING LINKS TO ACCESS DIFFERENT MANUALS:

- **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**. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

EASILY FIND INFORMATION IN THIS MANUAL USING THE FOLLOWING STEPS:

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

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

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

Important Information about the use of this manual

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

This manual will be amended as policies change.

PARTICIPATION AGREEMENT

In this manual, we refer to your Participation Agreement or contract with Community Plan as “Agreement”.

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

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

If a member asks to appeal a clinical or coverage determination on their behalf, follow the member appeal process in Chapter 10 of this manual or Member Handbook. You may locate the Member’s Handbook at **UHCCommunityPlan.com**.

Also reference Chapter 14 of this manual for information on care provider disputes, member appeals and member grievances.

UnitedHealthcare Community Plan Disclaimer

You are contractually obligated to adhere to and comply with all terms of the plan and provider Agreement, including all requirements described in this manual as well as all federal and state regulations governing the plan and care providers.

While this manual contains basic information about the Arizona Health Care Cost Containment System (AHCCCS) and the Developmentally Disabled (DD), you are required to fully understand and apply AHCCCS and DD requirements when administering covered services.

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Chapter 1: Introduction

AHCCCS Complete Care

The AHCCCS Complete Care Program will manage the care provider network for all health care services, including medical care and behavioral health services. Instead of navigating two separate networks for medical and behavioral services, members and care providers will have the convenience of a single health plan. This allows the member's primary care provider (PCP) to offer medical and behavioral health services as long as it is within the scope of their practice. Accordingly, our Complete Claim Program provides an integrated plan that includes health services for members with special needs and chronic health conditions.

Specific guidelines and policies related to the Developmentally Disabled and Long Term Care programs are addressed throughout this document as well as within their chapters.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call Provider Services at **800-445-1638**.

Our Approach to Health Care

WHOLE PERSON CARE MODEL

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

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

- Market-specific care management encompassing medical, behavioral and social care.
- Extended care team including PCP, pharmacist, medical and behavioral director.
- Field-based interventions engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plan.
- Assistance with appointments with PCP and coordinating appointments. The Community Health Worker (CHW) refers members to an RN, behavioral health provider or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The goals of the WPC program are to:

- Lower avoidable admissions and unnecessary ER visits, measured by inpatient (IP) admission and emergency room (ER) rates.
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames.
- Identify and discuss behavioral health needs, measured by number of BH care provider visits within identified time frames.
- Improve access to pharmacy.

- Identify and remove social and environmental barriers to care.
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics.
- Empower the member to manage their complex/chronic illness or problem and care transitions.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

REFERRING YOUR PATIENT

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Member Services at **800-348-4058**, TTY 711. You may also call Provider Services at **800-445-1638**.

How to Join the UnitedHealthcare Community Plan Provider Network

To join the UnitedHealthcare Community Plan provider network, use the following steps:

Register with AHCCCS before the credentialing process. Register with the same specialty and demographic information you will provide when starting the credentialing process. Be aware that you are not reimbursed for any AHCCCS-covered services unless you are an active AHCCCS-registered care provider.

For information on becoming an AHCCCS provider, please visit **azahcccs.gov**.

Once you have started the registration process with AHCCCS, you can start the credentialing process with UnitedHealthcare Community Plan. Please review the credentialing section in our Quality Management chapter.

Care Provider Resources

UnitedHealthcare Community Plan manages a comprehensive care provider network of independent practitioners and facilities. The network includes health care professionals such as PCPs, specialists, medical facilities, allied health professionals and ancillary service care providers. UnitedHealthcare Community Plan offers several options to support care providers who need assistance.

SECURE CARE PROVIDER WEBSITE

UnitedHealthcare Community Plan provides a secure portal to network care providers, facilities and medical administrative staff called Link at **UHCprovider.com**. This website offers an innovative suite of online health care management tools, including the ability to view all online transactions for UnitedHealthcare Community Plan members. It can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.

To access Link, the secure care provider website, go to **UHCprovider.com** and either sign in or create a user ID for **Link**. 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 limit.
- 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.
- Access **My Practice Profile** app.
- Search for CPT codes. Type the CPT code in the header search box 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.

LINK

Link is your digital health information connection. Its interface helps you make online interactions and easily use resources. You need an Optum ID to access Link. Sign-in screens help you get one if you don't have one.

Link offers:

- Patient eligibility and benefits
- Claims status
- Claims management
- Claim reconsideration
- Eligibility and benefit center
- Cost-share information/amounts
- Access to **UHCprovider.com**

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 the Provider Services Center will be acknowledged within three business days. You will be notified of resolution within 30 business days. Notification of resolution is the action of notifying you that your issues have been resolved. It states a detailed description of the actions to be taken and when to expect resolution.

- UnitedHealthcare Community Plan Provider Service Call Center (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.

NETWORK MANAGEMENT DEPARTMENT

Within UnitedHealthcare Community Plan, the Network Management Department can help you with your Agreement, credentialing and in-network services. The department has network account managers and provider advocates who are available for visits, contracting, credentialing tax ID changes, and other related issues.

If you need to speak with a network contract manager about credentialing status or contracting, call our **Network Management Phone Team**.

CULTURAL COMPETENCY RESOURCES

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program in accordance with the AHCCCS Cultural Competency, Language Access Plan and Family/Patient Centered Care guidelines. Linguistic and cultural barriers can negatively affect access to health care participation. You must help UnitedHealthcare Community Plan meet this obligation for our members.

This means you must:

- Recruit and support culturally and linguistically diverse representation within governance, leadership and the workforce responsive to the population in the services area.
- Educate staff in culturally and linguistically appropriate policies and practices on an ongoing basis. Care providers with direct care responsibilities must complete mandated Cultural Competency training.

Additional information is available in the AHCCCS Contractors Operations Manual, Chapter 400.

To comply with the Language Access Services (LAS), you must:

- Offer language assistance to individuals who have limited English proficiency (LEP) and/or other communication needs, such as sign language interpreters and American Sign Language-fluent staff, at no cost to them, to facilitate timely access to all health care and services.
- Tell all members that language assistance services are available in their preferred language, verbally and in writing.
- Help ensure the individuals providing language assistance are competent. Avoid using untrained family and friends and/ or minors as interpreters.
- Identify the non-English languages within your service areas to meet those needs.
- Provide easy-to-understand print and multimedia materials as well as signage in the languages commonly used by those in the service area.
- Provide services in a culturally competent manner,

considering members with LEP or reading skills and those with diverse cultural and ethnic backgrounds. This includes those who identify with deaf culture as well as members with visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in different formats as appropriate.

- Help ensure access to qualified oral interpreters and bilingual staff as well as certified sign language interpreters. Care providers must provide oral interpretation, translation, sign language and disability-related services as well as auxiliary aids and alternative formats on request. Oral interpretation and sign language services are provided at no charge to AHCCCS-eligible persons and those determined to have a Serious Mental Illness (SMI).
- Conduct evaluations of the primary non-English languages spoken within the Tribal Regional Behavioral Health Authorities (T/RBHA) Geographical Service Areas (GSAs) and T/RBHA programs that affect cultural competence, access and quality of care.

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** We provide oral interpreter services 24 hours a day, seven days a week to our members free of charge. More than 240 non-English languages and hearing impaired services are available. If a UnitedHealthcare Community Plan member needs Interpreter Services, we prefer care providers use a professional interpreter.
  - To access a professional interpreter, call 877-261-6608.
  - Enter the client ID 244722 for ACC/DD-CRS. Enter client ID 244162 for ALTCS EPD (do not hit #). Press 1 for Spanish and 2 for all other languages.
- Sign Language Interpreter in Tucson/Community Outreach Program for the Deaf (COP). Complete the service request for at **COPDaz.org**
- Valley Center of the Deaf (VCD) 602-267-1921 in Phoenix provides interpretation services for the rest of the state (outside of Tucson)
- Cultural competency in-service through a scheduled office training
- Pocket guide to culturally competent care
- Member Service language capacity
- **Cultural member materials:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

Help ensure applicants for employment, employees and those to whom you provide service are not discriminated against due to race, creed, color, religion, sex, national origin or disability.

You must comply with Federal Regulations and Arizona Revised Statute (A.R.S.) §36-2918, §36-2932, and §36-2957. These mandate that all persons, regardless of race, color, religion, sex, national origin, or political affiliation shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI.

The Division acts in accordance with contractual obligations, state and federal codes and laws, including the Civil Rights Act of 1964 Public Law § 88-352.

CARE PROVIDER PRIVILEGES

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

DIRECT CONNECT

Direct Connect is a free online portal that lets you securely communicate with UnitedHealthcare Community Plan to address credit balances, overpayments and errant claims. This portal has the ability to 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 Link. On-site and online training is available.

Call **888-457-4759** 7 a.m. – 5 p.m. CT Monday – Friday to get started with Direct Correct. Or email **directconnectsupport@optum.com**.

COMPLIANCE

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

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

Absent superseding State (AHCCCS) and/or CMS required guidelines, UnitedHealthcare Community Plan uses MCG, Substance Abuse and Mental Health Services Administration (SAMHSA) clinic criteria, followed by UHG evidence-based, peer reviewed concurrent review criteria. InterQual review criteria or hospital system review criteria are not adopted by UnitedHealthcare and are not acceptable.

How to Contact Us

Topic	Contact	Information
AHCCCS Provider Registration	Customer Service: 800-867-5808 • Maricopa County – 602-417-7670 option 5 • Outside Maricopa County – 800-794-6862 • Out of State – 800-523-0231 **azahcccs.gov**	
Arizona State Immunization Information System (ASIIS) Hotline	602-364-3899 or 877-491-5741	
Behavioral Claim	Provider Call Center: 800-445-1638 **United Behavioral Health** P.O. Box 30760 Salt Lake City, UT 84130-0760	Refer to Chapter 13 for timely filing guidelines. See Chapter 14 for reconsiderations, disputes and appeal information.
Benefits	**UHCprovider.com/benefits** Provider Call Center: 800-445-1638 ALTCS EPD Provider Call Center: 800-293-3740	Confirm a member's benefits and/or prior authorization.
Byram Healthcare (Incontinence Briefs)	866-340-0511 TTY 711	Byram Healthcare is the vendor for incontinence briefs for ALTCS EPD only. Incontinence briefs for members under age 21 are covered for a medical condition. For members over age 21, briefs are covered up to 180 per month. Anything exceeding 180 per month requires evidence of medical necessity. Please refer to **AMPM 310-P**.
Cardiology Prior Authorization	For prior authorization or a current list of CPT codes that require prior authorization, visit **UHCprovider.com/cardiology**. Provider Call Center: 800-445-1638	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Care Management Offices (ALTCS EPD)	Maricopa County (Phoenix): 800-377-2055 Fax: 855-465-3075 Local: 602-255-8913	

Topic	Contact	Information
Chiropractor Care	myoptumhealthphysicalhealth.com	Prior authorization not required for members younger than age 21. Chiropractic care is not covered for members 21 and older, Title XIX members 21 and older or Title XXI members 19 and older, according to AHCCCS Medical Policy Manual, Policy 300-1.
Claims	Use the Link Provider Portal at UHCprovider.com > Contact Us for a complete list of medical and behavioral health claims addresses. ALTCS EPD: 800-293-2740 AHCCCS Complete Care Provider Call Center: 800-445-1638	Submit claims, check claim status and submit reconsiderations through Link.
Claim Corrections, Disputes and Member Appeals	Sign in to UHCprovider.com/claims to access Link, then select the UnitedHealthcare Online app to submit reconsiderations online. Provider Call Center: 800-445-1638 ALTCS EPD Provider Call Center: 800-293-3740 Corrected Claim & Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5290 Kingston, NY 12402-5240 **PROVIDER DISPUTES (ACC/DD-CRS/ ALTCS EPD):** **UnitedHealthcare Community Plan** Provider Claim Disputes 1 East Washington, Suite 900 Phoenix, AZ 85004 **MEMBER GRIEVANCES AND APPEALS:** **Community Plan Member Grievances and Member Appeals** 1 East Washington, Suite 900 Phoenix, AZ 85004	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with. Member appeals include those related to pre-service denials.

Topic	Contact	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access Link, then select the UnitedHealthcare Online app Provider Call Center: 800-445-1638 ALTCS EPD Provider Call Center: 800-293-3740 Refund check mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800 Refunds requested by UnitedHealthcare Community Plan should be sent with a copy of the Overpayment Notification Letter to: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 101760 Atlanta, GA 30392-1760	Ask about claim overpayments.
Compliance	**UnitedHealthcare Community Plan Compliance Office** 1 East Washington, Suite 900 Phoenix, AZ 85004	
Coram CVS	Phone: 480-240-3200 Fax: 480-505-0455 Billing Address: 4601 E Hilton Ave., Suite 105 Phoenix, AZ 85034	Network provider for infusion and enteral services
Crisis Lines	Cochise, Gila, Graham, Greenlee, La Paz, Santa Cruz, Yuma Counties: 866-495-6735 Pima County: 800-796-6762 Maricopa County: 800-631-1314 Apache, Coconino, Mohave, Navajo, Yavapai Counties: 877-765-4090	Any member, regardless of eligibility, may call the crisis lines.

Topic	Contact	Information
Dental	Dental Providers Customer Service, Member Eligibility & Claims Status 855-812-9208 **uhcproviders.com**	Find more benefit information for members 21 years and older in Chapter 300 of the AHCCCS Medical Policy Manual.
DES/DDD Health Care Services	602-771-8080	
Dual Complete (HMO SNP)	877-614-0623 TTY: 800-842-481	
Early and Periodic Screening Diagnosis and Treatment (EPSDT)	Fax: 844-885-8445	
Electronic Data Intake Claim Issues	**ac_edi_ops@uhc.com** 800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues	800-842-1109	Information is also available at **UHCprovider.com/edi**.
Electronic Payments & Statements (EPS)	877-620-6194	
EDI Support Services	800-210-8315	
Eligibility	To access the app, sign in to **UHCprovider.com/eligibility** to access Link, then select the UnitedHealthcare Online app Provider Call Center: 800-445-1638 ALTCS EPD Provider Call Center: 800-293-3740 The AHCCCS website also helps you verify eligibility. Visit **azweb.statemedicaid.us** and follow the prompts to create an account. For technical issues, call AHCCCS Customer Support at 602-417-4451.	Confirm member eligibility.

Topic	Contact	Information
Enterprise Voice Portal	800-445-1638	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud and Abuse	800-455-4521 or 877-401-9430	Notify us of suspected fraud or abuse by a care provider or member.
Healthy First Steps/ Obstetrics (OB) Referral	800-599-5985 Fax: 877-353-6913 UHCCommunityPlan.com > Health Care Professionals > Arizona > Provider Forms > **Pregnancy Notification Form**	Refer OB members. Fax Notice of Pregnancy/OB Risk Assessment Form.
LabCorp for Providers	800-833-3984	LabCorp is the preferred lab provider.
Language Line	Phone: 866-874-3972 On site: 888-225-6056, press 1	Code 244722 for ACC, DD-CRS members. Code 244162 for Long Term Care members. When requesting services over the phone, you do not need an employee ID. Enter 0 to be connected to an interpreter.
Member Services	ACC/DD-CRS: 800-348-4058 ALTCS EPD: 800-293-3740	Assist members with issues or concerns. Available 8 a.m. – 5 p.m. Arizona Time, Monday through Friday.
National Credentialing Center (VETTS line)	877-842-3210 **https://ncc-optum.secure.force.com/rfp/**	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	**nppes.cms.hhs.gov** 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Phone Team	866-574-6088	Ask about contracting and care provider services.
NuMotion	Phoenix: 602-452-4320 Tucson: 520-323-4496	In-network provider for wheelchair services.
NurseLine	866-351-6827	Available 24 hours a day, seven days a week.

Topic	Contact	Information
Online Help Desk	866-842-3278 Press option 1 for **UHCprovider.com** Press 3 for Optum Link	
Optum Support Center	**LinkSupport@optum.com** 855-819-5909	Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.
Pharmacy Services	**UHCprovider.com** 877-305-8952 (OptumRx) Pharmacy Prior Authorization: 800-310-6826 Pharmacy Prior Authorization Fax: 866-940-7328	Prescription Drug List (PDL) information, including updates, is available on **UHCprovider.com**. You will be notified of changes before they take effect. The PDL, Pharmacy Prior Notification Request Form, and PDL Change Request Form are on the website and can be printed or saved. To obtain a print copy of the UnitedHealthcare PDL, contact Provider Services.
Preferred Homecare	800-636-2123 or 480-446-9010 Fax: 866-265-0455	Preferred Homecare is the in-network durable medical equipment provider for UnitedHealthcare Community Plan members.
Prior Authorization/ Notification for Pharmacy	**UHCprovider.com/priorauth** 800-305-0023 Fax: 866-940-7328	Request authorization for medications as required.
Prior Authorization/ Notification of Health Services	**UHCprovider.com/priorauth** ACC/DD-CRS Prior Authorization Department: 866-604-3267 ACC/DD-CRS Prior Authorization Fax: 888-899-1499 • ALTCS EPD: 800-377-2055 • ALTCS EPD Fax: 800-278-2907	Request authorization/notify of the procedures and services outline in the prior authorization/ notification requirements section of this manual. Complete and current list of prior authorizations.
Provider Services	**UHCprovider.com/AZcommunityplan** • ALTCS EPD: 800-293-3740, Fax: 855-465-03075 • ACC/DD-CRS: 800-445-1638	Available 8 a.m. – 5 p.m. Pacific Time, Monday through Friday. ACC/DD-CRS: Available 8 a.m. to 5 p.m. Pacific Time, Monday through Friday.
Quality Management	Email supporting documentation to **apipa_qualityofcare@uhc.com** ALTCS EPD: 800-377-2055	Call the health plan Member Services number on the member's ID card to report quality of care concerns.

Topic	Contact	Information
Radiology Prior Authorization	**UHCprovider.com/priorauth** 866-889-8054	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements. Complete and current list of prior authorizations.
Regional Behavioral Health Authority (RBHA)	Cenpatico Integrated Care (formerly CIC): 888-788-4408 Mercy Integrated Care (formally MMIC): 800-564-5465 Health Choice Integrated Care (formerly HCIC): 800-322-8670	
Tobacco Free Quit Line	800-784-8669	Ask about services for quitting tobacco/smoking.
Transportation	Medical Transportation Brokerage of Arizona (MTBA) 888-700-6822	Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance. Dual Complete/Dual Complete One: 24 Medicare transportation one-way trips to plan approved location every year.
Utilization Management		UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program Arizona State Immunization Program	602-364-3642 602-364-3899 **ArizonaVFC@azdhs.gov** **ASIISHelpDesk@azdhs.gov**	Care providers must participate in the VFC Program administered by the Arizona Health Care Cost Containment System (AHCCCS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with AHCCCS to bill for the administration of the vaccine.

Topic	Contact	Information
Vision Services	**NationwideVision.com**	All eligible members younger than 21 years may self refer to Nationwide Vision for routine vision services. Members younger than 21 years are limited to one diagnostic eye exam in a 12-month period without obtaining prior authorization. Additional exams require prior authorization and should be obtained by the PCP/PCO from Nationwide Vision. For members 21 years and older, diagnosis and/or treatment of refractive errors are not covered unless prescriptive lenses or contacts are the sole prosthetic device.
Website for Arizona Community Plan	**UHCprovider.com/AZcommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

NON-DISCRIMINATION

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

COMMUNICATION BETWEEN CARE PROVIDERS AND MEMBERS

The UnitedHealthcare Community Plan Agreement does not prevent you from advocating on behalf of the members. It does not interfere with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

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

1. Educate members, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.
6. Render covered services to members in an appropriate, timely, cost-effective manner and in accordance with their specific Agreement and AHCCCS requirements.
7. Maintain all licenses, certifications, permits or other prerequisites required by law to provide covered services.
8. Render services to members diagnosed with the Human Immunodeficiency Virus (HIV) or having Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other members
9. Tell all assigned AHCCCS pregnant women of voluntary prenatal HIV testing and the availability of medical counseling. Tell members where they can go for testing.
10. Use the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing controlled medications.
11. Complete required re-enrollment process in compliance with AHCCCS guidelines as stated in 42 CFR 455, Subpart E.
12. When transitioning a member to a new PCP or other network care provider, transfer the member's records within 10 working days of the change. If a member enrolls with a new health plan, share member information according to confidentiality rules.

GRANT/HOUSING FUNDING

The RBHAs will continue to receive and manage all housing funds in their regions. This includes housing

for both individuals designated SMI and members with general mental health or substance use disorders. Additional grant information can be found on the AHCCCS website at **azahcccs.gov** > Resources > Grants. Providers should assist members with necessary resources and how to contact their local RBHAs for more information.

PROVIDE OFFICIAL NOTICE

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

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

You may use the Physician/Provider Demographic Update Fax Form for demographic changes or update NPI information for care providers in your office. This form is located at **UHCprovider.com** > Menu > Find a Care Provider > View More Demographic Information Update Resources > Care Provider Paper Demographic Information Update Form.

You can also update your demographic and practice data information in the My Practice Profile app. Find more information on **UHCprovider.com**.

TRANSITION MEMBER CARE FOLLOWING TERMINATION OF YOUR PARTICIPATION

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

ARRANGE SUBSTITUTE COVERAGE

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers and care professionals.

For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at **UHCprovider.com** > Find Dr.

ADMINISTRATIVE TERMINATIONS FOR INACTIVITY

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

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

CHANGING AN EXISTING TIN OR ADDING A HEALTH CARE PROVIDER

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available at **UHCprovider.com** > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

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

UPDATING YOUR PRACTICE OR FACILITY INFORMATION

You can update your practice information through the My Practice Profile application on **UHCprovider.com**. Go to **UHCprovider.com** > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form. Or submit your change by:

- Completing the Provider Demographic Change Form and faxing it to the appropriate number listed on the bottom of the form.
- Calling our Enterprise Voice Portal.

Also notify AHCCCS about these changes. Details and forms are found on **azahcccs.gov**. Registered AHCCCS care providers may also change their address with AHCCCS using this website.

AFTER-HOURS CARE

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

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

PARTICIPATE IN QUALITY INITIATIVES

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

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 12 for more details on the initiatives.

PROVIDE ACCESS TO YOUR RECORDS

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

PERFORMANCE DATA

You must allow the plan to use care provider performance data.

COMPLY WITH PROTOCOLS

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

You may view protocols at **UHCprovider.com**.

OFFICE HOURS

Provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

PROTECT CONFIDENTIALITY OF MEMBER DATA

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

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

FOLLOW MEDICAL RECORD STANDARDS

Please reference Chapter 11 for Medical Record Standards.

INFORM MEMBERS OF ADVANCE DIRECTIVES

Members have the right to make their own health care decisions. This includes accepting or refusing treatment. They may execute an advance directive at any time. An advance directive is a document in which the member makes rules around their health care decisions if they later cannot make those decisions.

Several types of advance directives are available. You must comply with Arizona state law requirements about advance directives.

Members are not required to have an advance directive. You cannot provide care or otherwise discriminate against a member based on whether they have executed one. Document in a member's medical record whether they have executed or refused to have an advance directive.

If a member has one, keep a copy in their medical record. Or provide a copy to the member's PCP. Do not send a copy of a member's advance directive to UnitedHealthcare Community Plan.

If a member has a complaint about non-compliance with an advance directive requirement, they may file a complaint with the UnitedHealthcare Community Plan medical director, the physician reviewer, and/or the state survey and certification agency as well as with the ADHS Division of Licensing Services.

INFORMED CONSENT

Informed consent is an agreement to receive a service or treatment after the member has been told the associated risks and benefits. It must be obtained from a member or legal guardian prior to delivering services.

The AHCCCS guidelines regarding general and informed consent are available in the Medical Policy Manual, Chapter 300, Policy 320-Q.

In all cases where informed consent is required per Policy 320-Q, informed consent must include at a minimum:

- The member's right to participate in decisions regarding their care, including the right to refuse treatment and to express preferences about future treatment options;
- The information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;
- The risks of the proposed treatment, including side effects and refusing care;
- The alternatives to the proposed treatment, such as those that offer less risk or other adverse effects;
- That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, you must document the member's choice in the medical record;
- The risks involved in revoking informed consent to treatment; and
- A description of clinical indications that might require stopping the proposed treatment.

Review details about documenting informed consent in Chapter 11.

AHCCCS Appointment Standards

For the purpose of this section, "urgent" is defined as an appointment for medically necessary services to prevent deterioration of health following an acute onset of an illness, injury, condition or exacerbation of symptoms. Comply with the following appointment availability standards:

PRIMARY CARE

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: as quickly as the member's condition requires but no later than two business days of request
- Routine care appointment: within 21 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed 45 minutes from the scheduled appointment time, except during emergencies

SPECIALTY CARE

Specialists should arrange appointments for:

- Routine appointment type: within 45 calendar days of request/referral
- Urgent appointments – as quickly as the member's condition requires but no later than 2 business days

DENTAL CARE

Dental providers should arrange appointments for:

- Routine appointments: 45 calendar days of request
- Urgent appointments: as quickly as the member's condition requires but no later than 3 business days

PRENATAL CARE

Prenatal care providers should arrange OB/GYN appointments for:

- First trimester: within 14 calendar days
- Second trimester: within 7 calendar days
- Third trimester: within three days of request

- High-risk: as quickly as the member's health condition requires and no later than 3 business days of identification of high risk

UnitedHealthcare Community Plan periodically conducts surveys to check appointment availability and access standards. All care providers must participate in all activities related to these surveys.

General Behavioral Health Appointment Standards for ACC and ALTCS EPD

Behavioral health care provider appointments:

- Urgent appointments: as quickly as the member's health condition requires but not later than 24 hours
- Routine care:
  - initial assessment within 7 calendar days of referral or request for service
  - first service as quickly as the member's condition requires but no later than 23 calendar days after initial assessment,
  - all subsequent services as quickly as the member's health condition requires but no later than 45 calendar days
- For psychotropic medications:
  - Assess the urgency of the need **immediately**
  - Provide an appointment, if clinically indicated, with a behavioral health medical professional within a time frame that helps ensure the member:
    - Does not run out of needed medications; or
    - Does not decline in their behavioral health condition before starting medication, but no later than 30 calendar days.

BEHAVIORAL HEALTH CARE APPOINTMENT STANDARDS FOR MEMBERS IN LEGAL CUSTODY OF THE DEPARTMENT OF CHILD SAFETY AND ADOPTED CHILDREN

- 72-hour Rapid Response (RR) (or within two hours for an urgent need request) assessment be completed after notice is received that the Department of Child Safety (DCS) has removed the child from the home. The RR assessment includes screening for developmental delays, support to child/ family placement and connection to ongoing services.
- Seven days (or 24 hours for an urgent need) for a behavioral health assessment to be completed by an assigned service provider after an initial referral or a request for ongoing behavioral health service.
- The first appointment must begin within 21 calendar days of the completed behavioral health assessment.
- Ongoing behavioral health services should be provided, at a minimum, once a month for at least six months after the child enters DCS custody, unless services are refused by the guardian or the child is no longer in DCS custody. Services must be provided to:
  - Mitigate and address the child's trauma.
  - Support the child's temporary caretakers.
  - Promote stability and well-being.
  - Address the permanency goal of the child and family.

If a behavioral health service determined medically necessary is not initiated within 21 calendar days, the caregiver must notify AHCCCS Customer Service (602-364-4558 or 800-867-5808 or **DCS@azahcccs.gov**). Then any AHCCCS-registered care provider may be seen for the recommended services.

We coordinate care among the out-of-home placement, foster, adoptive or kinship parents, all care providers, and DCS, as appropriate.

TELEPHONE STANDARD AND REPORTING

In compliance with the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, Policy 435, we adhere to the following telephone performance standards when addressing member and care provider calls:

1. The Average Speed of Answer (ASOA) must be 45 seconds or less.
2. The Monthly Average Abandonment Rate (MAAR) must be 5% or less.
3. The Monthly First Contact Call Resolution Rate (MFCCR) must be 70% or better.
4. The Monthly Average Service Level (MASL) must be 75% or better.

UnitedHealthcare Community Plan will submit quarterly reports to AHCCCS as required by ACOM Chapter 400.

Care Provider Directory

Our online, searchable Provider Directory provides accommodation information for members with physical or cognitive disabilities such as the locations equipment, exam rooms, interior and exterior building accommodations for special needs and special treatment. The directory also lists the care provider's and staff's spoken languages and cultural competency. The icons and their descriptions about accessibility features are in the footer of the directory pages. Additional descriptions are provided online when a feature is selected.

To help keep the information current, you are required to tell us, within five business days, if there are any changes to your ability to accept new patients or any changes in your ability to provide accessible equipment, or accommodations for those members with physical or cognitive disabilities. Providers must update their locations' accessibility information online via My Practice Profile. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

We are required to contact all participating care providers annually and independent physicians every six months. We require you to confirm your information is accurate or provide us with applicable changes.

If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you. If these attempts are unsuccessful, we notify you that if you continue to be non-responsive we will remove you from our care provider directory after 10 business days.

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

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

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

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

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

PROVIDER ATTESTATION:

You must confirm your provider data every quarter. You may do this through Link or by calling Provider Services. If you have received the upgraded My Practice Profile and have editing rights, access Link's My Practice Profile App to make many of the updates required in this section.

Prior Authorization Request

Prior authorization requests may include procedures, services, and/or medication.

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

See Chapter 4 for more information about making or responding to prior authorization requests.

Timeliness Standards for Notifying Members of Test Results

After receiving results, notify members within:

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

Requirements for PCP and Specialists Serving in PCP Role

SPECIALISTS INCLUDE: INTERNAL MEDICINE, PEDIATRICS, OR OBSTETRICIAN/GYNECOLOGY

PCPs are an important partner in the delivery of care. The AHCCCS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a care manager in the UnitedHealthcare Community Plan system by improving

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

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

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

Nurse practitioners may enroll with the state as solo providers, but physician assistants cannot; they must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services** at any time during the month. Customer Service is available 8 a.m. - 5 p.m., Monday through Friday. Instructions for completing the **PCP Change Request Form** are available on UHCprovider.com.

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

You may print a monthly Primary Care Provider Panel Roster by visiting **UHCprovider.com**.

Sign in to **UHCprovider.com** > select the UnitedHealthcare Online application on Link > select **Reports** from the **Tools & Resources**. From the Report Search page, select the **Report Type** (PCP Panel Roster) from the pull-down menu > complete additional fields as required > click on the available report you want to view.

The PCP Panel Roster provides a list of UnitedHealthcare Community Plan members currently assigned to a care provider.

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

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the PCP care management system. They help ensure coverage will include availability of 24 hours a day, seven days a week. During non-office hours, members should have access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) that will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

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

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

Responsibilities of PCPs and Specialists Serving in PCP Role

SPECIALISTS INCLUDE INTERNAL MEDICINE, PEDIATRICS, AND/OR OBSTETRICIAN/GYNECOLOGY

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs.
- Use clinical practice guidelines.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Coordinate member's behavioral health care, the member's needs and services with their behavioral health provider or Regional Behavioral Health Authority (RBHA) system as needed for SMI members remaining with UnitedHealthcare Community Plan for their physical health services.
- Notify UnitedHealthcare Community Plan's Healthy First Steps to initiate a transfer to a Primary Care Obstetrician (PCO). PCOs perform EPSDT services for pregnant members younger than 21.
- Provide preventive health services in accordance with AMPM.
- Take part in the Individual Service Planning (ISP) process with DES/DDD representative, particularly for medically involved DD/ALTCS EPD members.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request within 10 business days. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per Agreement requirements. Purposes include medical record-keeping audits, encounter validation studies, STARS, HEDIS, other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the AHCCCS Appointment Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.
- Educate members about healthy behaviors during pregnancy. This includes proper nutrition and the dangers of lead exposure to mother and child. It also includes avoiding alcohol, tobacco and illegal drugs. Additionally, discuss sexually transmitted infections, the physiology of pregnancy, the process of labor and delivery, breastfeeding, prescription opioid use and postpartum follow-up.
- Report to us or other appropriate authorities any incident, accident and death (IAD) reports. These include abuse, neglect, injury, exploitation, alleged human rights violations, and death in conformance with the AHCCCS Medical Policy Manual, Chapter 900. Submit IAD reports in accordance with requirements established by AHCCCS and as specified in Exhibit-9, Deliverables.
- Inform applicants, members, parents and legal representatives how to file complaints, grievances and appeals as well as request administrative hearings. Also explain expedited reviews.
- Give members, parents and legal representatives information about continuing, reducing or denying services within 30 days of enrollment or changes to the information.
- Document immunization services in the Arizona State Immunization Information System (ASIIS).

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

Behavioral Health Provider Responsibilities

UnitedHealthcare Community Plan and its care provider network create, implement and support trainings to help ensure care providers receive appropriate training, education, and development opportunities. This practice results in:

- A consistent practice that provides voice and empowerment to staff members within your office.
- A qualified, knowledgeable and culturally competent workforce.
- Timely information about initiatives and best practices.
- Services delivered in a manner that results in achievement of the Arizona System Principles as outlined in AMPM Policy 1060.

PCO Responsibilities

- Schedule medically necessary care appointment for enrolled pregnant members to obtain prenatal care.
- Coordinate covered services for members.
- Counsel members and their families about members' medical care needs, including maternity, family planning and advance directives.
- Monitor progress and manage utilization of services to facilitate the return of care to the PCP within 60 days after delivery.
- Schedule time-specific office visits during an uncomplicated pregnancy based upon the recommended standards from the ACOG.
- Care for the member until the first day of the first month following the 60th day after delivery with at least one visit approximately six weeks postpartum.
- Follow reproductive health and wellness guidelines contained within our policies, such as screening members for perinatal and postpartum depression at least once during the pregnancy and then repeated at the postpartum visit. If needed, refer the member to the appropriate behavioral health care provider. The PCO will share health information about lifestyle habits that promote healthy pregnancies, including spacing of births and smoking cessation.
- Screening all pregnant members through the Controlled Substance Prescription Monitoring Program (CSPMP) once a trimester. Provide members receiving opioids with appropriate intervention and counseling, including referrals for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.
- Educate members regarding potential complications and adverse outcomes related to non-medically indicated cesarean sections and elective inductions prior to 39 weeks gestation.
- Refer members for support services to the Special Supplemental Nutrition Program of Women, Infants and Children (WIC), as well as other community-based resources to support health pregnancy outcomes. Learn more on **UHCprovider.com** in the Bulletin section, which provides free or low-cost primary, family planning, mental and dental health services to people without health insurance in Arizona.
- Upon the member's first prenatal office visit, fax the OB clinical record as a referral to the Healthy First Steps Program. Referrals can be made by faxing any of the following forms to 877-353-6913.
  - **ACOG Prenatal Form** pages 1 and 2. (Sign in to access the required forms.)
  - Other prenatal forms that document past and present medical, psychosocial and obstetrical history
- Follow our global billing guidelines for obstetrical services, found on **UHCprovider.com** in the Policies and Clinical Guidelines section.

Perinatology Referrals

A PCO or PCP may refer a member to a participating perinatologist when identifying a high-risk need. The PCO or PCP may transfer the member's care to a perinatologist by calling Provider Services.

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

Primary Care Provider Checklist

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

- Verify eligibility using PCP/PCO member roster, IVR, Emdeon, **AHCCCS Online**, or Link at **UHCprovider.com/eligibility** or by calling Provider Services. See also AHCCCS **Fee-For-Service Provider Manual, Chapter 2** for eligibility.
- Verify member identity with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth** to locate and view the current prior authorization information and notification requirements.
- Refer to UnitedHealthcare Community Plan participating specialists unless we authorize otherwise.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form. (DD/ALTCS EPD members do not pay copayments for services as indicated on their ID card unless they have primary insurance.) See Chapter 13 for more information on submitting forms.

Specialist Care Providers Responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care according to timely guidelines.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the AHCCCS Appointment Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

Prenatal Care Responsibilities

Pregnant UnitedHealthcare Community Plan members should only receive care from UnitedHealthcare Community Plan participating providers.

Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. This helps ensure appropriate follow-up and coordination by the **UnitedHealthcare Healthy First Steps** coordinator.

If you have questions, call **Healthy First Steps**. To begin patient outreach, fax the prenatal assessment form to 877-353-6913.

An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory. Care providers must ensure all pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP)

once per trimester. For members receiving opioids, appropriate intervention and counseling must be provided. This includes referring them for behavioral health services for assessment and treatment.

Licensed Midwife Services

We cover maternity care and coordination services provided by participating licensed midwifes. The members must have an uncomplicated prenatal course and an expected low-risk labor and delivery and must meet eligibility and medical criteria specified in the AMPM, Chapter 400, Policy 410.

Risk status must initially be determined during the first visit and 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 (MICA). A new risk assessment must be completed if a new complication or concern is identified. Refer to a qualified care provider 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 an action plan in case of complications, including the name and address of an AHCCCS-registered physician and nearby acute care hospital in close proximity to the planned location of labor and delivery for referral, in the even that complications should arise. The licensed midwife must notify us or the AHCCCS Newborn Reporting Line of the birth no later than one day from the date of birth to enroll the newborn with AHCCCS.

Ancillary Care Provider Responsibilities

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

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

Ancillary Care Provider Checklist

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

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

Chapter 3: Care Provider Office Procedures and Member Benefits

Assignment to PCP Panel Roster

Once a member is assigned a PCP, view the panel rosters electronically on the **UHCprovider.com** application on Link. The portal requires a unique user name and password combination to gain access.

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, it is removed from auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

Sign in to **UHCprovider.com** > select Link > select Reports from the Tools & Resources. From the Report Search page, select the Report Type (PCP Panel Roster) from the pull-down menu > complete additional fields as required > click on the available report you want to view.

Choosing a Primary Care Provider

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

- Member Request – All members are asked to choose who they want as a PCP. If the member identifies a PCP, UnitedHealthcare Community Plan will assign that enrollee to the requested PCP.
- Auto-Assignment – If a member does not choose a PCP within 10 days, the member will be auto-assigned to a PCP accepting new patients in the member's geographical area.
- Re-enrollments – Members that lost their AHCCCS eligibility and have become eligible again will be reassigned to the previous PCP unless the member requests a different PCP at the time of re-enrollment.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family medicine, general practice, internal medicine, pediatrics, gynecology and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Medically Necessary Service

UnitedHealthcare Community Plan only pays for medically necessary services.

MEDICALLY NECESSARY DEFINITION

Medically necessary health care services or supplies are medically appropriate and:

- Necessary to meet members' basic health needs.
- Cost-efficient and appropriate for the covered services.

Member Assignment

ASSIGNMENT TO UNITEDHEALTHCARE COMMUNITY PLAN

The AHCCCS assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. We are also responsible during Prior Period Coverage (PPC) to pay for any medically necessary covered service for which a member may be eligible. Prior Quarter Coverage (PQC) is provided by AHCCCS, not UnitedHealthcare Community Plan. AHCCCS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

At enrollment time, members can request a Member Handbook by calling Member Services at 800-348-4058. They can also find a copy at **UHCCommunityPlan.com**. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Members may select a participating PCP when more than one is available in the member's service area. Provider Services maintains a current list of all participating PCPs by service area.

If a member asks UnitedHealthcare Community Plan to change their PCP at any other time, the change will be made effective on the date of the request.

Members may change their PCP up to three times per year. In addition to the PCP, DD-CRS eligible members may receive services from a specialist who manages care related to their CRS condition.

Obtain copies of the Member Handbook online by contacting **UnitedHealthcare Community Plan Provider Services**.

IMMEDIATE ENROLLMENT CHANGES:

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

Get eligibility information by calling the **Medicaid Inquiry line**.

UNBORN/NEWBORN ENROLLMENT CHANGES:

Encourage your members to notify AHCCCS when they know they are expecting. AHCCCS notifies Managed Care Organizations (MCOs) daily of an unborn child when AHCCCS learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the Arizona website to report the baby's birth. With that information, AHCCCS verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify AHCCCS when the baby is born. When the newborn's mother is eligible and enrolled with an AHCCCS Health Plan, the newborn is enrolled in the same plan as the mother.

Members may call the AHCCCS Beneficiary Support Specialist at **602-417-7100**.

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

PCP SELECTION:

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

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

Removing Members From a Roster

A PCP may wish to have a member removed from the roster because the member is non-compliant or disruptive. The PCP must inform the member in writing of their removal from the panel. Remain available to assist with medical care for 30 days from the date of the letter.

1. To transfer the member, forward a copy of the member's notice along with a written request for removal to UnitedHealthcare Community Plan with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name.

   Mailing address:
   UnitedHealthcare Community Plan
   Member Services Department
   1 East Washington, Suite 900
   Phoenix, AZ 85004
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

If a transfer to a behavioral health care provider is recommended, the transition period to the behavioral health care provider or RBHA should take place within 30 days and no later than 90 days.

Member Eligibility

UnitedHealthcare Community Plan serves members enrolled with Arizona's Medicaid program. AHCCCS determines program eligibility. An individual who becomes eligible for the Arizona program either chooses or is assigned to one of the Arizona-contracted health plans.

Member ID Card

Check the member's ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license. AHCCCS has added MVD photos to its online verification tool that you can use to verify a member's eligibility.

If a fraud, waste and abuse event arises from a care provider or a member, notify UnitedHealthcare Community Plan in writing, as discussed in Chapter 12 of this manual. Or you may call the AHCCCS at 602-417-4193 or 888-487-6686. You may also call the **Fraud, Waste, and Abuse Hotline**.

The member's ID card also shows the PCP assignment on the front of the card, except for ALTCS EPD members. Some members with CRS designation might show two PCP assignments, one being the multi-specialty interdisciplinary clinic (MSIC) and one being the PCP. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

MEMBER IDENTIFICATION NUMBERS

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The AHCCCS Medicaid Number is also on the member ID card. See Member ID Card for Billing in Chapter 13, Billing and Submission, of this manual for more information.

Verifying Member Enrollment

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

- Provider Portal: access the Link portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Community Plan Provider Services** is available from 7 a.m. - 5 p.m. Central Time, Monday through Friday.
- **AHCCCS Online**
- ALTCS EPD Provider Service Center 800-293-3740

Benefit Information

UnitedHealthcare Community Plan covers the following services only when medically necessary. All covered

services must be provided by or arranged by the member's PCP. Some services require prior authorization.

For more details, review the AMPM. You may also call Provider Services.

Covered Services for UnitedHealthcare Community Plan Members

UNITEDHEALTHCARE COMMUNITY PLAN MEMBERS ARE OFFERED, BUT NOT LIMITED TO, THE FOLLOWING:

- PCP services
- Immunizations (shots)
  - ALTCS EPD older than 21 years; May receive diphtheria-tetanus, flu, pneumococcal, rubella, measles and hepatitis B immunizations
  - ALTCS EPD younger than 21 years; Refer to EPSDT chapter
- Prescriptions (subject to supply limits, formularies and prior authorization requirements)
- Lab and X-ray
- Radiology and medical imaging
- EPSDT services for Medicaid-eligible children younger than 21 years
- Specialist care
- Hospital services
- Emergency care
- Urgent care
- Incontinence briefs (diapers)
- Surgery services
- Physical exams
- Behavioral health services (See Chapter 9 for details)
- Well woman and family planning services
- Maternity care (pregnancy identification, prenatal, termination, labor and delivery, postpartum)
- Dialysis
- Glasses (for children younger than 21 years)
- Vision services/ophthalmology/optometry (for children younger than 21 years)
- Dental treatment and screening (See dental section for limits and restrictions.)
- Audiology services
- Hearing aids and exams (for children younger than 21 years receiving EPSDT services)
- Podiatry services
- Orthotics
- Services related to CRS-qualifying conditions for members with CRS designation
- Services provided at IHS or Tribal Facilities provided to Title XXI American Indian members
- AHCCCS-covered services Indian Health Care Providers (IHCPs) provide to American Indian members
- Chiropractic services (members younger than 21 years and Qualified Medicare Beneficiaries)
- Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention (members 21 years and older)
- End of life care
- Home- and community-based services (HCBS)
- Home health/hospice services
- Metabolic medical foods (members diagnosed with a metabolic condition included under the ADHS Newborn Screening Program)
- Medical equipment, supplies, and prosthetic devices
- Rehabilitation therapy
- Ambulatory surgery
- Anti-Hemophilic agents and related Services (treatment of hemophilia and von Wilebrand's disease)
- Nutritional assessments therapy
- Post-stabilization care services
- Respiratory therapy
- Substance abuse transitional facility (members older than 18 years)
- Organs and tissue transplant services and related immunosuppressant medications
- -riage/screening and evaluation of emergency medical conditions
- Treat and refer services

Non-Covered Benefits for Members Older Than 21 Years

UnitedHealthcare Community Plan, under the direction of AHCCCS, will not pay for certain medical care for anyone who is 21 years or older. These services include:

- Vision exam/prescriptive lenses (excluding emergency medical services)
- Bone-anchored hearing aids and cochlear implants
- Hearing aids
- Insulin pumps
- Percussive vests
- Any transplant deemed not medically necessary or does not meet the coverage criteria outlined in the AMPM, Chapter 300
- Outpatient speech therapy (excluding ALTCS EPD members)
- TMJ treatment (except for reduction of trauma)
- Microprocessor – controlled lower limbs and joints for lower limbs
- Medical marijuana, or an office visit/other service that is primarily for the purpose of determined if a member will benefit from medical marijuana

UnitedHealthcare Community Plan Developmentally Disabled (DD/ALTCS EPD) Members

The listed covered services are also available for Developmentally Disabled (DD/ALTCS EPD) members. Additionally available are:

- Adaptive aids
- Hospice care
- Specific prescriptions and over-the-counter medicines to meet special needs
- Certain specialized durable medical equipment (DME) approved by us
- Therapy (PT) – PT has a maximum of 30 visits per benefit year for members older than 21 years

DD/ALTCS EPD members have other services available to them outside the health plan. If your patient needs these services, please review the Developmentally Disabled Program Prior Authorization Criteria located on **UHCprovider.com** in the Prior Authorization and Notification section, or call 602-771-8080.

SERVICES PROVIDED BY DDD (NON-HEALTH PLAN-RELATED):

- Attendant care - assists with daily living
- Day treatment and training - services to promote independent living, self-care, communication and social relationships
- Employment support services – provided assistance in a job setting
- Home health aide/nursing - long-term care nursing, after acute benefit has been exhausted
- Respite care – certified caregiver to care for member while caregiver is away
- Group home or skilled nursing facility - provides long-term housing

Qualified Medicare Beneficiary Members

The previously listed covered services for all our members are also available for Qualified Medicare Beneficiary (QMB) members with the following additions:

- Respite services
- Chiropractic services
- Outpatient occupational therapy
- Any service covered by Medicare but not by AHCCCS

Durable Medical Equipment

UnitedHealthcare Community Plan's DME provider is Preferred Homecare. You can request authorization for incontinence briefs by calling Preferred Homecare at 800-636-2123 or 480-446-9010. For ALTCS EPD members, call Byram Healthcare at 866-340-0511. The following information should be included with authorization requests:

- Member's age
- Number of briefs to be provided in a 30-day period
- Diagnosis
- Any other pertinent information

Preferred Homecare will review the request with UnitedHealthcare Community Plan and provide generic-brand disposable incontinence briefs.

PREFERRED HOMECARE

Preferred Homecare provides the following DME and medical supplies:

- Covered medical supplies
- Oxygen and respiratory equipment
- Hospital beds
- Continuous positive pressure and bi-level positive airway pressure units
- Small volume nebulizers

To request services, call 800-636-2123 or 480-446-9010. Fax your order to 866-265-0455. To find a nearby Preferred Homecare location, visit **preferredhomecare.com**.

CORAM CVS

Coram CVS is a network provider for infusion and enteral services. Contact Coram CVS by phone at 480-240-3200 or fax at 480-505-0455.

NUMOTION

To request wheelchair services from Numotion, please call one of the following locations:

- Phoenix: 602-452-4320
- Tucson: 520-323-4496

UnitedHealthcare Dual Complete (HMO SNP)

For information about UnitedHealthcare Dual Complete, please see Chapter 4 of the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products. For state-specific information, go to **UHCprovider.com** > Menu > Health Plans by State.

Chapter 4: Medical Management

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

Ambulance Services

AIR AMBULANCE

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

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

EMERGENCY AMBULANCE TRANSPORTATION

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

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

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

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

According to the AHCCCS Fee-For-Service Provider Manual, **Chapter 5** and **Chapter 14**, you must abide by the following rules for non-emergent ambulance and transportation to be covered:

- You must submit original and destination modifiers for emergency and non-emergent transportation procedure codes.
- You cannot submit diagnosis code R68.89 (other general symptoms and signs), as it is not acceptable nor a valid diagnosis.
- If you submit a corrected claim, you must document the proper frequency code and original claim number in box 22 of paper claim submissions or loop 2300 of an electronic submission. This is outlined in this manual's corrected claim section.

For non-urgent appointments, members must call for transportation at least three days before their appointment. Call Medical Transportation Brokerage of Arizona (MTBA) at **888-700-6822**.

Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. They must be billed by the ambulance provider. This includes transporting the member to another facility for services (e.g., diagnostic testing) and returning them to the first hospital for more inpatient care.

Make urgent non-emergency trips, such as when a member is sent home from the hospital, through our Member Call Center after 7 p.m. Central Time (CT). Schedule rides up to 30 days in advance.

Members must call between 6 a.m. – 7 p.m. Arizona Time, Monday through Friday, to schedule transportation. If they have questions about their order, they may call **888-700-6822** or **602-889-1777**.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop.
- Has an appointment less than half a mile from the bus stop.

Emergency/Urgent Care Services

Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. An emergency is a medical condition that could cause serious health problems or even death if not treated immediately. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fever, cough and colds, and sore throats.

Covered services include:

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

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

EMERGENCY ROOM CARE

For an emergency, the member should seek immediate care at the closest emergency room (ER). If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an emergency room should be screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable. If UnitedHealthcare Community Plan does not respond within one hour or cannot be reached, or if the health plan and attending care provider do not agree on the member's care, UnitedHealthcare Community Plan lets the treating care provider talk with the health plan's medical director. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. UnitedHealthcare Community Plan and the treating care provider reach an agreement about the member's care.
4. The member is released.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services. Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

URGENT CARE (NON-EMERGENT)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services**.

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services.

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

Emergency care should be delivered without delay. Notify UnitedHealth Community Plan about admission. Call the **Prior Authorization Department** or **fax** your Prior Authorization Form by 5 p.m. the next business day. (The form is located at **UHCprovider.com/priorauth**.)

UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria, excluding InterQual

guidelines for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials.

The criteria are available in writing upon request or by calling the **Prior Authorization Department**.

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

End of Life Care Responsibilities

End of Life (EOL) care allows members to receive Advance Care Planning, palliative care, supportive care and hospice services. Members who receive EOL care may receive curative care until they choose to receive hospice care. To be in compliance with AMPM 310-HH, members younger than 21 years may receive curative care with EOL care and hospice care.

Participating PCPs and specialists should perform the following services when caring for members with a chronic or terminal illness.

ADVANCE CARE PLANNING

Have a face-to-face discussion with the member and persons designated by the member when conducting Advance Care Planning. This includes:

1. Teaching them about the member's illness and the care options available;
2. Identifying the member's care, social, psychological and spiritual needs;
3. Developing a written member-centered care plan that identifies the member's choices for care and treatment;
4. Sharing the member's wishes with family, friends, and their care providers;
5. Completing advance directives. Refer to AMPM Policy 640.

PALLIATIVE CARE

Help ensure members of any age with serious, chronic, or complex illnesses receive appropriate, medically necessary, member-centered palliative care in addition to treatment. Palliative care includes:

1. Improved pain management
2. Behavioral health services
3. Supportive care
   a. Coordination of natural supports
   b. Referrals to meet the member and family's social needs
   c. Referrals to the appropriate community resources for spiritual needs

Family Planning

Family planning services are covered when provided to members who choose to delay or prevent pregnancy. They include delivering information and counseling to help members make informed decisions about specified family planning methods available.

Care providers with members of reproductive age must document in the medical record that they have notified the member, either verbally or in writing, of the family planning services available. Enrolled members who are eligible to receive full health care coverage may receive family planning services. These medical, surgical, pharmacological and laboratory services include:

- Contraceptive counseling, medication and supplies. These include oral and injectable contraceptives, diaphragms, condoms, foams and suppositories and Long-Acting Reversible Contraceptives, sub-dermal implantable contraceptives and intrauterine devices. For more information about LARCs, see the Arizona DRG Payment Policies on **azahcccs.gov**.
- Counseling prior to insertion of LARC to minimize the likelihood of a request for early removal.
- Associated medical and laboratory examinations, including related ultrasound studies.
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Natural family planning education or referral to qualified health professionals.
- Emergency oral contraception within 72 hours after unprotected sexual intercourse. (Mifepristone, also known as Mifeprex or RU 486, is not postcoital emergency oral contraception.)
- Hysteroscopic Tubal Sterilization (Essure, procedure code 58565).

- Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. The procedure becomes effective three months following insertion.
- At the end of the three months, a hysterosalpingogram is performed. After the confirmatory test, the member is considered sterile. 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 following family planning services are not covered:

- Infertility services, including diagnostic testing, treatment services or reversal of surgically induced infertility.
- Pregnancy terminations except as specified in AMPM Policy 410 (including Mifepristone [Mifeprex or RU 486]).
- Pregnancy termination counseling.
- Hysterectomies for the purpose of sterilization. (Refer to AMPM Policy 310-L for hysterectomy coverage requirements.)

PARENTING/CHILDBIRTH EDUCATION PROGRAMS

- Childbirth education is covered.
- Parenting education is not covered.

VOLUNTARY STERILIZATION

In-network treatment with consent is covered. The member needs to give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent for:

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHHS Regulations for more information on sterilization.

Hearing Services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization and a certificate of terminal illness (COTI).

HOME HOSPICE

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice and not receiving continuous home care. We cover care provider hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

RESPITE HOSPICE

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to five days per month. This includes the day of admission but not the day of discharge.

INPATIENT HOSPICE

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. UnitedHealthcare Community Plan covers residential inpatient hospice services. UnitedHealthcare Community Plan will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory, X-rays, Imaging Procedures

ADVANCED OUTPATIENT IMAGING PROCEDURES

Advanced outpatient imaging procedures must be prior authorized by UnitedHealthcare Community Plan Clinical.

To get prior authorization, go to **UHCprovider.com/priorauth** > click on the Radiology tab > Online Portal link. Or contact Optum at **providerexpress.com**.

LAB SERVICES

LabCorp is the preferred lab provider. Contact **LabCorp** directly.

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

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

See the Billing and Encounters chapter for more information.

You can also prevent claims from being denied by referring members to a network lab and diagnostic services providers as well as obtaining appropriate prior authorization. Emergent laboratory services, coupled with same-day procedures, will not deny.

Bill these CPT codes in the following places of service:

- POS 11 (Office)
- POS 20 (Urgent Care)
- POS 49 (independent clinic)
- POS 50 (FQHC)
- POS 53 (mental health clinic)
- POS 54 (intermediate care facility)
- POS 71/72 (rural health clinic)

CPTs Codes			
81000	85014	87880	Q0091
81002	86490	89190	Q0111
82270	86580	36415	S3620
84030	87210	36416	
85013	87804	99000	

GENETIC TESTING PROVISIONS

Genetic testing is only covered when the results of such testing are necessary to determine treatment. It is not covered when used to determine:

- A diagnosis or syndrome when such diagnoses would not alter the member's treatment.
- The likelihood of future associated medical conditions.
- Current or future family planning.
- Whether a member carries a hereditary predisposition to cancer or other diseases.

Testing for medical conditions (e.g., renal disease, hepatic disease) that may be associated with an underlying genetic condition is covered when medically necessary.

Maternity/Pregnancy/ Well-Child Care

PREGNANCY/MATERNITY

Bill the initial pregnancy visit as a separate office visit.

You may bill global days if the mother has been a UnitedHealthcare Community Plan member for three or more consecutive months or had seven or more prenatal visits.

For more information about global days, go to **UHCprovider.com**.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

1. the woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and

2. if she has an established relationship with a non-participating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care. Care providers should call **866-604-3267** to obtain prior approval for continuity of care.

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

To notify UnitedHealthcare Community Plan of pregnancies, call Healthy First Steps at **800-599-5985** or fax the notification to **877-353-6913**.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for ob-gyn care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

MATERNITY ADMISSIONS

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review.

If the UnitedHealthcare Community Plan member is inpatient longer than the federal requirements, a prior notification is needed. Please go to **UHCprovider.com/priorauth** or call the **Prior Authorization Department**.

To notify UnitedHealthcare Community Plan of deliveries, call **866-604-3267** or fax to **800-897-8317**. Provide the following information within one business day of the admission:

- Date of admission.
- Member's name and Medicaid ID number.
- Obstetrician's name, phone number, care provider ID.
- Facility name (care provider ID).
- Vaginal or cesarean delivery.

If available at time of notification, provide the following birth data:

- Date of delivery.
- Gender.
- Birth weight.
- Gestational age.
- Baby name.

POST MATERNITY CARE

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. The attending care provider decides the location and post-discharge visit schedule. Prior authorization is required for home health care visits for postpartum follow-up. Post-discharge home care consists of a minimum of two visits, at least one in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date.

NEWBORN ENROLLMENT

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members.

If the mother delivers out of state, the member would need to contact the Enrollment Department to provide birth notification. The Enrollment Department would then add the baby to the health plan.

The hospital provides enrollment support by providing required birth data during admission.

HOME CARE AND ALL PRIOR AUTHORIZATION SERVICES

The discharge planner ordering home care should call the **Prior Authorization Department** to arrange for home care.

Medically necessary home uterine monitoring technology is covered for members with premature labor contractions before 35 weeks gestation as an alternative to hospitalization. Please refer to the AHCCCS Medical Policy Manual Policy 410 for more information.

HYSTERECTOMIES

Hysterectomies cannot be reimbursed if performed for sterilization. Members who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The member should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility.

Find the form on the **AHCCCS Medical Policy Manual, Chapter 800**.

Exception: AHCCCS does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgment was not possible. Include a description of the emergency.

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member's ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

PREGNANCY TERMINATION SERVICES

We cover pregnancy termination in the following cases:

- The pregnant member suffers from a physical disorder, injury or illness. This includes a life-endangering condition caused by or arising from the pregnancy. This condition would, as certified by a physician, place a 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 continuing the pregnancy could be pose a serious physical or mental health problem for the pregnancy member by:
  - Creating a physical or mental health problem for the pregnant member or 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. The attending physician must acknowledge that a pregnancy termination is medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. The certificate must certify that, in the physicians' judgment, one or more of the above criteria have been met. Other required documentation includes:
- The care provider must get written informed consent keep it in the member's chart for all pregnancy terminations. If the pregnant member is younger than 18 years, or is 18 years or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101), we require a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure.
- When the pregnancy is the result of rape or incest, you must get documentation 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. This documentation requirement must be waived if the treating care provider certifies the member was unable, for physical or psychological reasons, to comply with the requirement.

Except in cases of medical emergencies, you must get prior authorization for all covered pregnancy terminations from the UnitedHealthcare Community Plan medical director or designee. A completed Certificate of Necessity for Pregnancy Termination and Verification of Diagnosis by Contractor for Pregnancy Termination Requests must be submitted with the prior authorization request. The certificates are on **azahcccs.gov** in the AHCCCS Medical Policy Manual, Chapter 400, Exhibit 410-4 and 410-5.

In cases of medical emergencies, you must submit all documentation of medical necessity to UnitedHealthcare Community Plan within two working days of the date the termination was performed.

STERILIZATION AND HYSTERECTOMY PROCEDURES

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, UnitedHealthcare Community Plan must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the AHCCCS Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

The member must not be mentally incompetent or live in a facility treating mental disorders. The member may agree to sterilization at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since signing the consent form. However, in the case of premature delivery, they must have signed the form at least 30 days before the expected delivery date. If the requirements are not met for both sterilization procedures and hysterectomies, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital.

STERILIZATION INFORMED CONSENT

A member has only given informed consent if the **AHCCCS Consent Form** for sterilization is properly filled out. Make sure the member **is provided a thorough explanation of** the procedure, other family planning options **and confirm they** understand sterilizations **are irreversible**. Informed consent is an agreement to receive services before they occur after receiving all information regarding the associated risks and benefits. Other consent forms do not replace the Medical Assistance Consent Form. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

STERILIZATION CONSENT FORM

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. AHCCCS cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

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

Have three copies of the consent form:

1. For the member.
2. To submit with the Request for Payment form.
3. For your records.

Neonatal Resource Services (NICU Care Management)

Our Neonatal Resource Services program manages inpatient and post-discharge NICU cases to improve outcomes and lower costs. Our dedicated team of NICU nurse care managers, social workers and medical directors offer both clinical care and psychological services.

NEONATAL RESOURCE SERVICES

The Neonatal Resource Services (NRS) program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth (including babies who are transferred from PICU) and/or any infants readmitted within their first 30 days of life and previously managed in the NICU. All babies brought to the NICU are followed by NRS.

NRS neonatologists and NICU nurses manage NICU members through evidence-based medicine and care plan use.

The NRS nurse care manager will:

- Work with the family, the care providers, and the facility discharge planner to help ensure timely discharge and service delivery.
- Develop care management strategies and interventions based on infant and family needs.
- Coordinate services prior to discharge and after discharge if the member is under NRS care management.

The NRS nurse care manager's role includes:

- Planning and arranging the discharge.
- Coordinating care options and prior authorization, including home care, equipment and skilled nursing.
- Arranging post-discharge support for a minimum of 30 days and up to 15 months based on infant ongoing acuity
- Educating parents and families about available local resources and support services.
- Coordination with the Whole Person Care Team for additional care management needs and services.

Care managers provide benefit solutions to help families get the right services for the baby.

Radiology Prior Authorization Program

We use a Radiology Prior Authorization Program to improve compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain a prior authorization before ordering CT scans, MRIs, MRAs, PET scans, nuclear medicine and nuclear cardiology studies in an office or outpatient setting.

The following images do not require prior authorization:

- Ordered through ER visit.
- While in an observation unit.
- When performed at an urgent care facility.
- During an inpatient stay.

Not getting this prior authorization approval results in an administrative denial. Claims denied for this reason may not be balance-billed.

To get or verify prior authorization:

- Online: **UHCprovider.com/priorauth** > Radiology > Online Portal link.
- Phone: **866-889-8054** from 8 a.m. - 5 p.m. Central Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code. Each authorization number is CPT-code specific.

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, use Link through **UHCprovider.com** or use the search option at **UHCprovider.com**.

Screening, Brief Interventions, and Referral to Treatment (SBIRT) Services

SBIRT Services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed health care professional within the scope of their practice.
- Determining risk factors related to alcohol and other substance use/abuse disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.

For more information about billing SBIRT services, see the AHCCCS Behavioral Health Covered Guide at **azahcccs.gov**.

WHAT IS INCLUDED IN SBIRT?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other substance use problems and determine how severe those problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention: If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment: Refer members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder.

SBIRT services will be covered when all of the following are met:

- The provider is AHCCCS certified.
- The billing provider has an appropriate taxonomy to bill for SBIRT

The SBIRT assessment, intervention, or treatment takes places in an AHCCCS-allowed place of service.

For more information about SBIRT services and outreach, see the AHCCCS Behavioral Health Covered Guide at **azahcccs.gov**.

Pharmacy – Preferred Drug List

The UnitedHealthcare Medicaid Preferred Drug List (PDL) helps you select medically appropriate, high-quality and cost-effective drugs for members. The PDL applies only to prescription medications dispensed by participating

pharmacies to outpatient members. The PDL is organized by therapeutic class.

You must prescribe and encourage the use of generic drugs on the PDL whenever appropriate. If a non-preferred medication is required for a member's treatment, call the Pharmacy Prior Authorization Department at 800-310-6826 or fax a Pharmacy Prior Authorization Request form to 866-940-7328.

PDL information, including updates, is available on **UHCprovider.com**. You will be notified of changes before they take effect. The PDL, Pharmacy Prior Notification Request Form, and PDL Change Request Form can all be printed or saved. To obtain a print copy of the PDL, contact Provider Services.

Review the AHCCCS Drug List and the AHCCCS Behavioral Health Drug List on **azahcccs.gov** under Resources > Pharmacy.

E-Prescribing

With e-prescribing, you can electronically transmit new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescriptions. E-prescribing can improve members' health and financial well-being by helping them avoid preventable medication errors and optimizing their prescription drug benefits.

Members experience higher satisfaction rates and health outcomes through:

- Reduced adverse drug events,
- Fewer trips to the pharmacy,
- Lower wait time, and
- Greater accuracy.

The PHI contained in all prescriptions, whether written or electronic, is protected by federal and state laws, including HIPAA.

Specialty Pharmacy Medications

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

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

Specialty pharmacy medications are available through our specialty pharmacy network.

Drugs on the Preferred Drug List (PDL) that are part of this program are identified by a "SP" in the "Requirements and Limits" section of each page.

Pharmacy Controlled Substance Prescription Monitoring Program

The CSPMP lets you view controlled substances dispensed to a member. The report lists the drug, quantity, days supply, prescriber, pharmacy, and payment method (e.g., cash or billed to a third party). The default look-back period is 12 months but can be changed. The database can pull in data from other states, which helps you when seeing a new patient or those near the state borders.

Per Arizona law, before prescribing an opioid analgesic or benzodiazepine controlled substance, you must get a patient utilization report from the monitoring program's central database tracking system showing the member's prescriptions for the previous 12 months. You must get it at the beginning of each new course of treatment and at least quarterly while the member uses that prescription.

Learn more at **arizona.pmpaware.net/login**.

Step Therapy

Step Therapy Drugs are covered if the member's pharmacy history shows this process has been followed. If it does not, the care provider must submit a prior authorization request. The prescriber must submit information explaining why the member cannot use

the required drug first. However, members who have been stabilized on a medication while in service by the behavioral health provider for the treatment of ADHD, anxiety and/or depression will be maintained on that medication when discharged and seeing PCP for medication management. If the PCP identifies a change in the member's condition, they may use step therapy until the member is stabilized again. UnitedHealthcare Community Plan covers the cost of the medication and dose the member had been stabilized on.

Medical Management Guidelines

ADMISSION AUTHORIZATION AND PRIOR AUTHORIZATION GUIDELINES

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional and TIN/NPI.
- ICD-10-CM
- Anticipated date(s) of service.
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable.
- Service setting.
- Facility name and TIN/NPI, when applicable.

For behavioral health prior authorizations, please contact Prior Authorization **800-348-4058** or submit online at **UHCprovider.com**.

Locate the Prior Authorization Fax Request Form at **UHCprovider.com/priorauth**. If you have questions, please call **Prior Authorization Intake**.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt	Within 24 hours of the decision	Within two business days of the decision
Urgent/Expedited Pre-service	Within three days of request receipt	Within three days of the request	Within three days of the request
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within two business days

Medical Claims Review

We help ensure state and federal dollars are appropriately used on behalf of our members. To do so, we perform pre- and postpayment medical claims review.

Medical claims reviewers (MCRs) use medical review criteria to confirm billed services are covered and medically necessary. MCRs evaluate claims for emergency room, transportation, and inpatient and outpatient medical services.

MCRs also help determine if services were provided according to policy, particularly related to medical necessity and emergency services. They also audit appropriateness, utilization, and quality of the service provided.

Appropriate documentation to process a claim is required in the following scenarios:

- Out-of-state care providers' corrected claims — 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, we only consider the Bill type 114.
- All hospitals for inpatient claims that may qualify for outlier payment. Include itemization of charges.
- When unlisted procedures are billed, include 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.
  - Medicaid services:
    - Behavioral health/substance abuse.
    - ER notes.
    - Physician orders, MD, RN, and social work notes.
    - MARS for each day of hospitalization.
    - Discharge orders and/or instructions.
    - Psychiatric evaluation and discharge summary.
    - Cardiology services.
    - Radiological service interpretation.
    - Home health visits.
    - Injectable drugs.
    - Urgent care.
    - Pharmacy supplies.
    - Prosthetics.
    - 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.
    - Elective abortions require a Certificate of Medical Necessity and Operative Report.

Medical policies and coverage determination guidelines can be found at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

Concurrent Review Guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care, behavioral health admissions to psychiatric hospitals, Institution for Mental Diseases (IMD), and ambulatory facilities. Concurrent review nurses perform an on-site facility review or phone review of the services provided in these facilities for medical necessity, bed day limits and appropriateness of the level of care. Absent superseding State (AHCCCS) and/or CMS required guidelines, UnitedHealthcare uses MCG, SAMHSA clinical criteria for primary substance abuse events, followed by UHG evidenced-based, peer-reviewed concurrent review criteria to assist clinicians in making informed decisions in many health care settings. InterQual review criteria or hospital system review criteria are not adopted by UnitedHealthcare and are not acceptable review criteria.

You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

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

CONCURRENT REVIEW DETAILS

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

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

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day).

Determination of Medical Necessity

Medically necessary services or supplies are those necessary to:

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

Determination Process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws.

Evidence-Based Clinical Guidelines

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

Medical and Drug Policies and Coverage Determination Guidelines

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

Referral Guidelines

PCPs must coordinate member referrals for medically necessary services beyond their scope of practice. When possible, direct health plan referrals to participating care providers. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

Participating care providers who do not require PCP coordination are:

- Vision providers
- Dentists

- Radiologists

Female members who self-refer for their well-woman exam and members requesting behavioral health services do not need a referral. However, PCPs must consult with the member's behavioral health care providers about the member's treatment plan. Our behavioral health care coordinators and medical directors are available for consultation regarding the guidelines.

You may receive requests for prescription refill orders, DME orders and referrals for specialty care. When a care manager reaches out to you, respond as quickly as possible.

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

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

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

Reimbursement

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

- Determine if the member is eligible on the date of service by using Link available at **UHCprovider.com**, contacting UnitedHealthcare Community Plan's Provider Services Department, or the Arizona Medicaid Eligibility System.
- Review the **Reimbursement Policies** and Clinical Guidelines.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

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

Second Opinion Benefit

A UnitedHealthcare Community Plan member may obtain a second opinion about a treatment or procedure. Scheduling the appointment for the second opinion should follow the appointment availability standards established by AHCCCS and listed in the AMPM. These standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, services can be provided by a non-network provider if prior authorization is requested and approved. Please refer to Chapter 1 for Prior Authorization contact information.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services Not Covered by UnitedHealthcare Community Plan

The following services are not included in the UnitedHealthcare Community Plan program:

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:

- Prescription drugs.
- Long-term care services in a nursing home.
- Nursing facility services.
- Intermediate care facilities for members with mental disability.
- Home- and community-based waiver services.
- Residential inpatient hospice services.

- Phones and TVs used when in the hospital.
- Personal comfort items used in the hospital such as a barber.
- Sunglasses and photo-gray lenses.
- Ambulances, unless medically necessary.
- Infertility services.

Services Requiring Prior Authorization

UnitedHealthcare Community Plan provides AHCCCS-covered, medically necessary services that meet or exceed the AMPM standards and requirements. You are required to coordinate member care within our care provider network. When possible, direct all health plan member referrals to participating care providers. Referrals outside the network are permitted with prior authorization approval. Noncompliance may result in delay or denial of reimbursement.

Unless another department or unit has been specially designated to authorize a service, prior authorization requests are routed through the Prior Authorization Intake department. Department nurses and medical directors are available 8 a.m. to 5 p.m., local time. Requests can be made by phone, fax or online.

The most frequently used services requiring prior authorization are in our Prior Authorization Lists on **UHCprovider.com**.

Requesting Prior Authorization

Use the following steps to obtain prior authorization:

- Direct requests to UnitedHealthcare Community Plan's Prior Authorization Intake department:
  - Call 866-604-3267.
  - Call Provider Services at 800-445-1638.
  - Call the ALTCS EPD Prior Authorization at 800-377-2055.
  - Verify member eligibility using Link.
  - Complete the prior authorization form, if applicable, available on **UHCprovider.com** and fax to 888-899-1499 or 800-278-2907 for ALTCS/EPD.
  - Identify and bill other carriers as needed.
- All requests require:
  - A valid member ID number.
  - Name of referring care provider.
  - Name of servicing care provider.
  - The current applicable CPT, ICD-10 and HCPCS codes for the services being requested.
  - The designated place of service.

The department documents and evaluates requests. It checks:

- The member is enrolled with the health plan at the time of the request and on each date of service.
- The requested service is a covered benefit.
- The service is medically necessity and appropriate, using national medical review criteria based on AHCCCS program requirements, applicable policies and procedure, contracts and law.
- All rendering care providers, facilities and vendors must be actively registered with AHCCCS.
- The service is being provided by a participating care provider in the appropriate setting.
- All services rendered by a non-participating care provider include supporting documentation.
- Other insurance for coordination of benefits should handle the request first.

Responding to Prior Authorization Requests

The UnitedHealthcare Community Plan Pre-Service Review Team makes determinations and notifies requesters of approval or denial of authorization within the AHCCCS regulatory requirements:

- STANDARD Request (i.e., elective/routine/non-urgent) – A decision and notification is made no later than 14 calendar days following the receipt of the request. This time frame may be extended up to 14 days if the member or care provider requests an extension or if more information is needed and the delay is the member's best interest.
- EXPEDITED Request (i.e., Urgent/STAT) – These requests should ONLY be made when the standard time frame could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. A decision and notification will be made no later than 72 hours following the receipt of the request, with a possible extended up to 14 days if the member or care provider requests an extension or if more information is needed and the delay is in the member's best interest.

Authorization is not a guarantee of payment. Billing guidelines must be met.

Prior Authorization Denials

Denial of authorization requests for medical necessity occurs only after a UnitedHealthcare Community Plan medical director has reviewed the request and determines that the service does not meet criteria. You may speak with a medical director to discuss the decision.

Requests are often denied because they lack supporting medical documentation. If more information is requested and not received within the designated time frame, the request may be denied. You can submit additional medical records after receiving a denial of a service request. We enter a new case into the prior authorization system for review with the supporting documentation.

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

SEEK PRIOR AUTHORIZATION WITHIN THE FOLLOWING TIME FRAMES

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

Utilization Management Guidelines

Call **866-815-5334** to discuss the guidelines and utilization management.

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

UTILIZATION MANAGEMENT (UM) APPEALS

These appeals contest UnitedHealthcare Community Plan's UM decisions. They are appeals of UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. See Appeals in **Chapter 14** for more details.

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

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

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. Find the schedule at **UHCprovider.com** in the General Forms section and in the AHCCCS Medical Policy Manual at **azahcccs.gov**. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; behavioral health screening; and growth and development tracking.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule.

EPSDT Forms and Periodicity Schedules

AHCCCS EPSDT Tracking Forms, which you must use to document all age-specific required information related to EPSDT screenings and visits, are on **UHCprovider.com** in the General Forms section. They are also on **azahcccs.gov** in Appendix B of the AMPM.

The AHCCCS forms may be used. Submit the completed forms to UnitedHealthcare Community Plan at the following address or fax number. A copy of the form must be placed in the member's chart.

Send EPSDT forms to:

UnitedHealthcare Quality Management Attn: EPSDT
1 East Washington, Suite 900
Phoenix, AZ 85004

Fax: 844-236-1507

Development Disability Services and Coordination with Regional Centers

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment. AHCCCS is responsible for a system of diagnosis, counseling, care management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children older than 36 months to adulthood.

Referral – If you determine supportive services would benefit the member, refer the member to DES/DD for approval and assignment of a Regional Center Care Manager who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the Regional Center Interdisciplinary Team. While the Regional Center does not provide overall care management for their clients, they must assure

access to health, developmental, social, and educational services from birth throughout the lifespan of individual who has a developmental disability.

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

Full Screening

Perform a full screen. Include:

- Complete health and developmental history using AHCCCS-approved screening tools (including the Parents' Evaluation of Developmental Status tool obtained from **pedstest.com**; the Ages and Stages Questionnaire (ASQ) tool, obtained from **agesandstages.com**; and the Modified Checklist for Autism in Toddlers (MCHAT), which may be used only as a screening tool by a PCP for members 16 months to 30 months to screen for autism when medically indicated.
- PCP-provided nutritional assessment
- Interval history
- Age-appropriate physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead assessment
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental
- Developmental/behavioral health

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

Following the screening, PCPs may treat behavioral health conditions within their scope of practice. This includes substance use disorders, Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety. All other behavioral health conditions can be directed to an in-network behavioral health provider. When a PCP has started medication management service for a member to treat a behavioral health disorder, and then determines that the member should be transferred to a behavioral health provider (including RBHA, AIHP, or T/RBHA) for evaluation and/or continued medication management services, the PCP must coordinate the transfer of care.

Interperiodic Screens

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

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

PRESCRIPTIVE LENSES AND FRAMES

Prescriptive lenses are provided to correct or improve defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered when provided by an in-network provider, such as Nationwide Vision.

BLOOD LEAD TESTING

Required blood lead screening for children younger than 6 years is based on the child's risk as determined by either the member's ZIP code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

Children living in a targeted high-risk ZIP code:

As identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning, all children must have a

blood lead test at 12 months and 24 months old. Children between 36 months and 72 months old must receive a screening blood lead test if they have not been previously screened.

Children living outside the targeted high-risk ZIP codes:

Children must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months old and then annually through 6 years old), with appropriate follow-up action taken for those determined to be at high risk based on criteria in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

A blood lead test result, equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or finger stick, must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children 6 months through 72 months old to assist in determining risk. Appropriate follow-up must be provided. You must report blood lead levels equal to or greater than10 micrograms of lead per deciliter of whole blood to Arizona Department of Health Services.

ORGAN AND TISSUE TRANSPLANT SERVICE

EPSDT covers medically necessary organ and tissue transplants approved for reimbursement in accordance with respective transplant policies.

NUTRITIONAL ASSESSMENT

We cover the assessment provided by the member's PCP as a part of the EPSDT screening specified in the AHCCCS EPSDT periodicity schedule and on an interperiodic basis as determined necessary by the member's PCP. We also cover nutritional assessments provided by registered dietitian when ordered by the member's PCP. To initiate a referral for a nutritional assessment, the PCP must use the UnitedHealthcare Community Plan referral form. Prior authorization is not required when the PCP orders the assessment.

NUTRITIONAL THERAPY

AHCCCS covers nutritional therapy for EPSDT-eligible members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements or supplement a member's daily nutritional and caloric intake.

ENTERAL NUTRITIONAL THERAPY

Enteral nutrition provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Prior authorization is not required when provided by an in-network provider.

PARENTERAL NUTRITIONAL THERAPY

Parenteral Nutritional Therapy provides nourishment through the venous system to members with severe pathology of the alimentary tract.

Prior authorization is not required when provided by an in-network provider.

COMMERCIAL ORAL SUPPLEMENTAL NUTRITIONAL FEEDINGS

These feedings provide nourishment and increase caloric intake as a supplement to the member's intake of other age-appropriate foods. Prior authorization is required for commercial oral nutritional supplements unless the member is also receiving nutrition through enteral or parenteral feedings. Prior authorization is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

The PCP or attending physician must use Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form. This form must document that the PCP or attending physician has provided nutritional counseling as a part of EPSDT services. The documentation must specify alternatives that were tried to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

ORAL HEALTH SERVICES

A screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination. Depending on the results of the oral health screening, referral to a dentist should be made according to the time frames listed.

Although the AHCCCS EPSDT periodicity schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential

lesions or other conditions requiring assessment and/or treatment by a dental professional.

EPSDT covers the following dental service:

- Emergency dental services including:
  - Treatment for pain, infection, swelling and/or injury
  - Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth
  - General anesthesia or conscious sedation when local anesthesia is contraindicated or when management of the patient requires it.
- Preventative dental services provided as specified in the AHCCCS dental periodicity schedule, including but not limited to:
  - Diagnostic services including comprehensive and periodic examination. Two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months) for members 12 months through 20 years.
  - Radiology services, which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth X-rays, supplemental bitewing X-rays, and occlusal or periapical films as needed.
- Preventive services:
  - Oral prophylaxis performed by a dentist or dental hygienist, which includes instruction in self-care hygiene.
  - Fluoride varnish. PCPs who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visits for member's who are at least 6 months old with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until the member's second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Application of fluoride varnish must be billed in accordance with AHCCCS billing guidelines.

You must provide proof of certification to CAQH to be paid for completing these tools/services. The AHCCCS-recommended training for fluoride varnish application is located at **smilesforlifeoralhealth.org**. It includes:

- Dental sealants on all non-carious permanent first and second molars and second primary molars for members age 16, and
- Space maintainers when posterior primary teeth are lost permanently.

All therapeutic dental services will be covered when they are considered medically necessary but may be subject to prior authorization. Services include but are not limited to:

- Periodontal procedures, scaling/root planning, curettage, gingivectomy, osseous surgery.
- Crowns:
  - Stainless steel crowns may be used for both primary and permanent posterior teeth; composite, plastic or acrylic crowns must be used for anterior primary teeth, or
  - Cast non-precious or semi-precious crowns for members 18 through 20 years on all functional permanent endodontically treated teeth, except third molars.
- Endodontic services including pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar.
- Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 through 20 years and has had endodontic treatment, and
- Removable dental prosthetics, including complete dentures and removable partial dentures
- Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic. Examples of conditions that may require orthodontic treatment including the following:
  - Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services, or
  - Trauma requiring surgical treatment in addition to orthodontic services, or
  - Skeletal discrepancy involving maxillary and/or mandibular structures.

COCHLEAR AND OSSEOINTEGRATED IMPLANTATION

Candidates for cochlear implants must meet medical necessity, including but not limited to the following indications:

- A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation.
- Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT or MRI scan or other appropriate radiologic evaluation.
- No known contraindications to surgery.
- Demonstrated age appropriate cognitive ability to use auditory clues.
- The device must be used in accordance with the FDA- approved labeling.

Cochlear implantation requires prior authorization.

Coverage of medically necessary services for osseointegrated implantation is limited to EPSDT members.

CONSCIOUS SEDATION

AHCCCS covers conscious sedation for members receiving EPSDT services. Coverage is provided for the following procedures except as specified:

- Bone marrow biopsy with needle for trocar
- Bone marrow aspiration
- Intravenous chemotherapy administration, push technique
- Chemotherapy administration into central nervous system by spinal puncture
- Diagnostic lumbar spinal puncture, and
- Therapeutic spinal puncture for drainage of cerebrospinal fluid

Additional applications of conscious sedation for members receiving EPSDT services will be considered on a case-by-case basis. They require review for medical necessity and prior authorization.

BEHAVIORAL HEALTH SERVICES

AHCCCS covers behavioral health services for members eligible for EPSDT services. EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or improve mental illnesses and conditions discovered by the screening services.

CARE MANAGEMENT SERVICES

In EPSDT, care management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

CHIROPRACTIC SERVICES

Chiropractic services are covered when ordered by the member's PCP during an EPSDT visit to members younger than 21 years.

PERSONAL CARE SERVICES

AHCCCS covers personal care services, as appropriate.

INCONTINENCE BRIEFS

Incontinence briefs, including pull-ups, are covered to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:

- The member is older than 3 years and younger than 21.
- The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder.
- The PCP or attending physician has issued a prescription ordering the incontinence briefs.
- Incontinence briefs do not exceed 240 per month unless the prescribing physician presents evidence of medical necessity for more than 240 per month for the member diagnosed with chronic diarrhea or spastic bladder.
- The member obtains incontinence briefs from providers in the UnitedHealthcare Community Plan network.
- Prior authorization has been obtained as required.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES

AHCCCS covers physical therapy, occupational therapy and speech therapy necessary to improve defects and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

BILLING FOR ADDITIONAL SERVICES

Billing for a sick visit (CPT codes 99201-99215) at the same time as an EPSDT is acceptable if:

- An abnormality is encountered or a preexisting problem is addressed while performing an EPSDT service. The problem is significant enough to require additional evaluation and management service (E/M).
- The sick visit is documented on a separate note.
- History, exam, and medical decision-making components of a separate sick visit already performed during the course of an EPSDT visit are not considered when determining the level of the additional service (CPT code 99201-99215).
- The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Arizona Early Intervention Program

The Arizona Early Intervention Program (AzEIP) is a system of professionals working with parents and families of children, from birth to age 3, with developmental delays and/or disabilities. AzEIP provides assistance, encouragement and treatment. It allows early intervention and developmental services to occur in a family's natural environment.

UnitedHealthcare Community Plan works with AzEIP and DD support coordinators, PCPs, servicing care providers (therapists/ facilities) and member families. Together, they help ensure the child has medically eligible services, such as physical therapy, speech therapy and/or occupational therapy, in accordance with EPSDT guidelines. Care providers working with this population will receive an AzEIP Request for EPSDT Services and documentation completed by an AzEIP service coordinator. The AzEIP Request for EPSDT services and documentation is faxed to UnitedHealthcare Community Plan for review and then to the care provider. If the care provider feels the services are medically necessary, the care provider faxes back the request with signature, date and diagnosis codes related to the therapy request. The EPSDT coordinator at UnitedHealthcare Community Plan coordinates prior authorization and notifies the AzEIP service coordinator of approved services.

AZEIP EVALUATIONS FOR AT-RISK MEMBERS (YOUNGER THAN 3 YEARS)

To help ensure our members younger than 3 years who are at risk of developmental delays and/or disabilities receive services appropriate for their specific condition/ situation, we ask you to adhere to the following steps when requesting physical therapy, occupational therapy, or speech/feeding evaluation:

- After completing the evaluation, the servicing care provider submits an Evaluation Report to the PCP.
- If the evaluation indicates that the member scored two standard deviations below the mean, the child continues receiving all medically necessary EPSDT services through UnitedHealthcare Community Plan. Be sure to:
  - Request ongoing therapies through our Prior Authorization department at 866-604-3267, and
  - If you have not already submitted an online referral, please complete one and submit it through AzEIP.
- If the member is in need of non-medically necessary services not covered by Medicaid but are covered under individuals with Disabilities in Education Act (IDEA) Part C, please notify our EPSDT coordinator at 602-255-8196 or 602-255-8108 if you have not previously submitted an AzEIP referral.

Coordination of Therapy Services with DD-CRS Members Enrolled in AzEIP

To help ensure follow-up on EPSDT and AzEIP referrals for DD-CRS enrolled members, we coordinate receipt of care with the MSICs as the member's health home. The CRS coverage type determined the payer for these services:

Category	Criteria
Partially integrated – Behavioral Health	DD Plan of enrollment (which could be UnitedHealthcare Community Plan DD, or other DD Plan)
DD-CRS Only	Primary program of enrollment

We must review and respond to AzEIP referrals within 10 business days. The following process has been developed to meet the AHCCCS requirement:

- An AzEIP service coordinator submits a therapy (OT/PT/ST) request to our coordinator for EPSDT and AzEIP services.
- The coordinator forwards the referral to the DD-CRS liaison to determine if the MSIC can provide therapy.
- The member's liaison provides the MSIC with the Clinical Liaison Communication Log explaining the type of referral, along with the referral from AzEIP.
- The MSIC reviews the referral and responds to the CRS liaison within **7 days** if services will be provided at the MSIC.
- If services will not be provided at the MSIC, the MSIC responds to the liaison. We will authorize treatment to be performed by a participating provider outside the MSIC.
- Our coordinator emails a copy of the authorization to the clinical liaison to be saved to the member record.

Targeted Care Management

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

Identification – The five target populations include:

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

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

Vaccines for Children program (VFC)

EPSDT covers all child and adolescent immunizations as specified in the CDC-recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, maintain, up-to-date immunization status for each EPSDT member.

You must coordinate with the Arizona Department of Health Services Vaccine for Children Program in the delivery of immunization services. The "SL" (SL – state supplied) modifier indicates vaccines administered under the federal Vaccines for Children's (VFC) program and should be coded accordingly on the CMS 1500 claim form.

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

PCPs with members 0-18 years of age assigned to panel must participate in VFC and meet standardized vaccine management requirements related to ordering, storage/handling, and reporting.

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

Contact **VFC** with questions.
Phone: 602-364-3642
Fax: 573-526-5220

You must re-enroll in VFC annually in accordance with AHCCCS contract requirements.

Arizona law requires all immunizations of children 0-18 years of age be reported. Report immunizations given to all children on your panel to the Arizona State Immunization Information system (ASIIS). If you are not enrolled in ASIIS, visit **azdhs.gov**.

All immunizations administered to children younger than 19 years must be reported to ASIIS no less than once a month or within 30 days of immunization administration. You are also encouraged to update member demographic information into ASIIS.

For information regarding ASIIS trainings, visit **azdhs.gov**. You may also call the ASIIS hotline at 602-364-3899 or 877-491-5741. For information on Arizona immunizations, visit **Arizona Partnership for Immunizations**.

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

- Eligible for Medicaid.
- American Indian or Alaska Native, as defined by the Indian Health Services Act.
- Uninsured.
- Underinsured (these children have health insurance but the benefit plan does not cover immunizations.

Chapter 6: Developmentally Disabled Dually Enrolled Children's Rehabilitative Services (DD-CRS)

CRS Coverage Types

DD-CRS-eligible members will be enrolled under one of the following two coverage types depending on the primary program in which they are enrolled for acute care services. Benefits vary between the coverage types, and not all services are covered by both coverage types. DD-CRS members enrolled before age 20 are given a one-time option to remain in CRS after turning 21. AHCCCS will send a letter 60 days before the member's 21st birthday with instructions on how to contact AHCCCS to opt in.

Coverage Type	CRS	Acute	Behavioral Health	Notes
DD-CRS Partially Integrated – Behavioral Health	X		X	DD-CRS members receiving all behavioral health and CRS-related services from the CRS contractor and receiving acute health services from the primary program of enrollment **Coverage: CRS and behavioral health conditions only** (contact Primary AHCCCS Health Plan for other medical services)
CRS Only	X		DD-AI	Members receiving all CRS-related services from the CRS contractor, receiving acute health services from the primary program of enrollment, and receiving behavioral health services from the tribal RBHA

The DD-CRS program enrolls members who require treatment for certain medically disabling or potentially disabling conditions. Enrollment is based upon a member's qualifying condition and the need for active treatment of CRS condition through medical, surgical or therapy modalities.

Multi-Specialty Interdisciplinary Clinic

The MSIC is the DD-CRS member's health home. Upon enrollment, every member is assigned to one of four regionally based MSICs. The MSIC provides accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. We coordinate with the MSIC and the PCP to help ensure an integrated approach to care and the decision-making process.

DD-CRS Medical Records

The MSIC must have an integrated electronic medical record for each member maintained and available for the multi-specialty treatment team and community care providers. An integrated electronic medical record must contain all information necessary to facilitate the coordination and quality of care delivered by multiple care providers in multiple locations at varying times.

All participating care providers must retain medical records. The records must be retained for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the provider, whichever date occurs later, according to state law.

Please see Medical Record chapter for more information.

Telehealth and Telemedicine

This technology is used to deliver care and services directly to the member and to maximize the care provider network. The technology can also be used to enhance communication, increase educational opportunities for members, member's families, staff, and you. AHCCCS AMPM Policy 320-I provides additional information.

SERVICES PROVIDED

Services provided through telemedicine technology may include:

- Outreach clinics.
- Care provider consultation.
- Other professional consultation or services.
- Member, family and professional education, and video conference meetings or trainings.

Covered and Excluded CRS Services

AHCCCS determines eligibility for members who required specialized treatment for medical conditions for which functions can be improved. Long-term follow-up may be required for maximum achievable results. Confirm coverage type and covered benefits before providing services.

DD-CRS Services that Require Prior Authorization

Any service rendered outside the MSIC with a condition listed on the CRS Master Diagnosis List (CRS Condition Only) required prior authorization. The full prior authorization lists as well as the **Master Diagnosis List** are on **UHCprovider.com**. All services given by a non-network care provider require prior authorization and must have supporting documentation. Any service considered experimental or investigational is not covered.

The following directives apply to all CRS prior authorizations:

- The member must be eligible at the time the covered service is rendered.
- Only one service may be requested per Physicians Services Requisition (PSR) form.
- Authorization is not a guarantee of payment.
- ALL rendering providers/facilities/vendors must be actively registered with AHCCCS.

IMPORTANT REMINDERS:

- All services must be covered benefits as outlined by AHCCCS and as defined by AHCCCS for the DD-CRS coverage types. (See table in beginning of this chapter.)
- All prior authorization requests may be submitted by Link, phone or fax.
- Instructions for submitting prior authorization requests online can be found at **UHCprovider.com**.

Audiology Services

We provide covered audiology services to DD-CRS members who are hearing impaired or whose CRS condition poses a risk for hearing impairment. Covered audiology services include:

- Audiologic assessments
  - Audiologic assessments are consistent with accepted standards of audiologic practice.
  - DD-CRS may provide Brainstem Audiology Evoked Response (BAER) evaluations at the request of the physician.
- Hearing aid fittings and evaluations
  - Hearing aids are available and may be checked every year.
  - A hearing aid may be replaced once every three years, unless the member's hearing changes and needs a replacement.
  - Implantable bone conduction devices.
  - Cochlear implants.

EXCLUSIONS AND LIMITATIONS

Accessory items are excluded. Only items necessary for proper functioning and maintenance of the hearing aid are included.

Benefit and coverage guidelines for complete care members as stated in previous chapters pertain to DD-CRS members older than 21 years.

CONTRACTOR REQUIREMENTS

UnitedHealthcare Community Plan will:

- Provide an audiology area with the following:
  - An audiometric testing suite containing at least one sound booth (6' x 6' minimum);
  - Each sound booth will be equipped with two sufficient ohm loud speakers mounted 6' apart at 45 or 90 degrees azimuth; and
  - One two-channel pure-tone (air and bone conduction) audiometer per sound booth. Having masking capabilities and speech capabilities (both for recorded and monitored live voice stimuli) and can generate warble tones and/or narrow band noise stimuli for sound field testing.
  - Dedicated space for a hearing aid laboratory.
- Provide the following audiology equipment/supplies:
  - Speech (recorded and live voice) stimuli test materials.
  - A diagnostic impedance bridge.
  - Materials with capabilities for visual reinforcement and conditioned play.
  - One halogen lamp otoscope with assorted ear tips for each sound booth.
  - One electroacoustic hearing aid analyzer and an assortment of ear mold and hearing aid servicing tools, supplies and equipment.
  - Availability of hearing aids from various manufacturers, to meet the needs of each member.
  - A diagnostic Auditory Brainstem Response (ABR) unit for use on site. Appropriately licensed staff will be provided to administer sedation and monitor members requiring sedation for ABR testing
  - A bed and a quiet room will be available for ABR testing.

Dental and Orthodontia Services

DENTAL

We provide a full range of dental services for members with one of the following diagnosed conditions or circumstances:

- Cleft lip and/or cleft palate
- A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis
- A cardiac condition where the member is at risk for subacute bacterial endocarditis
- Dental complications arising as a result of treatment for a DD-CRS condition
- Documented significant functional malocclusion where malocclusion is defined as functionally impairing a DD-CRS member with a craniofacial anomaly (e.g., hemifacial microsomia, Treacher Collins Syndrome) or when one of the following criteria is present:
  - Masticatory and swallowing abnormalities affect the nutritional status of the individual resulting in growth abnormalities

- The malocclusion induces clinically significant respiratory problems such as dynamic or static airway obstruction
- Serious verbal communication disturbance as determined by a participating speech therapist. Report must indicate the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by the speech therapy alone

ORTHODONTIA SERVICES

Orthodontia services are covered for members with a cleft palate or documented significant functional malocclusion.

EXCLUSIONS AND LIMITATIONS

Dental and orthodontia services may be provided in MSIC clinics. When services are limited or in communities where there is no MSIC clinic, the dental and orthodontia services may be provided at the practitioner's office. Benefit and coverage guidelines for acute members as stated in previous chapters pertain to those DD-CRS members older than 21 years.

Diagnostic Testing and Laboratory Services

DD-CRS contractors provide member access to the following laboratory and diagnostic testing services:

- A full-service laboratory, including blood bank, pulmonary function, micro-processing, testing with STAT capability (including phlebotomy and blood specimen preparation services as well as equipment for performing CBCs and urinalysis).
- A full-service general radiographic unit in or adjacent to the outpatient clinic.
- Special diagnostic testing services including: visual evoked response, CT scan, ultrasound, BAER, magnetic resonance imaging (MRI), electroencephalogram (EEG), electrocardiogram (EKG), and echocardiogram.

EXCLUSIONS AND LIMITATIONS

Diagnostic Testing

Diagnostic testing is a covered service as otherwise stated in this manual. For the purposes of the DD-CRS program, the following exclusions apply.

Laboratory Services

Follow-up laboratory evaluations where discovered laboratory abnormalities unrelated to the CRS condition are excluded. The individual must be referred to their PCP for follow-up care.

For example, an applicant is found to have sickle cell anemia, a CRS condition but is also HIV positive. Follow-up care for the HIV status must be referred to the individual's PCP.

Genetic Diagnostic Testing Provisions

Prior authorization requests must include documentation regarding how the genetic testing is consistent with the genetic testing coverage limitations. Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options.

Genetic testing is not covered under the following conditions:

- To determine diagnoses when they would not alter the member's treatments.
- To determine the likelihood of associated medical conditions occurring in the future. Routine, non-genetic testing for other medical conditions (e.g., renal disease, hepatic disease) that may be associated with an underlying genetic condition is covered when medically necessary.
- As a substitute for ongoing monitoring or testing of potential complications of a suspected genetic anomaly.
- Used for family planning.
- To determine whether a member's family history means they are likely to develop cancer or other diseases.
- To determine whether a member's cancer is due to a genetic mutation known to increase the risks of developing that cancer.

Experimental or investigational testing is not covered, according to AHCCCS guidelines.

Durable Medical Equipment

Medically necessary DME is provided for rehabilitative care directly related to treatment for a DD-CRS condition. Please call Preferred Homecare at 800-636-2123. DME does not require prior authorization unless it is provided by a vendor

other than Preferred Homecare and/or if the cost is more than $500. Locate the **DME, Prosthetics, Orthotics & Supplies Request Form** at UHCprovider.com in the General Forms section.

Equipment repairs are covered when medically necessary. Oxygen therapy is covered when ordered by a care provider for the treatment of a DD-CRS condition.

EXCLUSIONS AND LIMITATIONS

Members are eligible for equipment when they follow up in a medical or surgical MSIC clinic. All equipment is directly related to the care of the DD-CRS condition. Equipment is covered only when an authorized CRS care provider orders it.

Coverage is excluded for equipment used only for school purposes. Oxygen and related supplies are not limited to 30 calendar days if it is for a CRS-related condition.

Coverage is excluded for the following items:

- Cranial modeling bands, except for members who are 24 months or younger who have undergone CRS-approved cranial modeling surgery and show loss after surgical correction. Without intervention, the loss would most likely require additional remodeling surgery
- Mobilizer walker
- Motorized caster carts
- Strollers, except when used as modified seating for positioning

EQUIPMENT MAINTENANCE

DD-CRS pays for necessary equipment modifications due to the member's growth or due to changes in the member's orthopedic or health needs. The care provider, the physical therapist, or occupational therapist will recommend equipment modifications:

- Contractors must have a clause with DME providers providing assurance that if an article is faulty within 60 calendar days of delivery, it will be returned to the contractor's provider to be corrected, adjusted, or replaced at no additional charge.
- A replacement for lost or stolen equipment will be requested through the prior authorization process. If the equipment was stolen, a copy of the police report, verifying the incident, must be submitted to the appropriate MSIC clinic. Lost equipment can be replaced if it has not been replaced within the previous 12 months due to loss.
- A repair can be made to equipment if it was provided by the contractor, or if it was not provided by the contractor and a CRS provider determines it is safe, appropriate and medically necessary.

DD-CRS does not pay for repairs needed because of improper use or neglect.

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices enhance the member's ability to perform activities of daily living. Prosthetic and orthotic devices may be part of the member's complete care benefit or under the DD-CRS program and are covered as outlined in AMPM Policy 430. Coverage and benefits for DD-CRS members depend upon the member's coverage type. Some covered services include:

- Medically necessary prosthetic and orthotic modifications or repairs due to the individual's growth or due to changes in their orthopedic or health needs or when equipment is no longer safe.
- Ocular prostheses and replacements when related to a DD-CRS condition. DD-CRS also provides and replaces ocular prostheses when medically necessary.
- Replacements for lost or stolen prosthetic and orthotic devices should be requested in writing for prior authorization. If the device was stolen, a copy of the police report must be submitted to the appropriate MSIC clinic. A lost device can be replaced if it has not been replaced within the previous 12 months due to loss.

DD-CRS will provide or fabricate orthotic/prosthetic devices that assist DD-CRS members in performing normal living activities and skills.

Accordingly:

- All orthotic/prosthetic devices will be made using high-quality products.
- All orthotics will be completed, modified or repaired and delivered within 15 working days of the order.
- All prosthetics will be completed, modified or repaired and delivered within 20 working days following the order.
- Urgent orthotic/prosthetic repairs will be delivered within five working days.
- Same-day service will be provided for emergency

adjustments for members who cannot complete normal daily activities without the repairs and/or modifications.

DD-CRS will help assure there will be no additional charge for modifications and/or repairs during the normal life expectancy of the device. The exception is when repairs are required to accommodate a documented change in the member's physical size, functional level, or medical condition.

EXCLUSIONS AND LIMITATIONS

- Myoelectric prostheses
- Microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs
- Shoes for prosthesis
- Repair or replacement required due to misuse by the member

Prosthetic and orthotic devices are covered for members 21 years and older if all the following apply. See AMPM Policy 310-P for more information.

- The use of the orthotic is medically necessary as the preferred treatment option and consistent with Medicare guidelines.
- The orthotic is less costly than all other treatment options or surgical procedures to treat the same diagnosed condition, and
- The orthotic is ordered by a PCP or physician.

Wheelchairs and Ambulation Devices

UnitedHealthcare Community Plan's network supplier for wheelchairs and ambulation devices is NuMotion. Call NuMotion at 866-248-4839.

DD-CRS will provide and modify wheelchairs for CRS members as well as provide ambulation assistive devices (crutches, canes, walkers).

DD-CRS will provide wheelchair fittings modifications and repairs within 60 working days from the order date.

DD-CRS will provide final fittings for ambulation assistive/adaptive devices from the date ordered within:

- 20 working days for routine fittings.
- Five working days for urgent repairs.
- Same-day service for emergency adjustments or repairs for members who cannot complete daily activities safely without the repair/adjustments.

DD-CRS covers medically necessary equipment modifications due to member's growth or changes in the member's orthopedic or health needs.

Wheelchairs and ambulation devices are covered when:

- The member's medical condition changes.
- The equipment is no longer safe to operate.
- The member has outgrown the equipment.

Custom-fit stander and parapodiums with click-clacks are covered for braced-walking potential for spinal cord defect patients.

Trays for wheelchairs are provided when documentation shows they are needed to improve function.

EXCLUSIONS AND LIMITATIONS

- Replacement of wheelchairs and ambulation devices when the equipment is functional and can be repaired so the equipment is safe to operate.
- Physical or structural modifications to a home.
- The DD-CRS member's family or guardian is responsible for the care of and transportation of equipment.
- The DD-CRS member and/or their family shows they can safely use all equipment provided to the member. Practical and functional use of equipment will be documented in the member's DD-CRS medical record.
- Wheelchairs and ambulation devices used solely for school purposes
- DD-CRS may repair equipment that, although not provided to the member by DD-CRS, a care provider has determined to be safe and appropriate.
- Wheelchair and ambulation device needs will be met through recycled items if they meet needed specifications.
- Short-term rental wheelchairs and ambulation devices are limited to 30 calendar days. A prior authorization request may be submitted for an extension.

High-Frequency Chest Wall Oscillation Therapy

Criteria for medical necessity include:

- Diagnosis of cystic fibrosis
- Documentation of excessive sputum production combined with the member's inability to clear it on their own.
- Chest X-ray report and pulmonary function tests showing moderate or severe chronic obstructive pulmonary disease (COPD)
- Prescription signed by M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily (or more frequent) chest physiotherapy
- Age 2 years or older or 20-inch chest size, whichever comes first
- Specific documentation supporting why high-frequency chest wall oscillation (HFCWO) therapy is superior to more cost-effective therapy methods, including at least one of the following:
  - Promotes self-care
  - Allows independent living or college attendance
  - Provides stabilization in single adults or emancipated individuals without able partners to assist with CPT
  - Severe end-stage lung disease requiring complex or frequent chest physiotherapy.
- Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy
- Coordination between the care provider's office and AHCCCS or other payer before starting HFCWO therapy for long-term use

DISCONTINUATION CRITERIA FOR HFCWO

- Patient and/or prescribing care provider request
- Patient treatment compliance at a rate of less than 50% usage as prescribed in the medical treatment plan, to be checked at two and six months of usage

HFCWO percussive vest requires prior authorization. All cases will be reviewed individually. Prior authorization requests must be accompanied by specific documentation in the individual's personal medical record that supports medical necessity.

Home Health Care Services

Home health care services include professional nurse visits, therapies, social work services, equipment, and medications for the DD-CRS member.

Pre-hospitalization

Home health care services are limited to pre-hospitalization for a procedure or surgery in lieu of hospitalization to provide total parenteral nutrition.

Post-hospitalization

These services are limited to the post-hospitalization rehabilitative or recovery period or are provided in lieu of hospitalization. The care provider must order services.

Home health care services provided in a member's place of residence include:

- Assessment of home health needs
- IV therapies
- Wound evaluation
- Administration of medications
- Monitoring vital signs
- Monitoring oxygen administration
- Monitoring and assessing patient physical signs
- Teaching and evaluating of therapies
- Enterostomal therapy and teaching
- Catheter insertion, care and teaching
- Instruction regarding home health care to member or caregivers

EXCLUSIONS AND LIMITATIONS

The care provider overseeing the member's DD-CRS care must order home health care services.

Inpatient Services

DD-CRS covers inpatient hospitalizations at participating facilities. The hospitalization is covered when used to treat a DD-CRS condition. Observation services do not require prior authorization.

REQUIREMENTS FOR ADMISSION AND CRS REIMBURSEMENT FOR AN INPATIENT ACUTE CARE STAY

- Only network DD-CRS care providers can admit and treat DD-CRS members for CRS conditions.
- The admitting care provider must obtain prior authorization for all non-emergency hospital CRS-related admissions.
- Prior authorization is not required for an emergency admission related to a DD-CRS condition under the member's specialty care coverage.
- The primary reason for hospitalization must be related to DD-CRS condition.
- DD-CRS does not provide hospitalization for the sole purpose of maintaining the member, i.e., long-term ventilator support, nutritional support.

See AMPM Chapter 300, for Discharge Planning.
DD-CRS will pay for the initial diagnostic evaluation to rule out a ventricular infection or ventricular shunt failure at a participating hospital. The rule-out time frame starts at the time of admission. It ends when the results of the CT scan, MRI, CSF culture, or measurements of ICP are available to the care provider. If the member does not have a shunt infection or failure as described, they must be decertified from payer liability from the point of the neurosurgeon's diagnosis forward. The acute illness and reason for hospitalization then falls under the acute benefits, if applicable.

Growth Hormone Therapy

DD-CRS covers growth hormone therapy only for members with panhypopituitarism.

Nursing Services

NURSING SERVICES INCLUDE:

- Direct nursing care given during specialty clinics and supervision of subordinate nursing staff during specialty clinics.
- Documented nursing care assessments, interventions, implementation, and revisions of care following evaluations.
- Educating members, families, caregivers, and other staff about treatment and testing procedures, health promotion, self-care skills, and anticipatory guidance.
- Discharge planning and care coordination services.

Nutrition Services

Covered nutrition services include screening, assessment, intervention, and monitoring. Care providers cover nutrition services for DD-CRS members with special nutritional needs when the nutritional need is related to a CRS condition.

EXCLUSIONS AND LIMITATIONS

- Preferred Homecare is the in-network provider for enteral services. To request these services:
  - Call Preferred Homecare at 800-636-2123 or 480-446-9010.
  - Fax an order to Preferred Homecare at 866-265-0455.
  - Provide written order on a prescription form and allow the member to directly request the order from Preferred Homecare.
- A registered dietitian must provide nutritional services.
- DD-CRS covers nutritional supplements upon referral with consultation by a registered dietitian in accordance with the following guidelines:
  - Metabolic disorders
    Formulas for metabolic disorders, such as PKU, MSUD, HCU, and isovaleric acidemia that are treated by a special diet are covered based on the contractor's formulary or CRS medical director approval and in accordance with the following guidelines:
    - PRODUCTS: Specified formulas for treatment of metabolic disorders such as Lofenalac, Phenyl-Free, Maxamaid X, MSUD Diet Oral Powder and formula component products such as Mead Johnson 80056 Powder
    - QUANTITY: As needed, based upon demands for growth and maintenance, to be determined by the registered dietician.
    - DURATION: As long as treatment through dietary modification continues
    - NOT COVERED: Lactose-free formulas for galactosemia;; infant formulas or milk products

used in conjunction with modified amino acid formulas; low-protein food products such as pasta, breads, and cookies for amino acid disorders

- Tube Feeding
  Tube feedings and medically necessary tube feeding equipment are available for DD-CRS members when the need is related to a DD-CRS condition.
  - PRODUCTS: Commercially available tube feeding formulas such as Compleat, Isocal, Osmolite, and formula component products such as Polycose.
  - QUANTITY: As needed, based on demands for growth and maintenance, to be determined by the care provider or registered dietitian.
  - EQUIPMENT: Tube feeding equipment, such as feeding pumps, will be provided by CRS when deemed medically necessary to provide adequate nutrition.
  - NOT COVERED: Foods and beverages recommended for blenderized recipes.
- Cystic Fibrosis
  Nutrition services are available for DD-CRS members with cystic fibrosis when appropriate growth and maintenance requires a supplemental product and no other resources or community nutrition support programs are available.
  - PRODUCTS: Commercially available nutrition supplements for additional calories and other nutrients. Examples include Ensure, Enrich, Sustacal, and formula component products such as MCT oil. (Consult manufacturers' product handbooks for nutritional content.)
  - QUANTITY: Limited to approximately 50 percent of daily caloric needs for infants, individuals, and adults as a supplement to a regular diet unless the cystic fibrosis individual is also being tube fed.
  - DURATION: Limited to 30 calendar days of coverage. The CRS medical director or designee must approve extensions for coverage.
  - NOT COVERED: Foods and beverages that constitute the member's regular diet.

Outpatient Services

Refer to the Prior Authorization list available at **UHCprovider.com**.

COVERED SERVICES

Covered outpatient services include:

- Ambulatory surgery.
- Outpatient diagnostic and laboratory services.
- Ancillary services.
- Clinic services.
- MSIC:
  - DD-CRS members require multi-specialty, interdisciplinary care
  - CRS specialty clinics may include but are not limited to:
    - Amputee
    - Arthritis/rheumatology
    - Cardiac
    - Cystic fibrosis
    - Ear, nose and throat (ENT)
    - Endocrine
    - Eye
    - Feeding
    - General Surgery
    - Genetics
    - Hand
    - Metabolic
    - Myelomeningocele
    - Neurofibromatosis
    - Neurology
    - Neurosurgery
    - Nutrition
    - Orthodontia
    - Orthopedics
    - Cerebral palsy
    - Plastic surgery
    - Pulmonary
    - Rhizotomy
    - Scoliosis
    - Sickle cell anemia
    - Urology
    - Wheelchair

- Community-Based Field Clinics
  - DD-CRS develops field clinics where the demand exists and resources are available. Community-based field clinics are specialty clinics held periodically in locations other than the CRS MSIC, rural communities in Arizona, or on Indian Reservations.
  - Outreach clinics may include:
    - Cardiac
    - ENT
    - Orthopedic
    - Neurology
    - Plastic Surgery

Pharmacy

DD-CRS has implemented an Integrated Preferred Drug List (PDL). The PDL covers DD-CRS and behavioral health drugs, depending on the member's DD-CRS coverage type.

PDLs are available at **UHCprovider.com** in the Pharmacy Resource and Physician Administered Drugs section.

COVERED SERVICES

Pharmaceuticals are covered when appropriate and ordered by the care provider. They are covered when provided through a participating pharmacy. Covered services also include formulation nutrition needs for metabolic patients.

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations are dependent upon the member's DD-CRS coverage type:

- Pharmaceuticals or supplies normally ordered by the PCP for the overall health maintenance of the individual are not covered (e.g., multiple vitamins, antibiotics, insulin, asthma drugs). Nor are drugs used for the treatment of a non-CRS condition.
- Medications covered under Medicare Part D for DD-CRS members who are dual-eligible (AHCCCS/Medicare) enrollees are not covered by DD-CRS
- Exceptions to the formulary may be made when approved through prior authorization. The Pharmacy Prior Authorization Request form and PDL is at **UHCprovider.com**.

Physical, Occupational and Speech Therapy Services

Physical, occupational and speech therapy services must be related to the member's DD-CRS condition. Coverage depends on the member's DD-CRS coverage type. Physical and occupational therapy has a benefit limit of 30 visits per fiscal year for members older than 21 years. Speech therapy services must be related to the member's DD-CRS condition. Speech therapy is not a covered outpatient service for members older than 21 years.

COVERED SERVICES

- Physical, occupational and speech therapy are provided when the member cannot obtain through a source other than DD-CRS.
- The member has a strong potential for rehabilitation as determined by a DD-CRS provider.
- AHCCCS age limits and benefit limits apply.

Physician Services

Physician services may be covered when rendered within the physician's scope of practice. A participating physician must be appropriately credentialed. UnitedHealthcare Community Plan contracts statewide with pediatric specialists to provide DD-CRS services.

Medically necessary physician services may be provided in an inpatient or outpatient setting. They include:

- Medical evaluations, consultation, and diagnostic workups.
- Medically necessary treatment for the CRS condition.
- Prescriptions for medications, supplies and equipment.
- Referrals to other specialists or health care professionals when necessary.
- Patient education.

Second Opinions

DD-CRS covers second opinions by other CRS-participating physicians when available. If not available, DD-CRS will provide a second opinion by a non-CRS-participating physician upon approved prior authorization.

EXCLUSIONS AND LIMITATIONS

- Only one second opinion is allowed per episode or specialty.
- Second opinion visits will be provided at the first available appointment.
- Office visits for second opinions may be arranged on an urgent basis at the discretion of the DD-CRS medical director.

Transplants

Covered services depend on the member's DD-CRS coverage type. DD-CRS covers transplant services for corneal transplants and incidental bone grafting transplants related to the CRS condition.

Vision Services

Covered services depend on the member's DD-CRS coverage type. Covered services include examinations, eyeglasses, and contact lenses for the treatment of a DD-CRS condition.

EXCLUSIONS AND LIMITATIONS

- Replacements for broken or lost glasses or contact lenses are limited to one replacement per prescription per calendar year.
- Lens enhancements such as ultraviolet (UV) tinting and safety glass are provided as medically necessary and ordered by a care provider.

Child Life Services

DD-CRS provides child life services at each of the four MSICs. Child life services include organization of individual, family, or group activities that help reduce the member and family's fear of an illness, medical care, and procedures. Child life activities may include:

- Group activities of expressive play.
- Pre-operative teaching and medical play that increases understanding and confidence.
- Support and coping strategies for the member during painful procedures.

Education Services

DD-CRS provides the following:

- Education for members and their families about the history and prognosis of the DD-CRS condition and treatment options, even if the medical services are not covered by CRS. Members learn about treatment planning, health risks, growth and development, transition planning, and offering of genetic counseling, support systems, and advocacy regarding the condition.
- Coordination with schools, care providers, parents, and clinic staff regarding accommodation of a member's special education needs.
- Coordination with the educational system regarding the educational needs of DD-CRS members to establish goals for an inpatient stay or homebound program.
- Public education for community groups and organizations, public health personnel, school personnel, health care providers, insurers, regional and national health organizations.
- Education for care providers, health care professionals, and other individuals regarding the unique needs and concerns related to the care and treatment of children with special health care needs
- Education for care providers and family involved with a member in adoptive, foster or kinship care. This training includes but not limited to:
  - Trauma-informed care.
  - Referral process.
  - Coping skills.
  - Navigating the behavioral health systems.
  - Rights and responsibilities.
  - Support for teaching and research initiatives.

Care Coordination Services

Care coordination services include:

- DD-CRS-integrated care.
- Coordination of health care through multi-specialty interdisciplinary approach to care.
- Coordination of member health care needs through a service plan. (See AHCCCS Medical Policy Manual, Chapter 300, Exhibit 330-1.)
- Collaboration with care providers, communities, agencies, service systems, member and families.
- Sharing information with other appropriate professionals, with the member's or family's consent.
- Coordination, communication, and support services that help manage the member's transition of care.
- Other activities as described in the AMPM.

Family-Centered and Culturally Competent Services

MEMBER ADVOCACY PROGRAM

The ombudsman/member advocate oversees the Member Advocacy Program. They work closely with Member and Provider Services to help ensure the DD-CRS program provides accessible, effective, person- and family-centered culturally and linguistically appropriate care delivered consistently and with evidence-based best practice guidelines.

This person coordinates and disseminates advocacy communications, providing assistance and support for members and families within the systems of care. They work closely with community and family advocacy organizations to share program updates, develop family-friendly materials, and act as a liaison for families and members to work with care providers to prevent or resolve issues.

The Member Advocacy Program supports families and care providers in navigating health and social service systems that provide care for children with special needs. The program works with state agencies, community service and advocacy organizations to identify barriers on an individual member basis and to identify systemic issues that may keep a member from accessing services.

Family-Centered Culturally Competent Care

We provide family-centered care in all aspects of the service delivery system. This includes:

- Recognizing the family as the primary source of support for the member's health care decision-making process. Service systems and personnel support the family's roles as decision- makers.
- Facilitating collaboration among members, families, care providers, and policy-makers for the:
  - Care of the member.
  - Developmental, implementation, and evaluation of programs.
  - Policy development.
- Promoting complete exchange of unbiased information between members, families and care professionals in a supportive manner.
- Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.
- Implementing practices and policies that support the needs of members and families, including medical, developmental, educations, emotional, cultural, environmental, and financial needs.
- Participating in Family-Centered Cultural Competence trainings.
- Facilitating family-to-family support and networking.
- Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet the family's diverse, unique needs.
- Acknowledging families are essential to the member's health.

Culturally and Linguistically Appropriate Services

Because linguistic and cultural barriers can affect access to health care, we have developed a Cultural Competency Program. This program helps:

- Ensure the member and family receive effective, understandable, respectful care compatible with their cultural health beliefs, practices and preferred language.

- Implement strategies to recruit, retain and promote a diverse staff and leadership representative of the demographic characteristics of the service area.
- Develop, implement, and promote goals and policies, operational plans, and management accountability/ oversight mechanisms to provide culturally and linguistically appropriate services (CLAS).
- Ensure all staff receives ongoing education and training in CLAS.
- Conduct initial and ongoing organizational self-assessments of CLAS-related activities and integrated cultural and linguistic competence related measures into internal audits, performance improvement programs, member satisfaction assessments, and outcome-based evaluations.
- Ensure data on member's race, ethnicity, and preferred language is collected in the member's medical record, integrated into management information systems and periodically updated.
- Maintain a current demographic profile of the service area as well.
- Communicate existing needs to accurately plan for and implement services that respond to the cultural and linguistic characteristic of the service area.
- Develop collaborative partnerships with communities and use a variety of formal and informal mechanisms to facilitate member, family, and community involvement in designing and implementing CLAS-related activities.
- Help ensure conflict and grievance resolution processes are culturally and linguistically sensitive. They should be able to identify, prevent and resolve cross-cultural conflicts.
- Regularly make available information about the progress and successful innovations in implementing CLAS to the public.

LANGUAGE INTERPRETATION LINE

We provide free translation and interpreter services to help ensure all members and their families understand the member's diagnosis and treatment plan in a culturally sensitive manner. You may use this service free of charge for translation needs. You may also access the Language Interpretation Line by contacting Member Services at 800-348-4058 (TTY 711).

T1013 (sign language or oral interpretive services, per 15min) will not be separately reimbursed. Interpretation Services are provided by Language Line on behalf of UnitedHealthcare Community Plan.

Member Action Council

The Member Action Council (MAC) is a partnership between us, our members and member families that includes representatives from the DD-CRS Program. MAC members will meet quarterly to provide input about service delivery, member communication including member materials, website, and family centered, people- first resources.

The MAC requires a representative from the DD-CRS program. UnitedHealthcare Community Plan will work with the four statewide MSICs and encourage them to recruit and identify DD-CRS member families, members, or graduates to participate on the MAC. The MAC provides the opportunity for DD-CRS members or their families to meet with other members and staff to share and discuss ideas and information about how they are experiencing care as a DD-CRS member.

Transportation

COORDINATION

Transportation services are provided as follows based on the member's coverage type.

DD-CRS Partially Integrated-Behavioral Health	MTBA contracted to provide nonemergency transportation excluding ambulance services for all DD-CRS and behavioral health services. The DD-CRS member's primary plan of enrollment provides non-emergency transportation for acute services.
DD-CRS Only	MTBA is contracted to provide nonemergency transportation excluding ambulance services for all CRS services. Transportation for acute and behavioral health services are the responsibility of the respective plans covering the member.

For members with private insurance, the non-emergency transportation should be coordinated through the insurance carrier if the transportation is a covered benefit.

Chapter 7: Long-Term Care Elderly, Physically Disabled (ALTCS EPD)

UnitedHealthcare Community Plan serves the North and Central Geographic Service Area's (GSA) for ALTCS EPD. Central GSA includes Maricopa, Gila and Pinal Counties. North GSA includes: Mohave, Coconino, Apache, Navajo and Yavapai.

Enrollment Choice in a County with Choice and Change of Contractor: Arizona Long-Term Care System Contractors

ENROLLMENT CHOICE IN A CHOICE COUNTY

Enrollment choice is available when:

- An applicant lives in a county with choice, and that county has fiscal responsibility.
- A member moves from another county to their own home in a county with choice, unless the member's current contractor is available in that county.
- A member moves from another county to a nursing facility or alternative residential setting in a county with choice, and the current contractor has chosen to negotiate an enrollment change.
- A member is currently enrolled with a contractor serving a county with choice, but a valid condition exists (see Section B) for requesting an enrollment change to another contractor serving in that county.
- A former member resides in a county with choice and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.
- A member reaches the annual anniversary date.

Enrollment choice is not available for:

- An American Indian member with on-reservation status.
- A member whose county of fiscal responsibility is not a county with choice (unless the current contractor chooses to negotiate a change).
- A member who was disenrolled from a contractor in a county with choice but then reestablishes ALTCS EPD eligibility that results in reenrollment within 90 days from disenrollment.
- A member who moves to a county with choice, and their current contractor is available in that county.

REQUESTS FOR CONTRACTOR CHANGES WITHIN A COUNTY OF CHOICE

An enrollment change from one contractor to another, in a county with choice, can be made outside of a member's annual enrollment choice for the following reasons:

Medical Continuity of Care Requests

Contractor changes may be approved on a case-by-case basis to help ensure the member's access to care. To provide continuity of care on a temporary basis for the member's period of illness, the current contractor may agree to a reimbursement schedule with the member's care provider rather than approve a contractor change.

If both contractors' medical directors approve the change request:

- The current contractor sends the completed Contractor Change Request (CCR) Form to the requested contractor and the AHCCCS Central Office. Refer to AMPM Exhibit 1620-8.

- The current contractor tells the member the change is approved and when it takes effect.

If the requested contractors deny the request:

- The CCR Form is returned to the current contractor.
- The current contractor must notify the member in writing when the change request is denied. The denial notice must include the contractor's grievance, appeal system policy and timeframes for filing a grievance.
- The current contractor may forward the CCR Form to the AHCCCS chief medical officer (CMO) or designee for a final decision.
- If the AHCCCS CMO or designee approves the change, the CCR Form is returned to the current contractor for submission to the AHCCCS Central Office.
- If the AHCCCS chief medical officer or designee denies the change request, AHCCCS will provide written notice of the denial. It will include notice of appeal rights to the member and to both the current and requested contractors.

Incorrect Network Information or Agency Error

The applicant or representative made an enrollment choice based on incorrect information about the facility, residential setting, PCP or other care provider contracting with the chosen contractor.

This decision might have been based on information supplied by the network database, marketing materials, or agency error. Such information includes omissions or failure to share network limitations in the contractor's marketing material or database submissions. The current contractor submits a Member Change Report for these requests.

Lack of Initial Enrollment Choice

In this case, an ALTCS EPD applicant residing in a county with choice was not offered a choice of contractors during the application process. The current contractor submits a Member Change Report for these requests.

Lack of Annual Enrollment Choice

The member was entitled to participate in an annual enrollment choice but was not sent notice. Or the notice was not received. Alternatively, the member was sent an Annual Enrollment Choice notice but could not participate due to circumstances beyond the member's control (e.g., member or representative was hospitalized, anniversary date fell within a 90-day disenroll/reenroll period). The current contractor submits a Member Change Report for these requests.

Family Continuity of Care

The member, either through auto-assignment or the choice process, was not enrolled with the same contractor as their family members. The current contractor submits a Member Change Report for these requests.

Continuity of Care Providers

The contractor's agreement with the institutional, residential or employment supports care providers from whom the member receives services is terminated. The member or their representative requests to change to a contractor who works with their care provider. The member must be receiving services from the care provider at the time of the Agreement termination. The current contractor submits a Member Change Report for these requests.

Failure to Correctly Apply the 90-Day Reenrollment Policy

A member who lost ALTCS EPD eligibility and was disenrolled, yet was reapproved for ALTCS EPD eligibility within 90 days of the disenrollment date but enrolled with a different contractor. The current contractor submits a Member Change Report for these requests.

MEMBER MOVES TO OWN HOME IN ANOTHER COUNTY

When a member lives in their own home, the following policies apply:

- The county of fiscal responsibility is the county where the member lives.
- Enrollment is with a contractor serving the geographic service area (or fiscal county) where the home is located.
- When the member moves to their own home in a county with choice and is not already enrolled with a contractor serving that county, the member must be given an opportunity to choose a contractor. The member will be enrolled with the contractor through the enrollment choice process.

Member Responsibilities

The member must report a move or anticipated move to the current contractor and AHCCCS.

Contractor Responsibilities

The current contractor must:

- Notify AHCCCS that the member moved by sending a Member Change Report.
- Explain service limitations to a member who moves out of the contractor's service area.
- Transitioning the member to the new contractor according to the requirements and protocols in AMPM, Chapter 500.

MEMBER MOVES TO A NURSING FACILITY OR ALTERNATIVE RESIDENTIAL SETTING IN ANOTHER COUNTY

When a contractor places a member in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the contractor's county), the county of fiscal responsibility and enrollment do not change.

When the current contractor chooses to contract with the nursing facility or alternative residential setting in another county, the enrollment and county of fiscal responsibility do not change.

When the member moves to a county with choice, the enrollment choice process must be completed before the current contractor can start negotiations with a requested contractor.

Current Contractor Responsibilities

- When the current contractor is notified that a member either has moved or plans to move to another county, and the current contractor does not serve the other county, the current contractor has the following options:
  - Retain the member and contract with an out of county provider.
  - Negotiate an enrollment change for the member.
  - Negotiate a single case agreement with the facility while plans are made to move the member to a participating facility.
- When enrollment change is the preferred option, the current contractor must:
  - Complete a CCR Form and send it to the contractor serving the GSA or the requested contractor in a county with choice.
  - Transition the member when a change is approved.

Requested Contractor's Responsibilities

When a CCR Form is received, the requested contractor must:

- Approve or deny the change request by completing the CCR Form.
- Transition the member when the change request is approved or the AHCCCS CMO or designee directs the change.

ADDITIONAL CONTRACTOR RESPONSIBILITIES

- The contractor must provide information on the contractor change policy in:
  - The Member Handbook.
  - The care provider manual.
- The current contractor must promptly address a member's concerns, including but not limited to:
  - Availability and accessibility of services.
  - Quality of care.
  - Case management responsiveness.
  - Transportation service availability.
  - Institutional care issues.
  - Care provider office hours.
  - Office waiting time.
  - Network limitations and restrictions.
- When the current contractor cannot resolve through the normal case management process issues the member raises about quality of care and delivery of medical service, they must refer the issue to:
  - The current contractor's Quality Management department.
  - The AHCCCS Quality Management department.
- When an enrollment change occurs while the member is hospitalized, the current contractor must notify the hospital before the enrollment with the receiving contractor.
- If the current contractor does not provide such notice to the hospital, the current contractor is still responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AMPM Policy 520.
- When the contractor denies the member's enrollment change request, the current contractor must process any resulting member grievances or hearing requests.

Long-Term Care Services

CASE MANAGEMENT

The UnitedHealthcare Community Plan case manager evaluates the member's health care needs to determine the appropriate residential setting, Level of Care (LOC) and necessary services to safely maintain them in the least restrictive environment. All LTC services require prior notification by the case manager. All facility settings require the appropriate registration, licensure and insurance liability coverage. You must send copies of updated licenses and certificates upon renewal. Not providing this information may result in non-payment of rendered services and termination of your UnitedHealthcare Community Plan agreement.

Case managers conduct onsite assessments of members to help ensure the appropriateness of the caregiver. They also assess the type and amount of services being rendered to the member. If we find out a care provider's performance is unsatisfactory, we will contact the care provider with the findings and care issues. The care provider must address the issues and follow up with UnitedHealthcare Community Plan promptly. If a quality management issue emerges, we follow appropriate procedures to help ensure the member receives the highest quality of care.

Members residing in nursing facilities or assisted living facility settings are responsible for the Member Share of Cost (MSOC) or Room and Board (R&B) payment as applicable. We use three long-term care settings:

1. **Nursing Facility** – Case management member evaluations are completed every 180 days or as the member's conditions changes. The case management must prior authorize the placement.
   - Nursing facilities, including skilled nursing.
   - Behavioral health level 1.
   - Inpatient psychiatric residential, only for enrollees younger than 21 years.
   - Institution for mental disease.
2. **Assisted Living Facility** – Case management member evaluations are completed every 90 days or as the member's condition changes. See "HCBS Alternative Residential Settings" in this chapter for more details. In some instances, a member may be eligible to receive home- and community- based (HCBS) services while residing in an Assisted Living Facility. The case manager determines if an HCBS services is appropriate. They also prior authorize the assisted living facility placement.
3. **Home- and Community-Based Services** Case management member evaluations are completed every 90 days or as the member's condition changes. Members living in a private home or apartment may receive the following services based on the case manager's evaluation and authorization of services:
   - **Adult Day Health Care** – includes supervision; medication assistance; recreation and socialization; personal living skills training; health monitoring; and preventive, therapeutic and restorative services. This service may be available to members residing in ALTCS EPD-approved alternative residential settings based on the case manager's evaluation and approval for the service.
   - **Attendant Care** – includes supervision, bathing assistance, food preparation and feeding assistance, housekeeping services, medication reminders, recreation and socialization.
   - **Behavioral Management Services** – See the Behavioral Health chapter of this manual.
   - **Community Transition Service** – The Community Transition Service is a fund that helps ALTCS EPD- institutionalized members reintegrate into the community by providing financial assistance to move from an ALTCS EPD institutional setting to their own home.
   - **Durable Medical Equipment** – Custom and standard items require an order by the member's care provider and must be prior authorized by the member's case manager and/or the Prior Authorization department. This service is limited to a one-time benefit per five years per member.
   - **Emergency Alert System** – Monitoring devices for members who live alone, are at risk of emergent care and cannot access emergency assistance. Emergency alert system equipment may not be provided without the member's PCP's order. A physician order is required to discontinue the provision of the Emergency Alert System.
   - **Group Respite** – An alternative to adult day health care.

- **Habilitation** – Provision of training independent living skills or special developmental skills: sensory-motor development; orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services.
- **Home-Delivered Meals** – Provides nutritious food to members who live in their own home but may not be eating adequate amounts of nutritious food to maintain good health. Only one meal may be approved for an enrollee on any given day. Providers of home-delivered meals, and those employed, must have applicable food handling/ preparation permits.
- **Menus:** Must be planned for a minimum of four consecutive weeks and rotated three times before changing menus, taking seasonal foods into consideration. Menus must be available for audit at the care provider's place of business for at least one year following meal services. The menus must use the predominant languages of the group serviced, with reflection of ethnic choices. They must be approved by a registered dietician prior to posting – any possible substitutions must be included.
- **Meals:** Must reflect one-third of the current recommended daily allowance of nutrients and follow dietary recommendations for sugar, salt and fat intake. Meals must be delivered safely and in a sanitary manner directly to the enrollee. Frozen meals may be provided in advance for days when no delivery is available. However, the member must be able to store three meals. The meals must be prepared therapeutically in accordance with the PCP order if a special diet is ordered. They must be signed for upon delivery.
- **Other:** Case records must be maintained confidentially. Services not provided are documented with reasoning. Printed educational materials must be delivered to members with meals at least two times per quarter. Care provider must respond to consultant concerns and initiate corrective action within three weeks.
- **Home/Environmental Modifications** – Allows modifications to member's existing residences to enable a member to function safely and as independently as possible. Our case managers conduct onsite assessments to determine the appropriateness of an environmental modification or repair.
- **Home Health Services** – Includes home health aides, home health skilled nursing, and private-duty nurses for ventilator dependent enrollees only. It also provides medically necessary supplies and therapy services. See "Medical Supplies Included in FFS Home Health Nursing Visits" for supplies included in the Fee-For-Service (FFS) rate at the end of the chapter.
- **Home Health Aide** – Provides nursing-related services under the direction of a registered nurse or care provider. These services must be ordered by the PCP and authorized by the case manager. Home health aides must have current Arizona Board of Nursing, CPR and First Aid certification. A home health aide visit may include any of the following:
  - Assessment of the enrollee's health or functional level.
  - Monitoring and documentation of vital signs.
  - Assistance with contingency programs.
  - Assistance with self-administration of medications.
  - Assistance with feeding.
  - Assistance with ambulation, transfer, range of motion and use of equipment.
  - Assistance with daily living activities.
  - Enrollee or family training of health care tasks.
- **Home Health Nurse** – Provides skilled nursing services the PCP ordered. They must be provided by a licensed nurse under the supervision of a care provider. These services can only be provided on an intermittent basis. These services are considered as skilled.

  If a licensed/Medicare-certified home health agency is not available in an enrollee's community, does not have adequate staff, or will not provide services through UnitedHealthcare Community Plan, a non-Medicare-certified, licensed home health agency or an independent RN may provide skilled nursing services. RNs providing these services must provide documentation of services performed according to PCP orders. We monitor the service delivery and quality of care.

Skilled nursing assessments and care for members with pressure sores, surgical wounds, tube feedings, etc. must be provided by a Medicare-certified home health agency or independent nurse. Written monthly reports must be submitted to the PCP and our case manager. Skin assessments must be performed at least monthly for members prone to breakdown of skin integrity due to their health status or care needs.

- **Private-Duty Nurse** – Home health private duty nurse services are provided on a continuous basis to avoid hospitalization or institutionalization when care cannot be safely managed intermittently. Private duty services must be ordered by the PCP and authorized by UnitedHealthcare Community Plan. If a LPN provides services, a physician must provide supervision. These services are only available to ventilator-dependent members.
- **Homemaker Services** – May be provided to preserve or improve upon the safety and sanitation of a member's living condition, nutritional value of meals and to maintain or increase the member's self-sufficiency. A homemaker only provides services that pertain to the member. A homemaker may clean the enrollee's living space, such as their bedroom; conduct meal planning, shopping, and food preparation with clean up; and clean and put away the member's laundry.
- **Home Maintenance Program** – If a member's restoration potential is evaluated as insignificant or at a plateau, a Home Maintenance Program can be initiated. A licensed therapist, the enrollee, family, caregiver or non-skilled personnel is trained to help maintain the member's functions. We authorize the initial establishment of the Home Maintenance Program through a licensed therapist if the service is determined appropriate by the PCP, our medical director, and Utilization Management.
- **Hospice** – Includes physician services, nursing services, medication for the terminal illness, therapies, aid services, homemaker services, medical social services, medical supplies and appliances, and short-term respite and counseling, including bereavement and support. The member's care provider must certify that the member is terminally ill, with a prognosis of six months or less. They must state the enrollee desires palliative versus curative treatment. Hospice is a prior-authorized service. If the member is receiving services under Medicare, the services do not require PCP orders or our case management's prior authorization. However, because our case manager monitors the member's care, the hospice provider must notify the case manager of the hospice election. Hospice services must be provided through a Medicare-certified agency. If the member has Medicare, hospice benefits must be chosen instead of regular Medicare benefits.
- **Partial Care** – Provides structured, coordinated programs that include therapeutic activities and promote coping, problem-solving, and socialization skills.
- **Personal Care** – Includes bathing assistance, food preparation and feeding assistance, homemaker services, medication reminders, and recreation and socialization. Personal care services may involve bathing, toileting, dressing, nail care and feeding; assistance with transferring, ambulating and use of special equipment. They may also include training of family/ caregivers.
- **Respite Care** – Is provided in both inpatient and outpatient settings for a short-term period to relieve the family. Respite services can be available up to 24 hours a day and is limited to 600 hours per fiscal year up to 25 days.

Gap in Critical Service Reporting

All critical service providers follow the Gap in Critical Service process to help assure care is provided to all at-risk HCBS members when the scheduled caregiver is unavailable. Care providers notify the health plan when a gap in service has occurred. They send the health plan's gap in service coordinator monthly reports using the required Critical Service Gap Report Form, which can be found at **azahcccs.gov**.

AHCCCS requires all critical service providers (home care agencies who provide attendant care, personal care, homemaker services or respite care), document and report to UnitedHealthcare Community Plan any gap in critical services.

Training on the AHCCCS required format and time lines is available through the provider manual, group meetings, in-services and orientations.

HCBS ALTERNATIVE RESIDENTIAL SETTINGS

Members residing in these settings are responsible for their room and board (R&B) payment at the beginning of each month. We determine the R&B amount in accordance with AHCCCS guidelines.

1. Alzheimer's treatment assisted living
2. Assisted living facilities – licensed by Arizona Department of Health Services (ADHS)
   - Adult Foster Care (AFC) – up to four residents in the home. The sponsors, or homeowners, reside in the home with the residents.
   - Assisted Living Home (ALH, formerly Adult Care Home) – up to 10 residents in the home. Owners of ALHs typically do not reside in the residence. ALHs must be staffed 24 hours per day, seven days per week.
   - Assisted Living Center (ALC) – more than 10 residents in the center. ALCs must be staffed 24 hours per day, seven days per week. Members residing in ALCs must be offered the choice of single occupancy rooms. If no single occupancy rooms are available at the time of move-in, or if a member is offered a single occupancy room and declines but later requests to move into a single-occupancy room, the member must be placed on a wait list for a single occupancy room. They may not be passed over by other residents (regardless of payer source) on the wait list. ALCs that have varying sizes and layouts for single-occupancy rooms may designate a room size/layout for ALTCS EPD members in which if a single-occupancy room size/layout not designated becomes available. In this case, the ALC is not required to place the ALTCS EPD member in that specific unit.
3. Adult Development Home – licensed by DES (Department of Economic Security) – up to three adults (18 years or older) in the home
4. Adult Therapeutic Foster Home – for behavioral health members only – up to three adults in the home
5. Behavioral Health Level II (Residential Treatment Center) – licensed by ADHS – 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or onsite medical services found in a Level 1 behavioral health facility
6. Behavioral Health Level III (Residential Treatment Center) - licensed by ADHS – 24-hour supervision and supportive protective oversight, behavior management or psycho-social rehabilitation. They help assure members receive required medications, obtain needed treatment and have transportation to outside treatment agencies if necessary. Life skills training, social and recreational activities may be provided directly or by referral to outside treatment agencies.
7. Child Development Foster Home – licensed by DES – up to three children in the home.
8. Group Home for Developmentally Disabled – licensed by DES - up to six adults in the home.
9. Rural Substance Abuse Transitional Agency.
10. Traumatic Brain Injury Treatment Facility – licensed by ADHS.

THERAPEUTIC LEAVE AND BED HOLD

UnitedHealthcare Community Plan members living in skilled nursing facilities may receive up to 12 days per AHCCCS contract year (beginning October 1) while the member is hospitalized or otherwise not occupying a bed in the skilled nursing facility and is expected to return, in accordance with our Therapeutic Leave/ Bed Hold Policy. Of the 12 days allowed, no more than nine are for therapeutic leave. The case manager must prior authorize all requests for Therapeutic Leave/Bed Hold payment days.

Our members younger than 21 years may use any combination of Therapeutic Leave/Bed Hold per AHCCCS contract year with a limit of 21 days per year. The total days may include days in multiple facilities.

MEDICAL/ACUTE CARE-ONLY SERVICES

Medical/acute care services and case management services are provided to those members eligible for ALTCS EPD but who live in an uncertified or

unauthorized facility. They also refuse LTC services, are awaiting disenrollment from the ALTCS EPD program, or have not received LTC services for more than 30 days. These members do not qualify for full LTC benefits. Services provided will be only those allowable under the auspices of AHCCCS ambulatory plans and case management services (e.g. DME, medically necessary transportation, physician services, prescriptions, laboratory, X-rays, behavioral health, outpatient services, inpatient acute services). These services do not include nursing facility placement, assisted living placement or HCBS.

MEDICAL SUPPLIES INCLUDED IN FEE-FOR-SERVICE HOME HEALTH NURSING VISITS

The following supplies are included in the AHCCCS Fee-For- Service (FFS) Home Health Nurse visit rate. This list is not all- inclusive and is for a general reference only.

- Adhesive spray or tape
- Antiseptics
- Bandage, cling type 6”
- Colostomy care
- Cotton balls, sterile or non-sterile
- Diabetic daily care
- Diabetic diagnostics and tape, cloth 2’’x10yds
- Dressing, N-Adhering with adhesive 2x3”
- Dressing, transparent
- Gauze bandage roll 1”x10yds Tape, cloth 2”x10yds
- Gauze pads, sterile and 4”x4”
- Gauze pads, sterile with gel 1/2”x72”
- Gauze pads, sterile with gel 6”x36”
- Gauze sponges, non-sterile 4”x4”
- Gloves, plastic disposable
- Glucose care starter kit
- Glucose reagent strips
- Hydrogen peroxide
- Iodoform packing 1/2’’x5yds
- Isopropyl alcohol swabs
- Lancets
- Lubricating jelly, 1oz
- Packaging gauze, plain 1/4”x5yds
- Petroleum jelly, 1oz
- Petroleum jelly gauze 1”x8”
- Syringes/needles
- Tape, paper 1”x5yds
- Tape, plastic 1”x5yds
- Tape, standard adhesive 2”x5yds or 11/2”x10yds
- Tape, waterproof adhesive 1”, 1”x5yds or 11/2”x5yds
- Urine test strips
- Wood applicator with cotton tips

NON-COVERED SERVICES

Services not covered by ALTCS EPD include, but are not limited to:

- DME (not ordered by the member’s PCP)
- Services provided by non-approved care providers
- Services or items furnished solely for beauty or cosmetic reasons
- For members 21 years or older: hearing aids, eye exams for glasses/lenses, services, unless deemed medically necessary and approved by the medical director
- Services defined by AHCCCS as experimental or provided solely for the purpose of research
- Sex-change operations
- Reversal of self-requested sterility.
- Care not deemed medically necessary by AHCCCS, UnitedHealthcare Community Plan or the care provider, and/ or care not covered under ALTCS EPD.
- Medical services provided to an enrollee who is an inmate or who is in the care of a state mental health center
- Man-made hearts or xenografts
- Organ transplants, except those identified under the “Covered Services” chapter of this manual or stated in ALTCS benefits
- Services provided in a center or facility in an area of a center or facility that is not Medicare/Medicaid-certified for such services.
- R&B in adult foster care (AFC), an assisted living home (ALH), an assisted living community (ALC) or other alternative residential settings.
- HCBS services not approved by the UnitedHealthcare Community Plan case manager

Well visits/well exams for members 21 years and older are covered. Well-woman exams, breast exams, prostate exams and other well visits are covered for members 21 years and older. For members younger than 21 years, AHCCCS covers medically necessary services.

Chapter 8: Value-Added Services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **800-445-1638** unless otherwise noted.

OB Homecare Nursing Services

Preterm Birth Prevention Program for Preterm Labor and History of Spontaneous Preterm Birth:

- Makena® or 17HPC Administration Nursing and Care Management service is designed to improve weekly injection adherence and reduce pre-term delivery

Nausea and Vomiting Management – Continuous antiemetic therapy utilizing micro-infusion pump with pharmacist and nursing support

Diabetes in Pregnancy – for members with gestational diabetes or existing Type 1 or Type 2 diabetes

- Home-based assessment, counseling, and monitoring of non-insulin or insulin managed care by RN and CDE, including visits as needed to assure stable glycemia

To refer a patient to OB case management or if you have questions about our maternity program, please call Healthy First Steps at **800-599-5985**.

Baby Blocks™ Program

Baby Blocks™ is a web-based, mobile tool that reminds and rewards pregnant women and new mothers to get prenatal, postpartum and well-child care. Baby Blocks™ is available to pregnant UnitedHealthcare Community Plan members or their newborns.

BABY BLOCKS™ BENEFIT

Baby Blocks engages members with text and email appointment reminders. Members who enroll early in their pregnancy can earn up to eight rewards by following prenatal and postpartum recommendations.

How it Works

1. Care providers and UnitedHealthcare Community Plan reach out to members to enroll them in Baby Blocks.
2. Members enter information about their pregnancy and upcoming appointments at **UHCBabyBlocks.com**.
3. Members get reminders of upcoming appointments and record completed visits at **UHCBabyBlocks.com**.
4. At milestones throughout the program, members choose a reward for themselves or their baby.

How You Can Help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Share a Baby Blocks brochure with the member and talk about the program.
3. Encourage the member to enroll at **UHCBabyBlocks.com**.

Members self-enroll on a smartphone or computer. They can go to **UHCBabyBlocks.com** and click on "Sign Up Here."

Chronic Condition Management

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

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

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

Dental Services

COVERED

A Dental Provider Manual is available for detailed coverage information at **uhcproviders.com**.

Adults older than 21 years are covered for Limited Medical and Surgical Services by a dentist. Adult ALTCS EPD and DD members have a $1,000 benefit limit per contract year (10/1 – 9/30). All members 21 years and older have emergency dental services of $1,000 per contract year (10/1 – 09/30). Additional details regarding these benefits can be located in Chapter 300 of the AHCCCS Medical Policy Manual.

PRIOR AUTHORIZATION

A prior authorization number cannot be issued by phone or fax. Emergency treatment done where prior authorization could not be requested in advance; must be mailed to UnitedHealthcare for retrospective review. Surgical center or hospital authorizations may continue to be called or faxed into the UnitedHealthcare Dental Unit if emergency or urgent treatment needs to be rendered at a hospital or surgi-center. Submit prior authorization requests and retro reviews to:

UnitedHealthcare Community Plan
Dental Unit
P.O. Box 2020
Milwaukee, WI 53201

BILLING

Send all dental service billing, except services requiring prior authorization or treatment requiring retrospective review as noted or indicated on the dental matrix for UnitedHealthcare members, to UnitedHealthcare Dental using the current ADA claim form. Members cannot be billed for AHCCCS-covered services.

Members may request services from care providers AHCCCS does not cover. Those members must sign a release form stating that they understand the service is not covered under AHCCCS and that they are responsible for the bill.

Submit dental claims through the provider web portal or send to:

UnitedHealthcare Community Plan
Dental Claims
P.O. Box 2185
Milwaukee, WI 53201

Submit corrected dental claims to:

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

If you disagree with the processing of a dental claim, submit a formal claims dispute. Please review to the disputes section in Chapter 14 for additional information.

Direct all dental claim inquiries to UnitedHealthcare Dental. Call UnitedHealthcare Dental directly at 855-812-9208. Check claim status at **UHCprovider.com**.

You must register using your UnitedHealthcare Dental provider ID, not with your AHCCCS ID. If you do not know your UHC Dental provider number, contact UnitedHealthcare Dental at 855-812-9208, and a dental customer service representative will assist you.

Early Intervention Program

Early Intervention promotes the development of infants and toddlers with developmental challenges and delays. It also covers certain disabling conditions. The program provides services to eligible children from birth to three years old and their families.

Foster Care

PEER SUPPORT SPECIALIST

We have a foster-care peer support specialist working with youth in the foster care system and their families. The specialist works with the member and the family to define the member's recovery goals. The specialist helps the member develop life skills and provides phone and/or face-to-face communications to members. The member and foster family receive support and help improve the member's overall physical and behavioral health. This benefit can also help to reduce hospitalizations and emergency room visits related to behavioral conditions in youth in foster care services.

Healthify

This web-based referral tool helps members gain access to food, housing, employment, energy, support groups, child care, and clothing. It is for members at risk for poor outcomes or inappropriate health care use.

Healthy First Steps

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

HFS-MATERNAL CARE MODEL

The HFS-Maternal care model strives to:

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

Tell UnitedHealthcare Community Plan when a member becomes pregnant. Faxing a Prenatal Risk Assessment form to the **Healthy First Steps program** at **877-353-6913** will initiate care management program outreach.

KidsHealth

The KidsHealth website offers health and wellness resources to encourage healthy behaviors among

children, young adults and their parents. These health care education resources include assistance for high-risk members managing such conditions as diabetes, asthma and stress. Links on the member website, **myuhc.com**, reveal videos and articles accessible through a computer, tablet or smartphone. KidsHealth is for members 20 years and younger.

Mobile Apps

Apps are available at no charge to our members. They include:

- **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.
- **Text4baby** is a free mobile information service that helps members through their pregnancy and baby's first year of life. The weekly text4baby messages give tips about:
  - Keeping healthy.
  - Labor and delivery.
  - Breastfeeding.
  - The importance of immunizations (shots).
  - Exercise and healthy eating.

  To sign up for text4baby, members must text the word BABY to 511411.
- **KidsHealth®** answers health questions online through a partnership between UnitedHealthcare Community Plan and KidsHealth. Visit the website at **kidshealth.org**. Search by topic, read articles or watch videos. Teens can also find straight talk and personal stories. Younger children can learn through health quizzes, games and videos.
- **Social Media** provides assistance on Facebook, Twitter: @UHCPregnantCare (In Spanish: @UHCEmbarazada) by delivering health and wellness information relating to pregnancy, child birth and general health information applicable to pregnant women.

My HealthLine (cellphone program)

My HealthLine, our free cellphone program, helps us more closely connect with our members. This is particularly important for high-risk members who need support for their overall health, wellness and access to care. Members can quickly and easily reach us to discuss health-related concerns or to locate a PCP. Our care managers make outbound calls to coordinate care and follow up on important activities to improve a member's health.

This Federal Lifeline program provides the cellphones. Our members who meet federal eligibility requirements receive 350 voice minutes per month and unlimited texting, plus a pre-programmed member services number that does not count against the minutes. They are also automatically enrolled in the Connect4health texting program.

Non-Emergency Transportation

Transportation is covered for AHCCCS-eligible members. Members should use their own transportation if available.

Medical Transportation Brokerage of Arizona (MTBA) provides non-emergency transportation for:

- AZ Complete Care: covered services.
- Developmentally Disabled with CRS designation: CRS services. MTBA is not responsible for transportation services DD covers.
- Long-Term Care EPD: all services, including behavioral health transportation.

For non-urgent appointments, members must call for transportation at least three days before their appointment.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop.
- Has an appointment less than half a mile from the bus stop.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **866-351-6827** to reach a nurse.

Quit for Life®

The Quit For Life® Program is the nation's leading phone-based tobacco cessation program. It uses physical, psychological and behavioral strategies to help members take responsibility for and overcome their tobacco addiction. Using a mix of medication support, phone-based coaching, and web-based learning tools, the Quit For Life Program produces an average quit rate of 25.6 percent for a Medicaid population. It also has an 88 percent member satisfaction. Quit for Life is for members 18 years and older.

SUD Recovery Support

Our SUD (Substance Use Disorder) recovery support team works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

UHC Latino

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

Women, Infants and Children Supplemental Nutrition Program (WIC)

This non-UnitedHealthcare Community Plan program provides federal grants for supplemental foods, health care referrals, and nutrition education for low-income pregnant, postpartum women. It also covers infants and children up to age five who are at nutritional risk.

Eligibility –

- Pregnant women: as soon as there is a positive pregnancy test (by a health care professional)
- Women who have been pregnant within the previous six months
- Breastfeeding women
- Children younger than five

Referral – Make referrals as a part of the initial health assessment of a pregnant, breastfeeding, or postpartum woman and children younger than five.

A current hemoglobin or hematocrit is required:

- Hemoglobin or hematocrit within 90 days of enrollment
- Hemoglobin or hematocrit within 90 days of each succeeding six-month certification except for a child whose blood value was within normal limits at the previous certification. For these children, the lab tests are required every 12 months
- For infants under nine months of age, height/length and weight dated within 60 days of enrollment and with each six-month recertification

Contact Information:

800-252-5942

azdhs.gov/prevention/azwic/

Chapter 9: Mental Health and Substance Use

United Behavioral Health provides UnitedHealthcare Community Plan members with mental health and SUD benefits. You must have a National Provider Identification (NPI) number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to **azahcccs.gov**.

Credentialing

Credentialing information is available at **providerexpress.com** > Clinical Resources > Guidelines/ Policies & Manuals > Credentialing Plans > Optum.

The National Credentialing Center's Request for Participation Form is at **https://ncc-optum.secure.force.com/rfp/**.

Covered Services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders without the requirement of a referral. A member, member's legal guardian, family member or care provider may make oral, written, faxed, or electronic requests for behavioral health services. We accept behavioral health referral requests at any time. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in one place.

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

For member resources, go to **providerexpress.com**. Go to the Live and Work Well (LAWW) clinician center. Locate Health Condition Centers at the Clinical Resources tab. The Provider Express Recovery and Resiliency page includes tools to help members addressing mental health and substance use issues.

Benefits include:

- Behavioral health therapeutic home care services
- Behavioral management (behavioral health personal care, family support/home care training, self-help/ peer support)
- Care coordination services
- Crisis services
- Court-ordered treatment
- Emergency and non-emergency transportation
- Behavioral health evaluation and assessment and treatment services
- Individual, group, and family therapy and counseling
- Inpatient behavioral health services (members ages 21-64 in an Institution for Mental Diseases)
- Inpatient services
- Residential treatment centers (level 1 and sub-acute facilities)
- Laboratory and radiology services for psychotropic medication regulation and diagnosis (laboratory services should be referred to LabCorp, the network laboratory provider)
- Nursing services
- Opioid agonist treatment (including medication-assisted treatment)
- Day program services (supervised day program, therapeutic day program and medical day program)
- Physician services

- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
- Psychotropic medication, adjustments and monitoring
- Rehabilitative services
- Respite care (600 hours max benefit)
- Screening, evaluation and diagnosis
- Substance abuse (drug and alcohol) counseling
- Support services

The following services are not covered under the Complete Care Program but are available through the members ALTCS EPD program. The member may be referred to a RBHA for the following services if they are not enrolled in our ALTCS EPD program. Review the Referral section in this chapter as well as the ALTCS EPD chapter for more information.

- Supported employment (LTC)
- Traditional healing (LTC-Non Title XIX benefit for members who are SMI)
- Supported housing (LTC-Non Title XIX benefit for members who are SMI)
- Acupuncture for SUD (LTC-Non Title XIX benefit for members who are SMI)

Eligibility

The service delivery system for behavioral health services involves:

- **AHCCCS Complete Care** – An integrated program that joins physical and behavioral health services to treat all aspects of our members' health care needs under UnitedHealthcare Community Plan.
- **Developmentally Disabled/DD** – Medical services are covered by UnitedHealthcare Community Plan. Members will continue to receive behavioral health services provided through the RBHA. Additional referral information is available in this chapter.
- **DD-CRS** – Members with developmental disabilities and a CRS designation will receive physical and behavioral health services.
- **Children in Foster Care with CRS Conditions** – Children in foster care with CRS conditions will be covered by the Comprehensive Medical and Dental Program (CMDP) for physical health services. This includes services for any CRS conditions. It also includes moving to the RBHA in their area for behavioral health services. The member may obtain participating care provider information by looking at **UHCprovider.com** or contacting Member Services. Members must have a CRS designation. The PCP does not need to refer the member.

DD-CRS members designated as SMI will receive their behavioral health services through the DD-CRS program network.

- **ALTC EPD** – Members evaluated and enrolled in the LTC Program will receive their medically necessary physical and behavioral health services within an integrated program provided by UnitedHealthcare Community Plan. SMI members assigned to the LTC program will receive their behavioral health services through the LTC network.
- **Serious Mentally Illness (SMI) Program** – Members evaluated and enrolled in the SMI program will be transitioned to one of the RBHA programs for all services. This is an integrated program providing all physical and behavioral health services.
  - *SMI Opt-Out Members – SMI members may opt out from physical health services from the RBHA and enroll in AHCCCS Complete Care for their physical health services.*

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on the Eligibility and Benefits application on Link at **UHCprovider.com**.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to **UHCprovider.com/priorauth**, or by calling **866-604-3267**.

Pre-Petition Screening, Court-Ordered Evaluation and Court-Ordered Treatment

Arizona state law permits any responsible person to submit an application for pre-petition screening when another person may be:

- A danger to self (DTS).
- A danger to others (DTO).
- Persistently or acutely disabled (PAD).
- Gravely disabled (GD).

Information about these screenings and court-ordered treatments can be found on the AHCCCS website in the **AHCCCS Medical Policy Manual, Policy 320-U**.

Outreach, Engagement and Re-Engagement

OUTREACH

UnitedHealthcare Community Plan provides outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. We disseminate this information to the general public and through our community partners, to care providers, and other interested parties. Outreach activities may include but are not limited to:

- Participation in local health fairs or health promotion activities.
- Involvement with local schools.
- Development of homeless outreach programs.
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved.
- Publication and distribution of informational materials.
- Liaison activities with local and county jails, county detention facilities, and local and county DCS offices and programs.
- Contact with pregnant women/teenagers who have a substance use disorder when identified through our maternity program, such as Healthy First Steps.
- Development and implementation of outreach programs that identify persons with co-morbid medical and behavioral health disorders and those who have been determined to have a SMI.
- Provision of information to mental health advocacy organizations.
- Development and coordination of outreach programs to American Indian tribes in Arizona to provide services for tribal members.

ENGAGEMENT

UnitedHealthcare Community Plan and our subcontracted behavioral health care providers actively engage the following in the treatment planning process:

- The person and/or person's legal guardian or designated representative.
- The person's family/significant others, if applicable and amenable to the member.
- Other agencies/providers as applicable.
- The member, guardian, designated representative, advocate or other individual designated to provide Special Assistance for members with SMI who are receiving Special Assistance (see AMPM Policy 320-R).

Behavioral health care providers must provide services in a culturally competent manner in accordance with our Cultural Competency Plan. See Chapter 1 for more information and resources.

RE-ENGAGEMENT

Participating behavioral health care providers attempt to re-engage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service. Try to re-engage the member by:

- Communicating in the member's preferred language,
- Contacting the member, guardian or designated representative by phone when the member may reasonably be available,
- Attempting in-person contact when possible if you cannot reach the member by phone.
- Sending a letter to the most recent address requesting contact. If all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues, note safety or confidentiality concerns in the progress notes section of the clinical record. Include a copy of the letter sent in the comprehensive record, and

- Contacting the person designated to provide special assistance for their involvement in re-engagement efforts for members determined to have SMI who are receiving special assistance.

If the person appears to meet clinical standards as a danger to self or others, or they are persistently and acutely disabled or gravely disabled, the care provider must determine whether to attempt to engage the person to seek inpatient care voluntarily. If this is not a viable option, and the clinical standard is met, the care provider may initiate the pre-petition screening or petition for treatment process for court-ordered evaluation, and court-ordered treatment.

FOLLOW-UP AFTER EVENTS

Document all activities in the medical record. Help ensure the following activities are complete to maintain engagement:

- Member is discharged from inpatient services in accordance with the discharge plan and within seven days of the member's release.
- Member is involved in a behavioral health crisis within time frames based upon the member's clinical needs, but no later than seven days,
- Reengage is member refuses prescribed psychotropic medications within time frames based upon the member's clinical needs and history, and
- Member needs a change in the level of care.

Out-of-State Placements for Behavioral Health Treatment

A child or young adult may need out-of-state placement to meet their clinical needs. Placing members in out-of-state placements for behavioral health care happens after the Child and Family Team (CFT) and the Adult Recovery Team (ART) have reviewed all other in-state options. Please refer to the AMPM Policy 450 for more information and guidelines.

Medication Management

In addition to treating physical health conditions, PCPs may treat behavioral health conditions within their scope of practice. Such treatment includes SUDs, anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD). For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services. This includes prescriptions and other diagnostic tests needed for diagnosis and treatment. However, the following conditions must be met:

- PCP feels comfortable in managing members' psychotropic medications.
- Treatment is within the care provider's scope of practice and expertise.
- PCP may request these medications for continuity of care by submitting a completed UnitedHealthcare Pharmacy Prior Authorization Form indicating step therapy has been completed. The member needs to continue on current medication and dosage for stabilization unless the medical condition changes. PDL medications requiring step therapy are covered only after a sufficient trial of an indicated first-line agent has failed.
- Before faxing the completed Pharmacy Prior Authorization Form with documentation, indicate on the Pharmacy Prior Authorization Form: "Request for Step Therapy Medication." To prevent any lapse in medication coverage, or for help, call UnitedHealthcare Pharmacy at 800-305-0023.

The UnitedHealthcare Pharmacy Prior Authorization Form is at **UHCprovider.com**.

When a PCP has started managing a member's medication to treat a behavioral health disorder, and the PCP sees the member should be transferred to a behavioral health provider for evaluation and/or continued medication management services, the care provider must coordinate the transfer of care. Refer to AMPM 520 for more information.

Psychotropic Medication Management

PCPs may provide psychotropic medication management under the following conditions.

- PCP feels comfortable managing member's psychotropic medications.
- These conditions are within the care provider's scope of practice.

PCPs may request these medications for continuity of care management by submitting a completed Pharmacy Prior Authorization Form. The form should note step therapy has been completed, and the member needs to continue on current medication and dosage for stabilization, unless the medical condition has changed. Preferred drugs requiring step therapy are routinely covered only after the first-line agent has been adequately tried and failed. Before faxing the completed Pharmacy Prior Authorization Form with documentation:

- Request the Step Therapy medication, and
- State if the request is expedited or routine.

If the medication is not listed on the AHCCCS Drug List or the AHCCCS Behavioral Health Drug List, more information may be required when obtaining prior authorization. To prevent lapse in coverage, or for help, contact UnitedHealthcare Pharmacy at 800-310-6826 or send a fax to 800-853-3844.

The PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the medication-assisted treatment (MAT) model and coordinate care with the behavioral health provider.

Informed consent must be obtained from the member/guardian/designated representative for each psychotropic medication prescribed. The clinical record must include documentation of the essential elements for obtaining informed consent. Information about these elements are in Attachment A of the AMPM, Chapter 300, Policy 310-V.

Behavioral Health Screenings

The PCP should screen members for behavioral health needs during routine or preventative visits. Based on the behavioral health screening and assessment, Best Practice Guidelines, and Evidence-Based-Medicine (EBM), While a referral is not required for behavioral health services, the PCP must refer the member to an in-network behavioral health care provider and consult with the behavioral health provider about the member's treatment plan. Our online Provider Directory can provide a list of care providers in our network.

SERIOUS MENTAL ILLNESS DETERMINATION

Per AMPM Policy 320, the determination of SMI requires both the qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

FUNCTIONAL CRITERIA FOR SMI DETERMINATION

A member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four areas for most of the past 12 months. Or it must last for most of the past six months with an expected duration of at least six months:

- Inability to live in an independent or family setting without supervision
- A risk of serious harm to self or others
- Dysfunction in role performance
- Risk of deterioration.

The Crisis Response Network (CRN) will send the member a Notice of Decision letter by mail informing them of the final decision regarding their SMI determination. This letter will include information about their rights and how to appeal the decision. Members can file an appeal by calling CRN at 855-832-2866.

Members determined to have a SMI may also appeal the following adverse decisions:

- Decisions regarding fees or waivers.
- The assessment report and recommended services in the service plan or individual treatment or discharge plan.
- The denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title XIX/XXI funds (appeals cannot be filed on services no longer available due to reduction of state funding).
- Capacity to make decisions, need for guardianship or other protective services or need for special assistance.

MEMBER WITH CO-OCCURRING SUBSTANCE ABUSE

For psychotic diagnoses (e.g., bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS), functional impairment is presumed to be due to the qualifying psychiatric diagnosis.

For other major mental disorders (e.g., bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis. The exceptions are:

- If the symptom severity, frequency, duration or characteristics contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
- The assessor can demonstrate the functional impairment is present only when the member is abusing substances or experiencing withdrawal from substances.

For all other mental disorders, functional impairment is presumed to be due to the co-occurring substance use unless:

- The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder; or
- The functional impairment is present during at least the next 30 days following stopping the substance use; or
- The functional impairment is present during a period of at least 90 days of reduced use unlikely to cause the symptoms or level of dysfunction.

Information about referral, evaluation and determination of SMI can be found on the AHCCCS website at azAHCCCS.gov under AMPM Policy 320-P Serious Mental Illness Eligibility Determination.

All members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the person either:

- Requests an SMI determination,
- Has qualifying SMI diagnosis.

Any ALTCS EPD members asking whether they have been determined SMI should contact their ALTCS care manager. This helps ensure SMI determinations and services are provided as specified in Title 9, Health Services, Chapter 21 AHCCCS Behavioral Health Services for Persons with a Serious Mental Illness (R9-21). For members already determined to be SMI, the care manager informs them of their grievance and appeal rights about their services as specified in R9-21.

An appeal of a denial of SMI determination goes through the AHCCCS-selected SMI Determination Agency and the care manager. The SMI coordinator assists the member with this process if needed (R9-21). The care manager informs the member of their rights to obtain special assistance from the Office of Human Rights as specified in R9-21.

During the member's initial ALTC EPD assessment and all reassessments, the care manager completes a screening. They check if the member has any of the qualifying diagnoses determined as SMI. If they do, the care manager discusses with the member or their legal guardian the SMI determination process to see if this is something they want to pursue.

PCP Coordination of Care Responsibilities

The PCP helps ensure a member-specific medical record is established when behavioral health documentation is received from the T/RBHA or behavioral health provider on an assigned member. Even if you have not seen the member, a record must be created.

The PCP will respond to behavioral health provider or T/RBHA information requests within 10 business days of receiving the request. The response should include current diagnoses, medications, laboratory results, last PCP visit and recent hospitalizations.

PCPs may contact an in-network behavioral health provider or T/RBHAs and request a phone consultation with a psychiatrist regarding the medication management, transition of care and treatment options for a member with a behavioral health diagnosis with co-morbidities.

If a transfer is recommended, PCPs receive a fax informing them of the member's enrollment status. If you do not receive a fax, contact the T/RBHA to speak to a liaison or behavioral health coordinator.

NON-BEHAVIORAL HEALTH CARE PROVIDER RESPONSIBILITIES

Non-behavioral health care providers receive correspondence from the care manager about psychotropic medications the member is prescribed. The PCP should establish a separate record for behavioral health information.

UnitedHealthcare Community Plan performs random Behavioral Health Record Reviews (BHRR) yearly on care providers with 10 or more members actively receiving behavioral health services, or in which the PCP is prescribing and/or managing member's medications for the treatment of ADHD, anxiety or depression.

Diabetic Members Admitted to Arizona State Hospital

Diabetic members who are admitted to the Arizona State Hospital (AzSH) for behavioral health services will receive training to use a glucometer and testing supplied during their stay at AzSH. Upon discharge, the PCP will be given the diabetic information to include the brand and model of equipment the member has been trained on.

The PCP must help ensure members have the same brand and model of both glucometer and supplies they were trained on. UnitedHealthcare Community Plan will coordinate with AzSH to help ensure the member has testing supplies to last until the member is scheduled an office visit with the PCP.

If the member's mental status renders them incapable or unwilling to manage their condition, and that condition requires ongoing medical care, UnitedHealthcare Community Plan will coordinate with the RBHA, member guardian, and AzSH to get the appropriate care.

Behavioral Health Toolkits

AHCCCS has developed a set of clinical toolkits to assist PCPs in assessing the needs of children/adolescents (8-17 years old), and adults (18 years and older). They also help PCPs determine the need and type of medication and if a behavioral health referral is indicated.

The toolkits are online at **UHCprovider.com** under Guides, Toolkits and Resources. They can also be found on **azahcccs.gov** in the Medical Policy Manual, Appendix E (Child and Adolescent Behavioral Health Tool Kits) and F (Adult Behavioral Health Tool Kits).

HOW TO JOIN THE OPTUM BEHAVIORAL HEALTH NETWORK

If you want to join our behavioral health provider network through Optum, note the following steps.

1. Register with AHCCCS. Use the same specialty and demographic information you provide when starting the credentialing process.
2. Start the credentialing process by going to the "Join Our Network" section of **ProviderExpress.com** and following the instructions for Arizona providers.

To help ensure proper maintenance of your clinician roster, complete and submit the **Roster Update Form** as staffing changes occur. The form may also be used to confirm that no roster changes are required at this time.

Portal Access

Website: **UHCprovider.com**

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

Also view the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at 866-815-5334 to verify eligibility and benefit information (available 8 a.m. - 5 p.m. Central Time, Monday through Friday).

Website: **providerexpress.com**

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at 866-815-5334.

Website: AHCCCS **azahcccs.gov**

Website: T/RBHA listings **azahcccs.gov**

Website: Arizona DES/DDD **des.az.gov**

Integrated Health Plan Contact Information

azweb.statemedicaid.us

Member Appeals and Grievances

Call Member Services at **800-348-4058** (TDD **711**) or **800-293-3740** for ALTCS EPD Member Services, and a representative will assist you with the Member Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the notice of adverse benefit determination. Find more information in Chapter 14 of this manual.

Send written requests to:

UnitedHealthcare Community Plan Member Appeals and Grievance
1 East Washington, Suite 900
Phoenix, AZ 85004

Claims

Submit claims using the 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in Chapter 13.

Monitoring Audits

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

Addressing the Opioid Epidemic

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

BRIEF SUMMARY OF FRAMEWORK

- Prevention:
  - Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support care management and referral to person-centered recovery resources.
- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community partnerships and approaches:
  - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.

INCREASING EDUCATION & AWARENESS OF OPIOIDS

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

Access these resources at **UHCprovider.com**. Then click “Drug Lists and Pharmacy”. Click Resource Library to find a list of tools and education.

PREVENTION

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC’s recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines on long-acting opioids are

available online at **cdc.gov** > More CDC Topics > Injury, Violence & Safety > Prescription Drug Overdose > CDC Guideline for Prescribing Opioids for Chronic Pain.

Medication-Assisted Treatment

UnitedHealthcare Community Plan PCPs can treat our members with MAT for opioid use disorder (OUD).

PCPs providing MAT must meet all regulatory requirements established for the medication type administered. MAT is both medication management with FDA-approved medication for OUD in conjunction with psychological and behavioral therapies. Providers who provide the medication management alone for OUD, must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

Find more information in the AMPM Policy 510.

Refer to the Pharmacy Program on **UHCprovider.com** for the UHCCP Preferred Drug List Search and AHCCCS/ Medicaid Preferred Drug List.

Duty to Warn/Report

A.R.S. §36-517.02 states that no cause of action or legal liability may be held against behavioral health care providers for breaching a duty to prevent harm to a person caused by a patient. The exception is if both the following occur:

a. The member has told the behavioral health care provider that they plan to seriously harm or kill a clearly identifiable victim, and the member has the intent and ability to carry out the threat, and

b. The mental health care provider fails to take reasonable precautions.

This statute says a behavioral health care provider's duty to take reasonable precautions to prevent a member from causing harm is discharged when the behavioral health care provider:

a. Shares the threat to all identifiable victims, when possible;

b. Notifies a law enforcement agency where the member or any potential victim lives;

c. Takes reasonable steps to hospitalize the member either voluntarily or involuntarily in accordance with AMPM Policy 320-U, if appropriate; or

d. Takes precautions a reasonable, prudent behavioral health care provider would take under the circumstances.

All care providers, regardless of specialty, must protect others against a member's potential danger to themselves or others.

Chapter 10: Member Rights and Responsibilities

Our Member Handbook has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy. If they do not, please call Provider Services and ask to speak with the member's care manager.

Privacy Regulations

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

ACCESS TO PROTECTED HEALTH INFORMATION

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

AMENDMENT OF PHI

Our members have the right to ask that information be changed if they believe it is inaccurate or incomplete. Any request must be in writing and explain why they want the change. This request must be acted on within 60 days. The timing may be extended 30 days with written notice to the member. If the request is denied, members may have a disagreement statement added to their health information.

DISCLOSURE OF MEMBER INFORMATION

Information obtained while providing a member with covered health services is confidential. It may only be disclosed according applicable federal and state law. If an unauthorized use/disclosure of unsecured PHI occurs, the covered entity responsible for the breach must notify all affected persons. Medical records must be maintained in accordance with written protocols related to their care, custody, and control as mandated by the AHCCCS program.

Before disclosing PHI, consult the specific citation to HIPAA and state law. Also consult with legal counsel.

To prevent breaches, maintain a list of every person or organization that inspects a currently or previously enrolled person's records other than the clinical team. Also track how the information is used. The access list must be placed in the member's record and be made available to them, their guardian or designated representative. Retain consent and authorization medical records as noted in A.R.S. §12-2297.

RIGHT TO REQUEST RESTRICTIONS

Members have the right to ask you or us to restrict the use and disclosures of their PHI for treatment, payment and health care operations. This request may be denied. If it is granted, the covered entity is bound by any restriction to which is agreed. Document these restrictions. We must agree to restrict disclosure. Members may request to restrict disclosures to family members or to others who are involved in their care or its payment.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

Members have the right to request communications from you or us be sent to a separate location or other means. Accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member Rights and Responsibilities

The following information is in the Member Handbook. You may obtain copies of the Member Handbook at **UHCprovider.com** or by calling Provider Services.

NATIVE AMERICAN ACCESS TO CARE

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

MEMBER RIGHTS

Members may:

- Request information on advance directives.
- Give and be treated with respect, dignity and privacy.
- Receive courteous and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures. This also includes the right to refuse care from specified providers.
- Receive information about us, their rights and responsibilities, their benefit plan and which services are not covered.
- Learn how to get AHCCCS-covered services not offered or available through the health plan. Also learn how to get family planning services from an appropriate AHCCCS-registered provider.
- Receive information about how the health plan evaluates new technology for inclusion as a covered benefit.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive. They may also refuse care from a specific care provider.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- Change care providers contracted with us up to three times per year.
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response.
- Tell us their opinions and concerns about services and care received.
- Register grievances or complaints concerning the health plan or the care provided.
- Appeal any payment or benefit decision we make.
- Review or request a copy of their medical records you keep and request changes and/or additions to any area they feel is needed.
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, alternative treatment options, and talk with you when making decisions about their care.
- Be informed of medical alternatives and other types of care and how they access care.
- Get a second opinion with an in-network care provider.
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage.
- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.
- Know if they need stop-loss insurance for very large claims.
- Know how we compensate you.
- Exercise their rights and not be negatively affected as a result.
- Request a summary of the member survey results.

MEMBER RESPONSIBILITIES

Members should:

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

- Use the emergency room only during a serious threat to life or health.
- Notify us of any change in address or family status.
- Make sure you are in-network.
- Follow your advice and understand what may happen if they do not follow it.
- Give you and us information that could help improve their health.
- Give a copy of their living will to their PCP.

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

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

Change of Contractor/ Complete Care Contractors

AHCCCS ACOM policy 401 sets guidelines, criteria and time frames for how, when and by whom insurance contractor change requests are processed for AHCCCS members outside of contractor choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period. This affects:

- The member.
- The member's current/relinquishing contractor.
- The receiving contractor.
- AHCCCS.

CRITERIA FOR CHANGE OF CONTRACTOR OUTSIDE OF INITIAL ENROLLMENT OR AEC PERIOD

Contractor change requests outside these periods are granted if certain conditions are met. These conditions are:

- **Administrative Actions That May Merit a Contractor Change**
  - A member was entitled to freedom of choice but was not sent an auto-assignment/freedom of choice notice.
  - A member was entitled to participate in an AEC but:
- Was not sent an AEC notice, or
- Was sent an AEC notice but could not take part due to circumstances beyond the member's control.
  - Family members were inadvertently enrolled with different contractors through the auto-assignment process. Upon receipt of AHCCCS notification, the member who was wrongly enrolled will be disenrolled from the contractor of assignment and enrolled in the contractor where the other family members are enrolled. Other family members may not change to the contractor to which the new member was auto-assigned. This process does not apply if a member was afforded an enrollment choice during their AEC period.
  - A member who was enrolled with a contractor, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled with a different contractor within 90 days from the date of disenrollment. In this case, the member will be reenrolled with the contractor they were enrolled with prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member with the correct contractor.
  - Newborns will automatically be assigned to the mother's contractor. If the mother is Title XIX or Title XXI-eligible, she will be given 30 days from notification to select another contractor for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto-assigned, and the mother will be given 30 days to select another contractor.
  - Adoption subsidy children will be auto-assigned, and the guardian will be given 30 days from notification to select another contractor.
  - A Title XIX-eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 30 days will be allowed to request a contractor change following auto-assignment. The member will be given 30 days to request a contractor change. A member who does not make a selection within 30 days will remain with the auto-assigned contractor.

- **Medical Continuity of Prenatal Care**
  A pregnant member enrolled with a contractor through auto- assignment or freedom of choice but who is receiving or has received prenatal care from a provider who is affiliated with another contractor may be granted a medical continuity contractor change if the medical directors of both contractors agree. If other individuals in the pregnant member's family are also AHCCCS-eligible and enrolled, they may remain with the current contractor or transition to the new one if the medical continuity plan change is granted. The member may not return to the original contractor or change to another after the medical continuity contractor change has been granted except during the AEC period.
  - Members who transition to a new contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS- registered care provider, regardless of contractual status, to help ensure continuity of care.
- **Medical Continuity of Care**
  AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all contractors serving a specific geographic area. In unique situations, contractor changes may be approved on a case- by-case basis to help ensure the member has access to care.

  A plan change for medical continuity is not an automatic process. The member's PCP, or other care provider, must provide documentation to both the receiving and relinquishing contractors that supports the need for a contractor change. The contractors must be reasonable in the request for documentation.

  However, the burden of proof that a contractor change is necessary rests with the member's medical provider. The contractor change must be approved by both contractor medical directors.

  When the medical directors of both contractors cannot agree, the relinquishing contractor will submit the request to the AHCCCS chief medical officer (CMO) or designee. The AHCCCS Acute Care Change of Contractor Form (Attachment A) and the supporting documentation must be sent to the AHCCCS DHCM/ Medical Management Manager within 14 business days from the date of the original request.

  The results of the review will be shared with both medical directors. The relinquishing contractor must issue a final decision to the member. If the member request is denied, the relinquishing contractor will send the member a Notice of Adverse Benefit Determination.

  The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.

CONTRACTOR RESPONSIBILITIES WHEN A CONTRACTOR CHANGE IS NOT WARRANTED

The current contractor must promptly address the member's concerns regarding availability and accessibility of service and quality of care or delivery issues that may have caused a contractor change request. These issues include but are not limited to:

- Quality of care delivery.
- Care management responsiveness.
- Transportation convenience and service availability.
- Institutional care issues.
- Care provider preference.
- Care provider recommendation.
- Care provider office hours.
- Timing of appointments and services.
- Office waiting time.
- Network limitations and restrictions.

When the member raises quality of care and delivery of service issues that cannot be solved through the normal care management process, call the health plan Member Services number on the member's ID card to report concerns.

The current contractor must also explore all options available to the member, such as transportation problems, care provider availability issues, allowing the member to choose another PCP or care provider, if appropriate.

The delivery of covered services remains the responsibility of the current contractor if a contractor change for medical continuity of prenatal or other medical care is not approved. The current contractor must notify the member, in writing, that a Contractor change is not warranted. If the contractor change request was the result of a member concern, as defined in Section III A (2) or A (3) of this policy, the notice must include the contractor's

resolution. The notice must also advise the member of the AHCCCS and contractor grievance policy and include timeframes for filing a grievance.

Contractors may reach an agreement with an out-of-network provider to care for the member on a temporary basis, for the members' period of illness, and/or pregnancy to provide continuity of care.

RELINQUISHING CONTRACTOR, RECEIVING CONTRACTOR AND AHCCCS ADMINISTRATION RESPONSIBILITIES WHEN A CONTRACTOR CHANGE IS WARRANTED

- **Relinquishing Contractor Responsibilities**
  If a member contacts the current contractor, verbally or in writing, and states the plan change request is due to situations defined in Section A(1) of this policy, the relinquishing contractor will tell the member to call the AHCCCS Verification Unit at 602-417-7000 or 800-962-6690 for AHCCCS to process the change.

  If the member contacts the relinquishing contractor, verbally or in writing, to request a plan change for medical continuity of care as defined in III A (2) or A (3) of this policy, the following steps must be taken:
  - The relinquishing contractor will contact the receiving contractor. If a plan change is needed for medical continuity of care, the AHCCCS Contractor Change Request Form (Attachment A) must be completed. All affected members are added to the form, which the medical directors or physician designees of both contractors sign. The form is then submitted to the AHCCCS CMO.
  - To facilitate continuity of prenatal care, contractors will sign off and forward the AHCCCS Contractor Change Request Form to the AHCCCS CMO within two business days of the change request. The timeframe for other continuity of care issues is 10 business days.
  - The AHCCCS CMO will review the contractor change documentation and forward to the Communications Center for processing.
- **Receiving Contractor Responsibilities**
  The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.
- **Member Responsibilities**
  The member will request a change of contractor directly from AHCCCS only for situations defined in Section III A (1) of this policy. The member should direct all other contractor change requests to the member's current contractor.
- **AHCCCS Responsibilities**
  AHCCCS will process change of contractor requests that are listed in Section III A (1) and send notification through the daily recipient roster to the relinquishing and receiving contractors. The contractor must identify members from the daily recipient roster who are leaving the contractor. If AHCCCS denies a Section III A (1) change of contractor request, AHCCCS will send the member a denial letter. The member will be given 60 days to file a grievance.

If AHCCCS receives a letter or verbal request from a member requesting a contractor change, for reasons defined in Section A(1) of this policy, and notes other problems, that information will be sent to the current contractor. If AHCCCS receives a letter or verbal request from a member requesting a contractor change for reasons listed in Section III A (2) or A (3), the information will be forwarded to the current contractor.

The AHCCCS Acute Care Change of Contractor Form is located in the AHCCCS Contractor Operations Manual, Chapter 400.

DD/ALTCS EPD Members

DD/ALTCS EPD members or their responsible person(s) are assisted with their rights and responsibilities through their DES/ DDD support coordinator. Their member rights and responsibilities include:

- Maintaining their ALTCS EPD eligibility redetermination appointments.
- Selecting a health plan at the time of ALTCS application.
- Selecting a PCP within 10 days of notification of plan enrollments.
- Coordinating all necessary covered medical services through their PCP.
- Notifying their AHCCCS-eligible worker and UnitedHealthcare of changes in their address or phone.
- Arriving on time for their appointments or calling ahead if they can't make it.
- Providing all the information to their PCP that is requested by the PCP.

- Providing DES/DDD and UnitedHealthcare with all the information, including changes, in private and public insurance, third-party liability, financial assistance, or other benefits received by the DD/ALTCS EPD member.
- Pursuing eligibility with Children's Rehabilitative Services (CRS) when referred by DES/DDD or UnitedHealthcare.
- Directing any complaints or problems to DES/DDD Managed Care Operations Health Care Services, Member Services, or their UnitedHealthcare DD Liaison as soon as possible.
- Participating in family-centered consultations at the request of UnitedHealthcare, their support coordinator or other personnel.

Chapter 11: Medical Records

Medical Record Charting Standards

UnitedHealthcare Community Plan and AHCCCS Medical Policy Manual, Chapter 900, Policy 940 require you to keep complete and orderly medical records, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. You must also keep medical records in accordance with written protocols related to their care, custody and control as mandated by the state of Arizona AHCCCS program and as prescribed in A.R.S. §12-2297. The review determines compliance to the following requirements:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location.
Record Organization	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be: - In order. - Fastened, if loose. - Separate for each member. - Filed in a manner for easy retrieval. - Readily available to the treating care provider where the member generally receives care. - Promptly sent to specialists upon request. • Medical records are: - Stored in a manner that helps ensure privacy. - Released only to entities as designated consistent with federal requirements. - Kept in a secure area accessible only to authorized personnel. - Backed up with initial and revised information.

Topic	Contact
Procedural Elements	**Medical records are readable in blue or black in or typewritten*** • Sign and date all entries. • Member name/identification number is on each page of the record. • Corrections made with a line drawn through the incorrect information, a notation, the date the correction was made, and the initials of the person altering the record. Correction fluid or tape is not allowed • If a rubber-stamp signature authenticates the entry, the individual whose signature the stamp represents is accountable for the use of the stamp. • Document language or cultural needs. • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English. • Procedure for monitoring and handling missed appointments is in place. • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a signed and dated acknowledgment of informed consent of proposed treatment from the member or member's legal guardian/ custodian. • Include a list of significant illnesses and active medical and behavioral health conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.* • Obstetric care providers must also complete a risk assessment tool for obstetric patients (i.e., Mutual Insurance Company of Arizona Risk Assessment Tool [MICA] or ACOG). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines. • Documentation that physician or other care provider has notified each member of reproductive age verbally or in writing of the family planning services available. • Documentation of review of the CSPMP database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances. • If assistants are allowed to provide services, the member's record must contain documentation indicating supervision by a licensed professional authorized by the licensing authority to provide the supervision.

Topic	Contact
History	An initial history (for members seen three or more times) and physical is performed. The initial history for members younger than 21 years should also include prenatal care and birth history. It should include: • **Medical, dental, laboratory, behavioral and surgical history* that includes disabilities, immunizations and serious accidents.** • A family history that includes relevant medical and behavioral history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults which must be maintained in a separate immunization record. - For all adult members 21 years and older, the record must show the member's immunization status for Td. - For all female members of childbearing age, the record must show blood titer and/or immunization status for rubella. - For members 65 years and older, include immunization status for influenza and pneumococcal. - For at-risk DD/ALTCS EPD members, include immunization status for influenza and pneumococcal. - For all high-risk members 21 years and older, include immunization status for influenza pneumococcal and/or hepatitis B. - For members younger than 21 years, include immunizations given according to CDC recommendations. If no record is available, include documentation about immunization status. For example, state who reported the status and that the copy was requested for the medical records. • Screenings of/for: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Topic	Contact
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - **Chief complaint*** - **Physical assessment*** - **Diagnosis*** - **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

***Critical element**

Medical Record Maintenance

Retain the original or copies of member medical records as follows:

- **Adult:** for at least six years after the last date the adult member received care services
- **Child:** either for at least three years after the child's 18th birthday or for at least six years after the last date the adult member received care services, whichever occurs later.

Sharing Medical Records and Information

You must comply with the following standards:

- Appropriate and confidential exchange of member information among providers, including behavioral health care providers to help ensure:
  - A care provider making a referral transmits necessary information to the care provider receiving the referral.
  - A care provider furnishing a referral service reports appropriate information to the referring care provider.
- You must request information from other treating care providers as necessary to provide appropriate and timely care.
- Information about services provided to a member by a non-network provider (e.g., emergency services, behavioral health) is transmitted to the member's PCP.
- When a member chooses a new PCP within the network, the member's records are transferred to the new care provider within 10 working days of the change continuity of care, or if a member subsequently enrolls with a new health plan, sharing of member information is accomplished in a manner to keep it confidential while promoting continuity of care.
- Information form, or copies of records may be released only to, authorized individuals. You must help ensure unauthorized individuals cannot gain access to, or alter, member records.
- Original medical records must be released only in accordance with federal or state laws, AHCCCS policy and contracts, compliance with the Health Insurance Portability and Assurance Act (HIPAA) requirements and 42 CFR 431.300 el seq.
- Confidentiality of member information must be protected by the policy and/or procedures as required by law. There must be documentation that office staff are informed of and agree to confidentiality standards.
- Records for members transitioning to a new contractor must be shared in a way that keeps it confidential while promoting continuity of care.

PCPs must forward medical records within 10 working days of a PCP change.

Medical Record Review

On an ad hoc basis, we conduct a review of our members' medical records. You must respond to information requests within 10 business days. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than two visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes

prenatal care, birth, operations and childhood illnesses.

- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

Chapter 12: Quality Management (QM) Program and Compliance Information

What is the Quality Improvement Program?

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

The program consists of:

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

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

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

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

- Providing requested timely medical records.
- Cooperation with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.

Care Provider Satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

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

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

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

Credentialing Standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable AHCCCS statutes and the National Committee of Quality Assurance (NCQA). As a participant of the Arizona Association of Health Plans (AzAHP), we also use the Council for Affordable Quality Healthcare **(CAQH)** Universal Provider Data Source. The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- A completed **Request for Participation Form** from the National Credentialing Center
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

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

Credentialing and Recredentialing Process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members. New and existing care providers are re-credentialed with the AzAHP credentialing process.

CARE PROVIDERS SUBJECT TO CREDENTIALING AND RECREDENTIALING

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or
- Nurse practitioners and physician assistants who practice under a credentialed UnitedHealthcare Community Plan care provider.

To notify UnitedHealthcare Community Plan about new hospital-based practitioners joining your group, send a fax to 855-314-6844.

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

The National Credentialing Center (NCC) completes these reviews. You can find applications on the CAQH website.

First-time applicants must call the **National Credentialing Center (VETTS line)** to get a CAQH number and complete the application online. If you need help, call our Network Management Phone Team at 866-874-6088.

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

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

ADVANCE DIRECTIVES REVIEW

As part of re-credentialing, we may audit records of primary care providers, hospitals, home health agencies, personal care providers and hospices. This process helps us determine whether you are following policies, procedures and state laws related to advance directives. These policies include:

- Respecting members' advance directives, and placing them prominently in medical records. If a member has a complaint about non-compliance with an advance directive, they may file a complaint with

our medical director, physician reviewer, and/or the state survey and certification agency.

- Adhering to charting standards that reflect the member's advance directives.

Peer Review

PROVIDER ADVISORY COMMITTEE

The Provider Advisory Committee (PAC) evaluates and monitors quality, continuity, accessibility, availability, utilization and medical care, The committee also monitors peer review activities, reviews and accepts the National Credentialing Plan and regulatory requirements and provides oversight by the Credentialing Committee for credentialing and recredentialing. It also monitors performance on clinical indicators such as encounter validation studies, STARS, HEDIS®, Quality of Care investigations, AHCCCS and DD performance measures – and makes recommendations as appropriate.

CREDENTIALING PROCESS

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review. In addition, we take part in the AzAHP, which uses the CAQH Universal Provider Data Source for all practitioner credentialing and re-credentialing applications.

RECREDENTIALING PROCESS

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

PERFORMANCE REVIEW

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

APPLICANT RIGHTS AND NOTIFICATION

You may review the information in support of credentialing/ recredentialing applications as well as your application status. This review is at your request and is facilitated by the credentialing staff. The staff notifies you of any information found during the credentialing or recredentialing process that varies from what you gave UnitedHealthcare Community Plan. You may correct errors if the credentialing staff asks for clarification.

CONFIDENTIALITY

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

FAILURE TO MEET RECREDENTIALING REQUIREMENTS

If you don't meet our recredentialing requirements, we will end your participation with our network. We will give you a written termination notice. The termination notice will include the reasoning, the effective date and an explanation of your appeal rights, if applicable.

HIPAA Compliance – Your Responsibilities

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

TRANSACTIONS AND CODE SETS

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

UNIQUE IDENTIFIER

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

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

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

SECURITY

Covered entities must meet basic security measures:

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

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

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

Ethics & Integrity

INTRODUCTION

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

COMPLIANCE PROGRAM

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

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

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior

managers from key organizational areas. The committee provides program direction and oversight.

REPORTING AND AUDITING

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

Call the health plan Member Services number on the member's ID card to report a member issue, such as a quality of care concern. Quality of care concerns include, but are not limited to, abuse, neglect, opioid abuse and attempted suicide.

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud and Abuse line**.

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

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

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

EXTRAPOLATION AUDITS OF CORPORATE-WIDE BILLING

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

RECORD RETENTION, REVIEWS AND AUDITS

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least three years after the child's 18th birthday or for at least six years after the last date the member received services from you, whichever date occurs later. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

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

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

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

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

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

DELEGATING AND SUBCONTRACTING

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this manual.

Office Site Quality

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

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

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

CRITERIA FOR SITE VISITS

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

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

Chapter 13: Billing and Submission

Manuals and Guides

For access to all UnitedHealthcare Manuals and Guidelines, please go to **UHCprovider.com/guides**.

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions.

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

Your clean claims must include your NPI and federal TIN. Also include the Unique Care Provider Identification Number (UPIN) on laboratory claims.

General Billing Guidelines

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

Payment for Provider

UnitedHealthcare Community Plan will not pay a claim initially submitted outside of the timely filing guidelines documented in this manual, or stated in your Agreement. Non-participating providers have up to 180 days to submit an initial claim. Please review the Timely Filing information provided in Chapter 13 of this manual.

PREVENTABLE CONDITIONS

Payment for services related to Provider-Preventable Conditions is prohibited, in accordance with 42 CFR Section 447.26.

A "provider-preventable condition" is one that meets the definition of a HCAC or an Other Provider-Preventable Condition (OPPC). More information is in the AMPM, Chapter 1000, Policy 1020.

Fee Schedule

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

AHCCCS Rate Codes

The rate codes found on member rosters refer to the member's eligibility category. Each member is eligible for a rate code that indicates their eligibility type, benefits and whether they are eligible for Medicare. Prior Period Coverage is indicated by a rate code ending in an alpha character. If you are a capitated PCP, the rate codes determine your per-member capitation payment. Updated AHCCCS rate codes can be found at **azahcccs.gov**.

FQHC/RHC Payment and Billing Information

UnitedHealthcare Community Plan pays the lesser of all-inclusive visit PPS rate or billed charges on a per claim basis. This replaces the previous reimbursement capped fee-for-service fee schedule.

This affects all Complete Care, DD-CRS, and Dual Complete/Dual Complete One members. AHCCCS has established a provider type for FQHCs, FQHC Look-alikes (LAs) (C2) and RHCs (29). AHCCCS requires all FQHCs, FQHC LAs, and RHCs to reregister under the applicable provider types. It also requires each clinic covered by the CMS FQHC, FQHC LA, or RHC designation to obtain a unique NPI not already associated with another active AHCCCS provider ID.

FQHC/RHC LOCATIONS

The FQHC/RHC location is the address attached to your AHCCCS NPI and provider type C2 or 29. The PPS rate will apply to services submitted at that address and NPI. Any services not provided at that location will be billed according to the AHCCCS Fee for Service Provider Manual.

FQHC/RHC BILLING AND PROCEDURE CODES

All FQHC, FQHC-LAs, and RHC visits must be billed using the CMS Form 1500 or the ADA Form. For reimbursements, AHCCCS has adopted HCPCS code T1015 for reporting physical health, behavioral health and dental visits. FQHC/RHC services should be reported on either a CMS 1500 claim form or an ADA claim form. A claim for an FQHC, FQHC-LA, or RHC visit must include all appropriate procedure codes describing the services rendered plus visit code T1015.

The following Rendering Provider information is required for all FQHC/RHC claim submissions:

- CMS 1500 Claim Form: Box 19
- ADA Claim Form: Field 35
- 837 Professional (Electronic Claim): Loop 2300 NTE.

A visit's reimbursement will be applied to the HCPCS code T1015. All underlying, covered services reported on the same claim will be bundled into the visit and valued at $0 with reason code CO 45.

Case Management (T1016) is not an FQHC/RHC visit to be reimbursed at the all-inclusive per visit PPS rate.

Case Management is reimbursed at the capped fee-for-service fee schedule when provided by a provider within their scope of practice. Excluding case management, the services of a Behavioral Health Technician (BHT) may qualify as a FQHC/RHC visit only when those services meet the requirements of 42 CFR Part 405, Subpart X. Behavioral health group therapy and/or any other services provided to a group do not satisfy the requirements of a face-to-face encounter and are not reimbursable at the all-inclusive per visit PPS rate.

Telehealth and Telemedicine may qualify as a FQHC/RHC visit if it meets the requirements as specified in AMPM Policy 320-I.

Further billing instructions and examples regarding the Referring Provider requirements are in the AHCCCS For-For-Service Provider Manual, Chapter 10 addendum and AHCCCS Medical Policy Manual, Policy 670.

AHCCCS-Approved Codes, Units and Values

Use valid and approved AHCCCS codes when submitting claims. This includes:

- Place of service codes.
- HCPCS codes.
- Revenue codes.
- CPT codes.
- Modifiers.
- ICD-10 codes.

Additional requirements may apply to UB claims. See Uniform Billing Manual for the UB-04.

We will apply AHCCCS and DD billing and payment requirements to all claims submitted. This applies to the application of max-unit guidelines, age/gender guidelines, place of service/procedure combinations, duplicate claim billing, duplicate line-item, and revenue/procedure/modifier combination guidelines.

Social Determinants

AHCCCS has found using specific ICD-10 diagnosis codes representing Social Determinants of Health is a valuable source of information that affects member health.

As appropriate, routinely screen for, and document, social determinants. Provide identified social determinant diagnosis codes on all claims for Community Plan members to comply with state and federal coding requirements beginning with dates of service on and after April 1, 2018.

Find more information about social determinant ICD-10 coding on **azahcccs.gov**.

Member ID Card for Billing

The member ID card has the UnitedHealthcare Community Plan member ID. UnitedHealthcare Community Plan suggests you bill with the member ID as shown on the member's ID card. UnitedHealthcare Community Plan ID cards reflect the member's Group ID number. However, this is not a required field. Some member's ID cards will also reflect their PCP assignment on the front of the card. Some DD-CRS members might show two PCP assignments, with one being the multispecialty interdisciplinary clinic (MSIC) and one being the PCP. You may view a copy of the members ID card image using Link online at **UHCprovider.com** while verifying member eligibility.

CLAIMS WITH DATES OF SERVICE ON OR AFTER OCT. 1, 2018

- AHCCCS Complete Care members with CRS Designation
  - Bill the members AHCCCS ID beginning with an 'A'
- DD members dually enrolled with CRS (DD-CRS)
  - Bill the members CRS ID beginning with a '2'
- DD members (any date of service)
  - Bill the members AHCCCS ID beginning with an 'A'
- ALTCS EPD members
  - Bill the members AHCCCS ID beginning with an 'A'

CLAIMS WITH DOS BEFORE OCT. 1, 2018

- AHCCCS Medicaid members
  - Bill the members AHCCCS ID beginning with an 'A'
- ALTCS EPD members
  - Bill the members AHCCCS ID beginning with an 'A'
- DD members (any date of service)
  - Bill the members AHCCCS ID beginning with an 'A'
- CRS Fully Integrated/CRS Partially Integrated Acute/ CRS Partially Integrated Behavioral Health/CRS Only
  - Bill the members CRS ID beginning with a '2'

Acceptable Claim Forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500, UB-04 claim forms as well as 837p or 837i electronic formats. All billing guidelines and requirements must be followed.

Visit the **National Uniform Claim Committee Website** to learn more about how to complete the CMS 1500 claim form. The AHCCCS guidelines in the Fee For Service Manual also include directions for completing the form. Refer to Chapter 5 on **azahcccs.gov**.

Use the most current claim form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

The AHCCCS guidelines for completing the UB-04 form can be found in the AHCCCS Fee For Service Manual, Chapter 6 on **azahcccs.gov**.

Submit claims and medical record attachments electronically, if possible. Paper claims can also be submitted to:

Medical:
United Healthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

Behavioral:
United Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

For more information please review the **Arizona Skilled Nursing Facility Billing Resource Guide**.

Clean Claims and Submission Requirements

The Arizona Revised Statutes says that a "clean claim" can be processed without obtaining additional information from the service provider or from a third party. It does not include a claim from a provider under investigation for fraud or abuse or a claim we have selected for medical review. We require the initial claim submission within 90 days from date of service, date of discharge or date of eligibility posting unless otherwise stated in your Agreement.

Non-participating providers have 180 days from the date of service to submit an initial claim. All providers are required to submit a claim for secondary payment within 180 days from the claim's date of service, even if payment has not been received from the primary carrier. Please review the Coordination of Benefit section for more information. You have 365 days from the date of service, date of discharge or date of eligibility posting to correct and resubmit claims only if the initial submission time period has been met. Not adhering to these requirements will result in a denial.

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

Mail initial medical claims, medical record attachments and encounters to:

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

Mail initial behavioral health claims, medical record attachments and encounters to:

United Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

Circumcision Billing

Per the AHCCCS Medical Policy Manual (AMPM), **Policy 410**, AHCCCS only covers circumcision for fee-for-service and contracted care providers as follows:

- Circumcision is only a covered service under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for male infants when it's determined to be medically necessary.
- According to Arizona Revised Statute (A.R.S) § 36-2907, routine circumcision for newborn males isn't a covered service.
- You must submit a prior authorization request for all circumcision procedures, and UnitedHealthcare Community Plan must approve the request.

All services provided in addition to the circumcision should be bundled, including anesthesia, medication or evaluation and management services. Please keep these guidelines in mind when preparing for circumcision procedures and submitting claims for those services.

Electronic Claims Submission and Billing

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

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.
- Our payer ID is 03432.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit.
- We follow the **National Uniform Claim Committee (NUCC)** and **National Uniform Billing Committee (NUBC)** guidelines for 1500 and UB-04 forms.

For more information, contact **EDI Claims**. You can also email **ac_edit_ops@uhc.com** or contact Provider Services at **800-445-1638**. Or you may call ALTCS EPD Provider Services at **800-377-2055**.

EDI Companion Documents

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

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows

multiple choices.

- Provide values the health plan will return in outbound transactions.
- Outline which situational elements the health plan requires.

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

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

Importance and Usage of EDI Acknowledgment/Status Reports

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

To get your reports, make sure your software vendor has connected to our clearinghouse OptumInsight at **enshealth.com**.

If you are not yet an OptumInsight client, we will tell you how to receive Clearinghouse Acknowledgment Reports.

e-Business Support

UnitedHealthcare Community Plan 's EDI Support offices are open 9 a.m. - 3 p.m. (Arizona Time), Monday through Friday. They can help you with Electronic Data Interchange such as: Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse or entity that uses OptumInsight.

Support is also available for **EPS** and **Community Plan-specific EDI information**.

Find more information at **UHCprovider.com** > Claims and Payments > Electronic Data Interchange (EDI).

IMPORTANT EDI PAYER INFORMATION

- Claim Payer ID: 03432
- ERA Payer ID: UFNEP

UnitedHealthcare Community Plan Remittance Advice

All online transactions for members enrolled in ACC, DD/CRS, and Dual Complete/Dual Complete One will be accessible on **UHCprovider.com** as well as Link.

If you are not registered on **UHCprovider.com**, you may do so on the website. Below is an explanation of fields found on the UnitedHealthcare claim remittance advice that is issued:

The box located on the top right hand corner of the remit contains:

- **Payment Date:** The date the remit was issued
- **Payee Tax Number:** The TIN the claims were processed to pay under
- **Payee NPI:** The NPI of the Practice/Group
- **Payee ID:** The UHCCP Internal ID associated with the Providers/Facility used to process the claims
- **Payee Name:** The name of the Practice/Group associated with the Provider/Facility used to process the claims
- **Payment Number:** The check number (if paper) or electronic reference number associated with the payment
- **Payment Amount:** The net paid amount of the remit
- **GRP ID:** The line of business associated with the processed claims on the remit
- **RA Reference ID:** The electronic reference number associated with the remit

Within the remit, the claim information is listed for each member's date of service that was included on the remit. Please see the following for details regarding the information provided:

- **Patient:** The member's name
- **Subscriber ID:** The internal ID number assigned to this member's program with which the claim processed under. Please remember to submit claims to UHCCP with the ID number shown on the member's ID card.
- **Subscriber Name:** the name of the Subscriber.

- **Prompt Pay Disc:** Prompt Pay Discount amount (if applicable)
- **Claim Number:** the claim number assigned. The last digit in the claim number will change as the claim is adjusted (01,02, etc.)
- **Patient Account:** The account number submitted on the claim details provided
- **Member ID:** The members ID number as shown on their card
- **Interest Amount:** The interest amount applied to qualified claims (if applicable)
- **PCP Number:** The UHCCP internal ID number of the PCP assigned to this member
- **Remit Detail:** Indicates whether it is a Professional or Institutional claim
- **Product Desc:** Description of the program under which the claim processed (This will be updated in accordance to AHCCCS Codes and Values Document)
- **Servicing Prov NPI:** The rendering provider's NPI
- **Servicing Prov NM:** The name of the rendering provider applied to the claim
- **Coverage Date:** The effective date we have listed for the member under this program
- **PCP Name:** The name of the PCP assigned to the member
- **Billing NPI:** The pay to NPI provided in the claim details
- **COB Primary Ins:** The members Primary Ins
- **Policy Number:** The member's Primary Ins Policy Number
- **Carrier ID:** Not used at this time.

The individual line items we received on the claim image or in the electronic information provided are listed with processing details as shown below:

- **Date(s) Of Service:** The dates of service
- **Description of Service:** The CPT, modifier and place of service (POS)
- **Units:** The number of units for each line item.
- **Billed Amt:** The billed amount for each line item.
- **Disallow Amt:** The amount that exceeds the contracted rate. This amount is not billable to the member
- **Discount Amt:** Calculated discount applied to qualified claims (if applicable)
- **Allowed Amt:** Amount allowed per UnitedHealthcare Community Plan agreement or non-participating rate
- **Deduct Amt:** Portion of payment for which the member is responsible before benefit is payable. You may not balance bill a member.
- **Copay/Coins Amt:** A monetary amount a member may be required to pay directly to a care provider at the time a covered service is rendered.
- **COB Amt:** (Coordination of Benefits) The amount of which other insurance has paid to the claim
- **Withhold Amt:** Amount withheld, if any, according to the participation agreement
- **Paid to Provider Amt:** Amount paid after any applicable discounts, penalties or member responsibilities were applied
- **Patient Resp Amt:** The members responsibility amount
- **Auth#:** The authorization number on file used for processing the claim (if applicable)
- **RMK CD:** The Remark Code providing details regarding each lines individual processing or denial reason. These codes are explained within the same remit as shown below and are also available on our website.
- **GRP CD/RSN CD:** The Group Code or Reason Code providing details regarding each lines individual processing or denial reason. These codes are explained within the same remit as shown below and are also available on our website.
- **PROVIDER TOTALS:** The totals calculated for each provider listed on the claim. Includes total billed amounts, total discount amounts, and total paid to provider amounts.
- **PAYEE TOTALS:** The total amounts calculated from the remit as a whole. Includes total billed amounts, total discount amounts, and total paid to provider amounts.

The last few pages of the Remittance Advice provide additional detail to assist in understanding the information provided. Please review this information prior to taking action on a claim. Many denials or details regarding why a claim processed as it did are provided as shown below:

- **REMARKS:** Provides details and explanation regarding the RMK Code (remark codes) listed for each line item.
- **Provider Communications:** A contact number for the Provider Services Center
- **National Provider Identifier Information:** Information regarding the national NPI guidelines
- **Balance Billing:** The Arizona Administrative Code (AAC) regarding billing United Healthcare Community Plan members.
- **EDI, ERA, & EFT:** Contact information for our Electronic Data Interchange department. They can assist with your electronic payments and submissions.
- **UnitedHealthcare Community Plan Online Services:** Provides details on some resources available online
- **Corrected Claim Resubmissions and Claim Adjustments:** Definition/Explanation for Corrected Claim vs Claim Adjustment
- **Claim Disputes:** Information regarding filing a Claims Dispute

Any Recovery or Overpayments that have been applied or will be applied are listed in the Summary of Overpayments/Payments Recovered section. Only those claims listed with a dollar amount in the Current Recovered Column have actually been applied on this remit. The claims that still have an amount to recovery are listed in the Remaining Amount Column. Please see details below:

- **Overpayment Creation Date:** The date the overpayment was identified
- **Member Last Name:** Member's last name
- **Patient First Name:** Member's first name
- **Member Number:** the Internal ID number assigned to the member
- **Patient ACCT Number:** The providers patient account number provided on the claim details
- **Claim Number:** The claim number assigned identified for recovery
- **Date(s) of Service:** The date of service identified for recovery
- **Original Overpayment Amount:** The total amount identified for recovery
- **Previously Deducted:** Any amount that has been previously recovered (not recovered on this remit)
- **Current Recovered:** The amount that was recovered on this remit. This amount should be subtracted from the Total Paid Amount, leaving the Net Paid Amount balance
- **Remaining Amount:** The amount flagged for overpayment that will be recovered at a later date/on another remit.
- **Total Deductions:** the total amount currently recovered
- **Total Overpayment Carried Forward:** The balance of overpayments listed in the Remaining Amount column
- **Total Paid to Provider:** The Net Paid Amount paid to Provider

You can view remits on **UHCprovider.com** and Link. This web- based portal offers the convenience of online support 24 hours a day, seven days a week.

Completing the CMS 1500 Claim Form

Companion documents for 837 transactions are on **UHCprovider.com** Click Menu, then Resource Library to find the EDI section.

Visit the **National Uniform Claim Committee** website to learn how to complete the CMS 1500 form. See also the AHCCCS Fee For Service (FFS) Provider Manual for submitting claims as well as the **AHCCCS 837 EDI Companion Guide** at **azahcccs.gov**. More information on corrected claims, corrected claim submission requirements and claim reconsiderations can be found in Chapter 14 of this manual.

Completing the UB-04 Form

Visit **CMS.gov**, **National Uniform Billing Committee**, or the AHCCCS Fee For Service Provider Manual, chapter 4 for more information about how to complete the UB-04 form. Bill all hospital inpatient, outpatient and emergency room services using revenue codes and the UB-04 claim form:

- Include ICD-10 diagnosis codes.
- Identify other services by the CPT/HCPCS and modifiers.

We may deny claims submitted with service dates that don't match the itemization and medical records.

Group ID Numbers

UnitedHealthcare Community Plan added a group ID number to the member ID cards. If submitting the member's group ID number, submit in box 11 of CMS 1500 claims form or box 62 of UB-04 claim form.

Claims for ALTCS EPD members will still require a Group ID number to be submitted on all claims. Review the ALTCS EPD chapter in this manual for more additional information.

Form Reminders

- Note the Attending Provider Name and identifiers for the member's medical care and treatment on institutional claims for services.
- Send the Referring Provider NPI and name on outpatient claims when this care provider is not the Attending Provider.
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims.
- Behavioral health care providers can bill using their site-specific NPIs.

Coordination of Benefit

Our benefits contracts are subject to coordination of benefits (COB) rules.

- We coordinate benefits based on the member's benefit contract and applicable regulations.

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

Secondary claims must be received within six months (180 days) from the date of service, even if the primary carrier has not made payment. If the primary carrier makes payment after this time limit, a reconsideration must be resubmitted with the primary EOB. Claims are processed according to the AHCCCS requirements.

Per R9-22-1002, AHCCCS is not the payer of last resort when the following entities are the third party:

1. The payer is Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.

Per the AHCCCS FFS Provider Manual, Chapter 9; Community Plan's reimbursement responsibility is limited to no more than the difference between the provider's contracted rate (or the AHCCCS Capped Fee-For-Service rates for non-participating providers) and the amount of the first- or third-party liability.

An AHCCCS registered provider agrees to accept the contracted rate* as payment in full. If the first- or third-party coverage paid more than the provider's contracted amount*, then no further reimbursement is made by Community Plan.

For example, a provider bills $4,500.00 for a surgical procedure:

- The first-party plan allowed $1,388.23, paid $1,110.58 and shows a 20% coinsurance amount of $277.65.
- The provider's contracted rate* allows $753.21 for the surgery.

There will be no Community Plan payment, as the provider has already been paid more than their contracted* amount. The provider must accept the $1,110.58 as payment in full and cannot balance bill the member for any amount.

When the first-party payer is an HMO-type health plan, the same coordination of benefits process would apply.

For example, a contracted HMO provider bills $150.00 for an office visit.

- The HMO plan benefit has a member co-pay of $30.00 and the plan pays the contracted provider $50.00.

- The provider's contracted rate* allows $41.39 for the office visit.

There will be no additional payment from Community Plan, as the provider has already been paid more than their contracted rate*. The provider must accept the $50.00 as payment in full. AHCCCS does not reimburse co-pays, deductibles or coinsurance amounts. If more than one coverage plan makes payment and the total paid by the multiple coverage plans is more than the provider's contracted rate* then there will be no payment. The provider cannot balance bill the member for any amount.

If the first- or third-party payer denies a covered service the provider must follow the payer's appeal process and exhaust all remedies before Community Plan can consider the covered service. The provider must submit a copy of plan's final appeal decision with the claim resubmission or the claim may be denied as incomplete.

*The AHCCCS Capped Fee-For-Service Schedule would be used for non-participating providers that do not have a contracted rate with Community Plan.

MEDICARE DUAL COST-SHARING

Some UnitedHealthcare Community Plan members are eligible for both Medicaid and Medicare. Claims for dual-eligible members will be paid according to the Medicare Cost Sharing for Members Covered by Medicare and Medicaid policy located in the **ACOM policy 201**. We are not responsible for cost-sharing should the payment from the primary payer be equal to or greater than what is received under Medicaid. Additional information is available in the Dual Complete Provider Manual.

Behavioral and Physical Health Services Financial Responsibility

This section applies to those members who are not enrolled in an integrated line of business. This includes DD-CRS or those who are not enrolled in a single health plan for their physical and behavioral health services, such as SMI or American Indian members.

- Payment for AHCCCS-covered behavioral health and physical health services is determined by the principal diagnosis on the claim, except in limited circumstances as described in **attachment A** of the AHCCCS Contractor Operations Manual (ACOM), Chapter 432.
- If physical health services are listed on a claim with a principal diagnosis of behavioral health, the member's behavioral health program pays for covered physical health services as well as behavioral health services, regardless of the setting.
- If behavioral health services are listed on a claim with a principal diagnosis of physical health, the member's medical/physical health program pays for covered behavioral health services as well as physical health services, regardless of the setting.
- Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the claim. Payment responsibility for the inpatient facility claim and the associated services is not necessarily the same program.
- Payment for an emergency department facility claim of an acute care facility is the responsibility of the member's insurance carrier, regardless of the principal diagnosis. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim. Payment responsibility of the emergency department visit and the associated services is not necessarily the same program.
- PCPs may treat a member's behavioral health condition if it falls within their scope of practice.
- The use of seclusion and restraint shall only be used to the extent permitted by and in compliance with A.A.C. R9-21-204. If restraint or seclusion is used this shall be reported on the Seclusion and Restraint Individual Reporting Form (AHCCCS Policy 962 Attachment A). The form should be completely filled out and faxed to 888-821-5101 or emailed to specialcare_UB2@optum.com. Any questions can be directed to this email address as well.

AHCCCS FFS pays for physical and behavioral health services claims provided by an IHS or a tribally owned and/or operated facility to Title XIX members whether enrolled in managed care or FFS.

Principal Diagnosis: The condition established to be chiefly responsible for the admission or care (as indicated by the Principal Diagnosis on a UB-04 claim form or the first listed diagnosis on a CMS 1500 claim).

The principal diagnosis is not the admitting diagnosis or any other diagnoses on the claim. Neither the admitting diagnosis nor other diagnoses should be used to assign payment responsibility.

Refer to the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, Policy 432, for more information.

Behavioral health care providers must help members with eligibility verification and screening or their application for public health benefits in accordance to **AMPM Policy 650**.

Hospital and Clinic Method of Billing Professional Services

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

Correct Coding Initiative

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

COMPREHENSIVE AND COMPONENT CODES

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

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

Clinical Laboratory Improvements Amendments

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

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the service reported may not be reimbursed. For more information about the CLIA number, contact the CMS CLIA Central Office at 410-786-3531 or go to the **cms.gov**. Any claim that does not contain the CLIA ID, invalid ID and/or the complete servicing care providers demographic information will be considered incomplete. As a result, it may be rejected or denied.

Billing Multiple Units

When billing multiple units:

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

Your claim may require more information and medical records to support the units you are billing.

Billing Guidelines for Obstetrical Services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we may deny the claim. More information regarding OB Billing, including bundled and unbundled services, can be found at **UHCprovider.com** in the Billing Resources and Reference Guides section.

- Use CPT Evaluation and Management codes (99201-99215*) or OB visits (59425-59426) to report prenatal visits.
  - The beginning date of service is the initial prenatal visit.
  - The ending date of service is the last prenatal visit prior to delivery.
  - Use one unit with the appropriate charge in the charge column.
- Use global delivery code (59400, 59519, 59610 and 59618).
- If the PCO provides prenatal services but does not perform the delivery, you must indicate that on the claim "Prenatal Visits Only." Or provide documentation that the care provider did not perform delivery.

*Only use CPT Evaluation and Management (E/M) Codes 99201-99215 when three or less prenatal visits are performed. Bill with up to three units.

Billing for Long-Acting Reversible Contraceptives

Effective with date of discharge on or after Oct. 1, 2016, LARC devices may be separately reimbursed outside the APR-DRG payment when billed by the hospital on a CMS 1500 claim form with the appropriate HCPCS procedure code. AHCCCS has identified LARC procedure codes as follows:

- J7297 levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3-year duration
- J7298 levonorgestrel-releasing intrauterine contraceptive system, 52mg, 5-year duration
- J7300 intrauterine copper contraceptive
- J7301 levonorgestrel-releasing intrauterine contraceptive system, 13.5mg
- J7307 Etonogestrel (contraceptive) implant system, including implant and supplies

This does not apply to individuals on the Federal Emergency Services Program (FESP).

Refer to the AHCCCS Fee-For-Service (FFS) Provider Manual, Chapter 11 for more information.

Billing Guidelines for Transplants

AHCCCS covers medically necessary, non-experimental transplants as described in the Medical Policy Manual, Chapter 300, Policy 310-DD. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

We require transplant centers to coordinate and prepare the transplant packet containing all invoices for services related to the transplant. No invoices are to be billed outside the transplant packet by subcontractors or non-transplant department within the transplant organization. Claims not included in the packet may be denied.

CARE PROVIDER RESPONSIBILITIES

- Coordinate all professional services associated with the referenced transplantation services.
- Help ensure and facilitate all required referrals and evaluations needed to complete the pre-transplant evaluation process in a timely manner once the member is referred to the center as a possible candidate.
- Not providing medical documentation or obtaining prior authorization may result in denial of reimbursement.
- In a timely fashion, provide all information/documentation requested at no additional charge.
- Help ensure subcontracted care providers do not bill the health plan directly for service reimbursed under this contract.
- Submit claims within six months of the date of service for all services provided to AHCCCS members relating to covered organ and tissue transplant services.
- Contractors are paid at the contracted rates in effect for each covered component after the invoices for all medically necessary services relating to the at component have been submitted to AHCCCS and meet the clean claim criteria pursuant to A.R.S. 36-2904(H).
- Bill all medically necessary services provided to the transplant recipient related to the transplant using the appropriate diagnosis/CPT codes (see FFS Provider

Manual, Chapter 24 on the AHCCCS website.) and procedure/revenue codes, as appropriate to meet clean claim status:

- UB-04 (Form B) – All contracted transplant services provided by the facility, including accommodation days, organ acquisition, and related inpatient or outpatient hospital services must be submitted on the UB-04 form using the proper revenue codes and bill types. Services must be itemized as they would be on any non-transplant encounter and must not include physician or other non-facility services.
- HCFA 1500 (Form A) – All physician and other professional services provided as part of the transplant contract, including transportation and medical supplies must be submitted on the HCFA 1500 form using the proper CPT and HCPCS procedure codes. Services must be itemized as they would be on any non-transplant encounter.
- Universal Drug (Form C) – Submit on Form C any prescription drugs covered under the transplant contract.

Ambulance Claims (Emergency)

Ambulance claims must include the point of origin, destination address, city, state, and ZIP in box 32 (or its electronic equivalent) of the CMS 1500 claim form. The accident state must be listed in box 10 (or its electronic equivalent) and ambulance claims must not be billed with diagnosis code 799.9 (Other unknown and unspecified cause).

National Drug Code

Claims must include:

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

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

Medical Necessity

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

Reimbursement Policies

For reimbursement guidance for Community Plan members, view the current **UnitedHealthcare Community Plan Reimbursement Policies** and Clinical Practice Guidelines.

Place of Service Codes

Go to azahcccs.gov for **Place of Service codes** and the **AHCCCS FFS Provider Manual**.

Asking About a Claim

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

PROVIDER SERVICES

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

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

Allow Provider Services 45 days from date of contact, resubmission or reconsideration before asking about a claim. Limit phone calls to five issues per call.

UNITEDHEALTHCARE COMMUNITY PLAN PROVIDER PORTAL

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

LINK: YOUR GATEWAY TO UNITEDHEALTHCARE COMMUNITY PLAN ONLINE PROVIDER TOOLS AND RESOURCES

Link lets you move quickly between applications. This helps you:

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

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

Find Link training on **UHCprovider.com**.

Resolving Claim Issues

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

Mail paper claims and adjustment requests to:

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

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and 45 days to receive adjustment requests.

FOR PAPER CLAIMS

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

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

TIMELY FILING

We will not pay a claim initially submitted outside the timely filing guidelines.

The receipt date of the claim is the date stamp on the claim, the date electronically received or the date we received the claim. Claim submission deadlines are calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later.

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

- A denial/rejection letter from another carrier.
- Another carrier's explanation of benefits.
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service.

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report. Please review the Valid Proof of Timely Filing section in this manual.

Secondary claims processed after Nov. 1, 2017, must be submitted within 180 days of the date of service. This includes members with Medicare coverage. Claims will be denied if they're submitted without an Explanation of Benefits (EOB) from the primary carrier. Care providers have 365 days from the date of service to resubmit the claim with an EOB from the primary carrier.

If a claim is rejected after submission and not processed for payment or denial, and a corrected claim is not received within 90 days from the date of service or according to the timely filing limits set forth in your Agreement, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and Agreements. If you don't know your timely filing limit, refer to your Provider Agreement. Non-participating care providers, please refer to the AHCCCS FFS Provider Manual at **azahcccs.gov** for more details.

TIMELY FILING FOR RECOVERED CLAIMS

The AHCCCS FFS Provider Manual, Chapter 4, A.R.S. §36-2903.01 L requires us to conduct post-payment review of all claims and recover any money erroneously paid. Under certain circumstances Community Plan may find it necessary to recover money previously paid to a provider.

Overpayments are identified through reports, medical review, grievance and dispute decisions, internal audits review and provider initiated recoveries.

Upon recovery completion, the Remittance Advice will detail the action taken. If a payment is recovered for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), the providers will be allowed additional time to provide justification for re-payment as outlined below.

In case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter. The time allowed for resubmission of a clean claim will be the greatest of:

- 12 months from date of service, or
- 12 months from date of eligibility posting (for retro eligibility claim), or
- 60 days from the date of the adverse action.

If the recovery is initiated by the AHCCCS Office of Inspector General (OIG) as a result of identified misrepresentation, you will not be afforded additional time to resubmit a clean claim.

Billing Members

If a member requests a service not covered by AHCCCS, have the member sign a release form indicating understanding that they are financially responsible for all applicable charges. This form must be signed before they receive services.

Arizona Revised Statute §36-2903.01 (K) prohibits you from billing AHCCCS recipients, including QMB-only recipients, for AHCCCS-covered services or covered services denied for exceeding benefit limits. AHCCCS-registered care providers may charge AHCCCS members for services excluded from AHCCCS coverage. These services are provided in excess of AHCCCS limits, as otherwise described in A.A.C. R9-28-701.10(2).

Upon oral or written notice from the member they believe the claims are covered by the AHCCCS system, a care provider or non-provider of health and medical services prescribed in §36- 2907 should not do either of the following unless they have verified through the administration that the person has been determined ineligible, has not been determined eligible or was not eligible or enrolled at the time of services were rendered:

6. Charge, submit a claim to, or demand or otherwise collect payment from a member or person who has been determined eligible.
7. Refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for system covered care or services unless specifically pursuant to the statute.

QMB is a Qualified Medicare Beneficiary Dual Eligible member determined eligible under A.A.C. R9-29-101 et seq. for Qualified Medicare Beneficiary (QMB). They are eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. For cost-sharing rules, see AHCCCS ACOM Policy 201 at **azahcccs.gov**.

COPAYMENTS

Some people may pay copayments for some AHCCCS medical services they receive. Every member is assigned a copayment level that reflects their amount owed or if they are don't have copayments. Members may have non-mandatory (nominal/optional) or mandatory copayments. Refer to the Glossary for the definition of mandatory vs non-mandatory copayments. Bill members at the time of service.

Copayments are **not charged** to the following people:

- Children younger than 19 years
- People determined to be SMI
- An individual with a CRS designation
- ACC members who are placed in nursing facilities, residential facilities such as an assisted living home, when such placement is made as an alternative to hospitalization. The exemption from copayments for ACC members is limited to 90 days in a contract year.
- People enrolled in ALTCS EPD
- Qualified Medicare beneficiaries A.A.C. Title 9, Chapter 29
- Those who receive hospice care
- Members in the Breast and Cervical Cancer Treatment Program (BCCTP)
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs

- An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age
- An individual to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age
- An individual who is pregnant and through the postpartum period following the pregnancy

Copayments referenced in this section means copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

Members must be told about any copay changes before they happen. In addition, copayments are never charged for the following services:

- Hospitalizations
- Emergency services
- Family planning services and supplies
- Pregnancy-related health care and for any other medical condition that may complicate the pregnancy, including tobacco cessation
- Services paid on a FFS basis
- Preventative services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms
- Provider preventable services
- Services paid on a fee-for-service basis

NON-MANDATORY, NOMINAL (LOW) COPAYS FOR SOME AHCCCS PROGRAMS

Most people who get AHCCCS benefits may pay the following nominal copayments for medical service:

Service	Copayment
Prescriptions (per drug)	$2.30
Outpatient services for physical, occupational, and speech therapy	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$3.40

Missed appointment fees may be charged if the member lives outside of Maricopa or Pima County. Services may not be refused if copayments are not paid. This excludes DD-CRS members.

PEOPLE WITH REQUIRED COPAYMENTS

Members eligible for AHCCCS through the Transitional Medical Assistance (TMA) program have mandatory copayments for the following services:

Service	Copayment
Prescriptions (per drug)	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$4.00
Physical, occupational and speech therapies	$3.00
Outpatient non-emergency or voluntary surgical procedures.	$3.00

The members may not be charged a missed appointment fee. Pharmacists and medical care providers can refuse services if the copayments are not made.

Members subject to copays will not pay additional copayments once the total amount of the copays the family has made is more than 5% of the family's gross family income (before taxes and deductions) during a calendar quarter year (January through March, April through June, July through September, and October through December). AHCCCS will track each member's copayment levels by service type to identify those who have reached the 5% copayment limit.

Except for prescription drugs, only one copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member pays the highest copayment amount.

Copayments and exceptions for other groups may change.

Check **UHCprovider.com** or call Provider Services if you have any questions.

Prescriptions will only be covered at participating pharmacies. A list of participating pharmacies is at **UHCprovider.com**. You can also get one by calling Provider Services.

MISSED APPOINTMENT FEE

You may charge a $3 fee for missed appointments for certain AHCCCS members who live outside of Maricopa and Pima counties. You may charge:

- Persons eligible for AHCCCS Care who live in a rural county, AND
- Adults eligible for AHCCCS for Families with Children under Section 1931 of the Social Security Act who live in a rural county when certain conditions are met. (See below.)

A missed appointment is one where the member is more than 20 minutes late for the scheduled appointment or has failed to cancel the appointment at least 24 hours in advance. Refer to the AHCCCS website for additional information regarding penalties for missed appointments on **azahcccs.gov**.

Balance Billing

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ.
- A claim is denied for late submission, unauthorized service or as not medically necessary.
- Services are covered and rendered during an eligible visit.
- UnitedHealthcare Community Plan is reviewing a claim

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

If you don't know who your provider advocate is, email **Arizona_PR_Team@uhc.com**. A provider advocate will get back to you.

Chapter 14: Claim Reconsiderations, Provider Dispute, Member Appeals and Grievances

There are a number of ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider Agreement.

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

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

Denial

Your claim may be denied for administrative or medical necessity reasons.

An **Administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file a dispute.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim Correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix one that has already processed. Submit corrected claims within one year from the date of service, or as otherwise stated in your Agreement.

How to use:

Use the claims submission application on Link. To access Link, sign in to **UHCprovider.com** using your Optum 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.

Mailing address:

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

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 17A23xxxxxxx, additional characters such as CLM 15A23xxxxxxx 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 - 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 17A23xxxxxxx, additional characters such as CLM 17A23xxxxxxx are incorrect.

Corrected claims submitted without the above information will be rejected and not processed in the claims system. Refer to the claim rejection report provided by your clearing house for a list of rejected claims.

Resubmitting a Claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected or denied one. A rejected claim has not been processed due to problems detected before processing.

When to use:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no dispute – the claim needs to be corrected through the claim reconsideration process. If submitting a corrected claim that is meant to replace a previously received and processed claim, follow the information provided in the Claim Correction section above.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.
- Incorrectly submitted corrected claims either submitted with invalid frequency code or missing/ invalid original claim number.

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information within 365 days from the date of service or the date of eligibility to:

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

Warning! If your claim was denied and you resubmit it, you will receive a duplicate claim rejection. A denied claim has been through claim processing and we determined it

cannot be paid. You may submit a corrected claim, claim reconsideration or dispute a denied claim. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim Reconsideration

What is it?

We are committed to improve the experience on all reconsiderations. Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with can be addressed with a claim reconsideration. This request allows a full medical necessity review to be performed. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly without the need to file a formal claim dispute.

When to use:

Submit a claim reconsideration within 365 days from date of service or as stated in your Agreement, when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim.
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation.

How to use:

Use the claims reconsideration application on Link. To access Link, sign in to **UHCprovider.com** using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

- **Electronically:** Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone:** Call Provider Services at **800-445-1638** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- Mail: Submit the Claim Reconsideration Request Form to the appropriate claims and medical record mailing address shown on the back of the member's ID card.

  This form is available at **UHCprovider.com**.
- Fax: Send the Claim Reconsideration Request Form to **801-994-1224**.

Include all appropriate documentation to support the services provided when submitting the reconsideration request.

To submit a corrected claim or reconsideration, include:

- The claim.
- The Remittance Advice.
- Original Claim Number documented in Box 22.
- A completed Reconsideration Form with the reason for resubmitting the claim. Note any corrections. Sign and date the cover letter, and provide a contact phone number.

Do not use this reconsideration process for DRG Outlier Payment Reconsideration. Please submit reconsiderations for DRG Outlier Payments to Medical Review as documented on the letter received.

Valid Proof of Timely Filing Documentation

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- UnitedHealth Group correspondence (data entry send back letter) OR
- A computer-generated activity page/print screen listing the date the claim was submitted to UnitedHealthcare Community Plan. Submission must contain:
  - Member name and Identifying information
  - Date(s) of service
  - Billed amount
  - Date submitted to insurance

- Electronic Claims – Acceptance Report, must include:
  - Universal Electronic Data Interchange (EDI) acceptance code **A1:19** coding and an acceptance date within the timely filing period, OR
  - A combination of a version of the words **accepted by payer, acknowledged by payer or received by UnitedHealthcare Community Plan**
- A billing statement with the date you found out the member had UnitedHealthcare Community Plan
- Other insurance carrier Denial/Rejection EOB or letter (e.g., terminated coverage, not their member)
- A letter from an obstetrical provider indicating they could not complete all the services required to bill the global code, as the patient was no longer in their care or lost coverage.
- Primary carrier EOB showing payment. Secondary claims must be submitted within 180 days from date of service, even if primary carrier has not made payment. Once the primary carrier has paid, you may submit a reconsideration with the primary EOB within 365 days from the date of service.

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request with a completed Reconsideration Form electronically, or by mail with your valid proof of timely filing from the options above.

Additional Information:

Reconsideration guidelines are available in the Reconsideration section provided previously in this chapter.

Claims Dispute

What is it?

You may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by UnitedHealthcare Community Plan. In agreement with AHCCCS guidelines, all claim disputes must be filed in writing within the time frame described as follows.

When to use:

If you do not agree with the outcome of the claim reconsideration decision, use the claim dispute process. All claim disputes challenging claim payments, denials or recoupments must be filed in writing with UnitedHealthcare Community Plan no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

How to use:

The dispute must state that you are filing a "dispute." To help ensure appropriate handling, do not refer to the matter as an appeal. The dispute must include the factual and legal basis for the relief requested, along with all supporting documentation. Please include a cover letter, medical records and any additional information. Send your information electronically or by mail. In your dispute, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments.
- **Mail:** Send the dispute to the following address.

  For Medicaid disputes:

  UnitedHealthcare Community Plan
  Medicaid Claim Disputes
  1 East Washington, Suite 900
  Phoenix, AZ 85004

  For Dual Complete disputes: Please refer to the Dual Complete Provider Manual on **UHCprovider.com** for more information.

You should receive an acknowledgment letter for all claim disputes received within five business days. If you do not, please follow up with the Dispute Department.

TIPS FOR SUCCESSFUL CLAIMS RESOLUTION

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.

- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call **Provider Services**.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within six months from the date of service, even if the primary carrier has not made payment. If the primary carrier makes payment after this time limit, a corrected claim must be resubmitted with the primary EOB. Claims are processed according to the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, section 434.
- When submitting reconsideration requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.
- Refer to your Agreement for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.
- Claims for dual-eligible members will be paid according to the **ACOM Policy 201**; Medicare Cost Sharing for Members Covered by Medicare and Medicaid. We are not responsible for cost-sharing should the payment to the primary payer be equal to or greater than what you would have received under Medicaid. Additional information regarding Medicare Cost Sharing is available in the Dual Complete Provider Manual.

Overpayment

What is it?

Notify UnitedHealthcare Community Plan of an overpayment on a claim. You may request an adjustment completed or a refund check.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your Agreement. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Return Overpayment through the Adjustment Request form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number (e.g., ACC, DD CRS, ALTCS EPD).
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Return Overpayment through Adjustment Request form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 101760
Atlanta, GA 30392-1760

Instructions and forms are on **UHCprovider.com**.

If you do not agree with the overpayment findings, submit a dispute within the AHCCCS-required time frame.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can file a dispute. See Dispute section in this chapter.

We may make claim adjustments without requesting additional information from you. You will see the adjustment on your EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Recovery requests greater than $50,000 or older than one year from payment will be submitted to AHCCCS/DD for approval and may take more time to complete.

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Agreement states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

Provider Grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.
- Member issues or UnitedHealthcare Community Plan issues.
- Availability of health services from UnitedHealthcare Community Plan to a member.
- The delivery of health services.
- The quality of service.

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services toll free at **800-445-1638**
- **Mail:** Send care provider name, contact information and your grievance to:

UnitedHealthcare Community Plan
Medicaid Grievances
1 East Washington, Suite 900
Phoenix, AZ 85004

You may file a grievance regarding a peer review determination or action to the UnitedHealthcare Community Plan medical director by labeling "ATTN: Medical Director" and mailing it to the aforementioned address.

Member Appeals and Grievances Definitions and Procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for member appeals and grievances.

MEMBER APPEALS

What is it?

You may assist members in filing an appeal on their behalf with the member's written permission. The appeal may be filed either verbally and later confirmed in writing and must be received within 60 days from the date of the Notice of Adverse Benefit Determination letter. If you, on behalf

of the member, believe the member's health or ability to function will be harmed unless a decision is made in the next 72 hours, the member or you can ask for an expedited appeal.

For expedited appeals, call 800-348-4058. Reasons for filing an appeal include:

- The denial or limited authorization of a requested service, including the type of level of service.
- The reduction, suspension, or termination of a previous authorization.
- The denial, in whole or in part, or payment of a service.
- Not providing service in a timely manner.
- For residents of a rural area with only one health plan, the denial of the member's request to obtain services outside of the network.

You or a member may appeal when the plan:

- Makes a determination with which you or the member disagrees or limits a requested service(s). This includes the type or level of service.
- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame CMS or AHCCCS requires.

When to use:

You may act on the member's behalf with their written consent within 60 days from the date of the Notice of Adverse Benefit Determination (NABD). You may provide medical records and certification of the appeal as appropriate.

Where to send:

Call, mail or fax the information within 60 calendar days from the date of the Notice of Adverse Benefit Determination to:

UnitedHealthcare Community Plan
Member Appeals
1 East Washington, Suite 900
Phoenix, AZ 85004

Send UnitedHealthcare Dual Complete member appeals to:

UnitedHealthcare Dual Complete
Attn: Member Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

Toll-free: **800-587-5187** (TTY **711**)

Fax: **800-757-2617**

How to use:

Whenever a service is denied, you must provide the member with UnitedHealthcare Community Plan member appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- The member or representative may review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal by calling 800-348-4058 if waiting for this health service could harm the member's health. You have two business days to represent evidence and allegations of fact or law in person and in writing.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service.
- We must resolve a standard appeal 30 calendar days from the day we receive it.
- We must resolve an expedited appeal within 72 hours from when we receive it. We may extend the response times up to 14 calendar days if the following conditions apply:
    1. Member requests we take longer.
    2. We request additional information and explain how the delay is in the member's interest.

MEMBER GRIEVANCE

What is it?

The member and family have the right to voice dissatisfaction with the treatment or care the member receives. They must be free from any punishment, restraint or seclusion for decisions pertaining to filing a complaint. Grievances are complaints related to UnitedHealthcare Community Plan policy, procedures or payments.

When to use:

You may file a grievance as the member's representative.

Where to send:

You or the member may file a grievance by calling Member Services or writing UnitedHealthcare Community Plan:

Mailing address:

UnitedHealthcare Community Plan
Attn: Member Appeals and Grievances
1 East Washington, Suite 900
Phoenix, AZ 85004

Dual Complete Member Appeals
ATTN Member Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

We will send an answer within 10 business days but no later than 90 calendar days from when you filed the complaint/grievance. This time frame may be extended up to 14 days if the health plan, member or care provider requests an extension or if more information is needed and the delay is the member's best interest.

State Fair Hearings

What is it?

If you disagree with your claim dispute decision, you may submit your written request for a State Fair Hearing.

When to use:

You have 30 days from the receipt of their claim dispute Notice of Decision to file a State Fair Hearing request.

How to use:

Your request must include the claim dispute number from the Notice of Decision, the member's name and be clearly identified as a State Fair Hearing. Requests for State Fair Hearing must be sent to the following address:

UnitedHealthcare Community Plan State Fair Hearings
1 East Washington, Suite 900
Phoenix, AZ 85004

- If you submit State Fair Hearing requests for DD-CRS members, submit according to the information provided on the Notice of Decision letter.
- AHCCCS will send the information on how the State Fair Hearing will be handled, such as meeting date and time.

Processes Related to Reversal of Our Initial Decision

If the State Fair Hearing reverses a decision to deny, limit, or delay services not provided while the dispute was pending, we authorize or provide the disputed services within 15 business days. If the decision reverses denied authorization of services and the disputed services were received pending dispute, we pay for those services as specified in policy and/or regulation.

Fraud, Waste and Abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and agreements. You are contractually obligated to cooperate with the company and government authorities.

You can also call the UnitedHealthcare Special Investigations Unit Fraud Hotline at **877-401-9430**.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

AHCCCS has published to its website an e-learning seminar – "Fraud Awareness for Providers" – that discusses care provider and member fraud. Any training must be appropriately documented and may be requested at any time by AHCCCS or UnitedHealthcare Community Plan. We encourage you have your staff review/listen to this **seminar**.

In addition, in accordance to your Agreement, you must cooperate with the review process to include any requests for medical records. This includes outreach meetings and/or written correspondence to care providers, record review and/or site audit, individual case peer-to-peer reviews, and referral for further investigation. Once an intervention has occurred, we monitor the practice patterns of an identified care provider to help ensure the potential fraud, waste or abuse practice pattern has been corrected.

As warranted, care providers will be reported to the Arizona Department of Insurance, licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Fraud and Abuse Policies and Procedures

You must have established policies and procedures that meet AHCCCS requirements for reporting incidences of health care-acquired conditions, abuse, neglect, exploitation, injuries and unexpected death. The policies and procedures should specify the process of submitting a report of HCACs, abuse, neglect, exploitation, injuries and unexpected death.

Reporting Fraud and Abuse

If you are aware of any such actions, mail your documentation of the issue to:

UnitedHealthcare Community Plan
Compliance Office
1 East Washington, Suite 900
Phoenix, AZ 85004

For Dual Complete plans and LTC, Complete Care and DD-CRS members, email **apipa_qualityofcare@uhc.com** with documentation.

Also complete the form on the AHCCCS-OIG website at **azahcccs.gov**.

A form from the AHCCCS website is available on **UHCprovider.com** under the External Guidelines and Resources section. Attach any documentation that would assist AHCCCS in its investigation.

Submit any incidents involving UnitedHealthcare Community Plan members or non-UnitedHealthcare members directly to the AHCCCS OIG. Complete and submit the reporting form available on the **AHCCCS-OIG** website. Non-UnitedHealthcare members must be reported to the AHCCCS-OIG immediately.

All information provided to UnitedHealthcare Community Plan regarding a potential fraud or abuse occurrence will be kept confidential in accordance with UnitedHealthcare Community Plan'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. Direct any questions to the UnitedHealthcare Compliance Officer. HIV-related information should not be disclosed when releasing information related to fraud and abuse.

If you have questions, call the UnitedHealthcare Community Plan Compliance Office or the AHCCCS Administration.

EXCLUSION CHECKS

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management**

WHAT YOU NEED TO DO FOR EXCLUSION CHECKS

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Chapter 15: Care Provider Communications & Outreach

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and Arizona's managed care program. It includes the following care provider components:

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual

Care Provider Websites

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. The **UHCprovider.com** portal facilitates care provider communications related to administrative functions. Our interactive website empowers you to electronically determine member eligibility, submit claims, and view claim status.

We have also implemented an internet-based prior authorization system on **UHCprovider.com**. This site lets you request medical and advanced outpatient imaging procedures online rather than by phone. The website also has:

- An online version of this manual
- Clinical Practice Guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (UHC on Air, PreCheck MyScript, etc.)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is **UHCCommunityPlan.com** > select Member.

Care Provider Office Visits

Care Provider Advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a care provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Arizona network at least three times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical Practice Guidelines
- Special initiatives
- Emerging health topics

The newsletters also include notifications about changes in laws and regulations. UnitedHealthcare Community Plan posts electronic bulletins on **UHCprovider.com** Click Menu, then Resource Library, News.

Find more information about the Network Bulletin, Medical Policy Update Bulletin and other communications on **UHCprovider.com** in the Bulletins and Newsletters section.

Care Provider Manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, a removable quick reference guide and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

Find these forms on the state's website at **azahcccs.gov**:

- **Sterilization Consent Form**
- Hysterectomy Consent and Acknowledgment Form
- Provider Service Agreement (MC 19 Form)

Chapter 16: Glossary

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Action
The denial or limited authorization of a requested service, including the type, level or care provider of service; reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or as stated in your Agreement.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Active Treatment
A current need for treatment or evaluation for continuing treatment of the qualifying condition, or it is anticipated that treatment or evaluation for continuing treatment of the qualifying condition will be needed within the next 18 months.

Advance Care Planning
Advance care planning is a billable service, a voluntary face-to- face discussion between a physician or other qualified health care professional and the member to: a) teach the member and their family about the member's illness and the health care options available to them; b) develop a written plan of care that identifies the member's choices for treatment; and c) consistent with HIPAA, share the member's wishes with family, friends and their care providers.

Advance directive
A document by which a person makes provision for health care decisions in the even that, in the future, he/she becomes unable to make those decisions.

AHCCCS
The Arizona Health Care Cost Containment System – which is composed of AHCCCSA, contractors, and other arrangements – through which health care services are provided to eligible persons as defined by Arizona Revised Statutes, Title 36, Chapter 29.

AHCCCSA

The Arizona Health Care Cost Containment System Administration.

AHCCCS Benefit
AHCCCS-covered medical services.

ALTCS EPD (Arizona Long-Term Care System Elderly, Physically Disabled)
A component of AHCCCS which, in addition to medical and behavioral health services, provides long-term care services to eligible elderly and/or physically disabled (EPD) members and developmentally disabled (DD/ALTCS) members. UnitedHealthcare Community Plan provides long-term care (sometimes referred to as "ALTCS") services to DD/ALTCS members as a separate line of business.

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called "outpatient care". Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services
Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Anniversary Date
The anniversary date is 12 months from the date the member is enrolled with the contractor and annually thereafter. In cases, the anniversary date will change based on the last date the member changed contractors or the last date the member was given an opportunity to change.

Annual Enrollment Choice (AEC)
The annual opportunity for a member to change their contractor. The member is offered annual enrollment choice in the 10th month following their anniversary date. If an individual member makes a timely (within the period stated on the annual enrollment choice letter) annual enrollment choice, the change in contractors will occur on the first of the month in which their anniversary date occurs.

Appeal
A member request that their health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Authorization
Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation
A prepaid, periodic payment to providers, based upon the number of assigned members made to a care provider for providing covered services for a specific period.

Care Provider
Generally used to identify hospitals, nursing homes, home health agencies, etc., that provides medical services.

Care Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's Primary Care Provider (PCP).

Categorically Eligible
Individuals who are mandatorily eligible under federal law because they receive TANF or SSI benefits. These individuals are not required to complete a separate AHCCCS eligibility determination.

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

Certified Nurse Midwife (CNM)
An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intra-partum, postpartum, gynecological and newborn care within a health care system that provides for medical consultation, collaborative management or referral.

CHIP
Children's Health Insurance Program.

Chiropractic Services
Treatment provided by a licensed chiropractor that meets uniform minimum Medicare standards by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray. Any such services require prior authorization.

Chronic
Expected to persist over an extended period of time.

Claim Adjustment
A previously paid claim that requires additional research due to an overpayment or underpayment.

Claim Resubmission
A previously denied claim requiring additional documentation or correction. (e.g., EOB, proof of timely filing, corrected CPT code, diagnosis code, care provider ID, member ID).

Clean Claim
As defined by Arizona Revised Statues 36-2904.H and AHCCCS rules within Title 9 of the Arizona Administrative Codes, a claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

CMS
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

Contracted Health Professionals
Primary care providers, care provider specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers

deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of two or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Copayment
Refers to a monetary amount, specified by the AHCCCS Director that the member pays directly to the participating care provider at the time covered services are provided.

- **Mandatory:** Care providers can deny services to members who do not pay the copayment.
- **Non-Mandatory:** Care providers are prohibited from denying the service when the member is unable to pay the copayment.

Copayment Levels
Copayment requirements will be indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member will be assigned a copayment level which will reflect whether they are exempt from copayments, subject to optional (nominal) co-payments, or subject to mandatory copayments.

County with Choice
A county or GSA with more than one Complete Care, DD-CRS, or ALTCS EPD contractor.

Covered Services
The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse as delineated in Annex B and/ or C of the provider Agreement or mentioned in AHCCCS Rules.

CRS-Designation
AHCCCS makes CRS eligibility determinations for CRS designation. A CRS covered condition is based upon meeting AHCCCS eligibility requirements as define in A.A.C. R9-22-1303.

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (CPT) Codes
A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

DES
Arizona Department of Economic Security.

DHS
Arizona Department of Health Services.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

Division of Developmental Disabilities (DDD) with CRS Designation
Effective October 1, 2018 through September 30, 2019, UnitedHealthcare Community Plan will manage the CRS statewide for DD-CRS members. DDD is a program for members with developmental disabilities with CRS conditions/designations.

UnitedHealthcare provides acute care services to these members through a separate line of business. These members are referred to as DD-CRS/ALTCS EPD members.

Discharge Planning
Identification of the need and provision for a patient's health care requirements after discharge from the hospital.

Disenrollment
Discontinuance of a member's eligibility to receive covered services from a contractor. The member's name is deleted from the approved list of members furnished by AHCCCSA to the contractor.

Dispute
A disagreement involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R) in accordance with the AHCCCS EPSDT periodicity schedule. Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic Data Interchange (EDI)
The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

Emergency Dental Services
Services and operational procedures required to eliminate acute infection, prevent pulpal death and related imminent tooth loss, treat injuries to teeth or supportive structures, or provide palliative therapy for pericoronitis associated with impacted teeth.

Encounter
A record of health care-related services by care providers registered with Medicaid to an patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Encounter Validation Studies

Per CMS requirements, AHCCCS conducts encounter validation studies of our encounter submissions. These validation studies compare recorded utilization information from a medical record or other source with the contractor's submitted encounter data.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Member Appeal
An oral or written request by a member or member's representative received by UnitedHealthcare Community Plan requesting a faster reconsideration of an action. This speed is necessary when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance
A grievance where delay in resolution could harm the member's health or life.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Federally Qualified Health Care Center (FQHC)
FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers and Health Care for the Homeless Programs. An entity may qualify as an FQHC if it: (1) receives a grant and funding pursuant to Section 330 of the Public Health Service Act; (2) is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant pursuant to Section 330 of the Public Health Service Act; (3) is determined by the Secretary of the Department of Health and Human Services (DHHS) to meet the requirements for receiving such a grant (look- alike) based on the recommendation of HRSA within PHS; or, (4) was treated by the Secretary of DHHS as a federally funded health center (FFHC) for purposes of Part B Medicare.

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

FQHC/RHC Visit

A visit defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS- covered ambulatory service is provided when that service is not incident to another service and the site of service is at an FQHC/RHC registered location.

Functionally Limiting
A restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a provider.

General Consent
A one-time agreement to receive certain services. It is usually obtained from a member during the intake process at the initial appointment. General consent is always obtained before delivering services. It must be obtained from a member or legal guardian.

Geographic Service Area (GSA)
An area designated by AHCCCS within which a contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record as defined in 9 A.A.C. 22, Article 1.

Grievance
An oral or written complaint a member or their representative has and communicates to UnitedHealthcare Community Plan.

Health Insurance Flexibility and Accountability Act (HIFA)
The waiver for parents of eligible SOBRA children not otherwise eligible for AHCCCS coverage.

Healthcare Effectiveness Data and Information Set (HEDIS)
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

HIPAA
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home Health Care (Home Health Services)
Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

Informed Consent
An agreement to receive medical and behavioral health services before the provision of a specific treatment that has associated risks and benefits. Informed consent must be obtained from a member or legal guardian prior to the provision of services or procedures.

In-Network Provider
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have

choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in serious danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine according to AHCCCS.

Member
An individual who is AHCCCS-eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventative Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services. FQHC cannot be considered a PCP per AHCCCS AMPM.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

QMB
Qualified Medicare Beneficiary.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Regional Behavioral Health Authority (RBHA)
The entities through which state and federally funded behavioral health services may be provided.

Rural Health Clinic
A clinic, located in a rural area, designated by AHCCCS as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by AHCCCS.

Specialist
A care provider licensed in the state of Arizona and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member or care provider does not agree with a Notice of Decision or Notice of Dispute Resolution from the UnitedHealthcare Community Plan Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

Title XXI
Section of the Social Security Act, referred to in federal legislation as the State Children's Health Insurance Program (SCHIP). The Arizona version of SCHIP is referred to as KidsCare.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Utilization Review
System of review conducted by professional health personnel of the appropriateness, quality of and need for health care services rendered to patients covered by Medicare or other third party payers, including AHCCCS.

Visit
All services received in one day from a single provider, or components of the same service received in one day from multiple care providers, e.g. a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.