2017/2018 Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

California Medi-Cal 2017/2018
Sacramento and San Diego Counties

PCA-1-007582-08192017

UnitedHealthcare®
Community Plan

Welcome to UnitedHealthcare Community Plan

Welcome

Welcome to the Community Plan manual. This comprehensive and up-to-date reference PDF manual allows you and your staff to find important information such as processing a claim and prior authorization. This guide/manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and additional electronic tools are available on our website at **UnitedHealthcareOnline.com**.

If you are looking for Medicare Advantage member information, click **here** to access the UnitedHealthcare guide.

If you are looking for capitated provider info, click **here** or go to **uhcwest.com** > Provider, then click library menu at top of screen.

If you are looking for a different Community Plan manual, click **here** or go to **uhccommunityplan.com** > health-professionals, then select the correct state.

You may easily search for a specific topic or word in the manual using the following steps:

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

Depending upon your version of Adobe Reader, you may see a binocular icon that also allows you to search.

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

If you have any questions about the information or material in this manual or about any of our policies or procedures, please do not hesitate to contact Provider Services at 866-270-5785.

Important information regarding the use of this Manual

In the event of a conflict or inconsistency between your applicable Provider Agreement and this manual, the terms of the Provider Agreement shall control.

In the event of a conflict or inconsistency between your participation agreement, this manual and applicable federal and state statutes and regulations, applicable federal and state statutes and regulations 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 is amended as operational policies change.

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Chapter 1: UnitedHealthcare Corporate Overview

UnitedHealthcare's mission is to help the people we serve live healthier lives. UnitedHealthcare understands that health care cannot be delivered in a vacuum. That is why our services seek to address the social and economic factors that affect a person's health.

UnitedHealthcare understands that compassion and respect are essential components of a successful health care company. UnitedHealthcare employs a diverse workforce, rooted in the communities we serve, with varied backgrounds and extensive practical experience that gives us a better understanding of our members and their needs.

Our Approach to Health Care

Our personalized programs encourage the utilization of services. These programs, some of them developed with the aid of researchers and clinicians from academic medical centers, are designed to help our chronically ill members avoid hospitalizations and hospital emergency room visits — in short, to live healthy, productive lives.

The unique UnitedHealthcare Personal Care Model™ features direct member contact by UnitedHealthcare clinicians trained to foster an ongoing relationship between the Health Plan and members suffering from serious and chronic conditions. The goal is to use high quality health care and practical solutions to improve members' health and keep them in their communities, with the resources necessary to maintain the highest possible functional status.

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, UnitedHealthcare's Health First Steps program uses an early identification to:

- Help overcome common social and psychological barriers to prenatal care;
- Increase member understanding of the importance of early prenatal care;
- Increase the mother's self-efficacy by identifying and building a mother support system;
- Ensure appropriate postpartum and newborn care;
- Develop the physician/member partnership and relationship before and after delivery.

In addition to the usual Health Plan reminders to get preventive care services, UnitedHealthcare employs its proprietary Universal Tracking Database to identify members who have fallen behind in scheduling appointments and providers who are failing to focus on preventive care and optimal treatment.

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Chapter 2: Quick Reference Guide

UnitedHealthcare Community Plan of California Quick Reference Guide

This reference guide provides you with quick access to a variety of resources to help make it easier for you to contact us about UnitedHealthcare Community Plan.

Provider Services

Phone: 866-270-5785

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

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

Link and UnitedHealthcareOnline.com

Use Link to perform secure transactions such as checking member eligibility and benefits, managing claims and requesting prior authorization. To access Link, sign in to UnitedHealthcareOnline.com using your Optum ID.

If you don't have an Optum ID, go to UnitedHealthcareOnline.com and select "New User" to begin registration.

To learn more about using Link, please visit UnitedHealthcareOnline.com > Tools & Resources > Health Information Technology > Link.

Eligibility, Benefits and Prior Authorization

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

Network Referrals

You may find a network provider online or by calling us.

Online: Link > UnitedHealthcare Community Plan application > For Health Care Providers > California > Find a Physician.

Phone: 866-270-5785

To submit a behavioral health service referral, please call 866-270-5785.

Prior Authorization Requests

Phone: 866-270-5785

Fax: 855-432-2828

Prior Authorization forms are available at Link > UnitedHealthcare Community Plan application > For Health Care Professionals > California > Provider Forms.

Prescription Drugs

Please use the Prescription Drug Prior Authorization Request Form available at Link > UnitedHealthcare Community Plan application > For Health Care Professionals > California > Provider Forms. Some drug-specific forms are available at Link > UnitedHealthcare Community Plan application > For Health Care Professionals > California > Pharmacy Program.

To view a complete list of services that require prior authorization, please go to Link > UnitedHealthcare Community Plan application > For Health Care Professionals > California > Billing & Reference Guides > Advanced Notification/Prior Authorization List.

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Claims Submission

Electronic Claims:
Please submit claims within 180 days of service to: UnitedHealthcareOnline.com > Claims & Payments > Claim Submission.

Payer ID: 87726

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

Appeals Submission

The appeal form is located at Link > UnitedHealthcare Community Plan application > For Health Care Professionals > California > Provider Forms > Provider Disputes.

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

Claims Management and Reconsideration

Please call 866-270-5785 or use the Claims Management and Claims Reconsideration applications on Link.

Other Resources

For more information, please contact your Physician Advocate or visit Link > UnitedHealthcare Community Plan application > For Health Care Professionals > California.

Sample Member ID Card

UnitedHealthcare® | Community Plan
Health Plan (80840) 911-87726-04
Member ID: 999999999 Group Number: CAMCMP
Member:
SUBSCRIBER A MEMBER
Payer ID: 87726
PCP Name:
PROVIDER PHYSICIAN
PCP Phone: (999)999-9999
OPTUMRx
Rx Bin: 610494
Rx Grp: ACUCA
Rx PCN: 4444
0501 Administered by UnitedHealthcare Community Plan of California, Inc.

In case of emergency call 911 or go to nearest emergency room. Printed: 07/18/17

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call. Emergency Services rendered to the Member by non-Contracting providers are reimbursable by the Contractor without Prior Authorization.
For Member Customer Service: 866-270-5785 TTY 711

For Providers: uhccommunityplan.com 866-270-5785
Claims: PO Box 30884, Salt Lake City, UT 84130-0884

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952

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Chapter 3: Member Benefits

The following section contains a summary of covered and excluded services. Please contact Provider Services for questions regarding these benefits, exclusions or other covered services at 866-270-5785.

Acupuncture Services	Limit of two services in any one calendar month. There may be additional services available under some circumstances.
Cancer Clinical Trials.	Contact Provider Services for more information.
Cancer Screening.	• Cervical cancer screening, including human papillomavirus (HPV) screening. • Mammography for breast cancer screening. • Prostate cancer screening and diagnosis.
Chiropractic Services.	Limit of two services in any one calendar month. Services must be provided at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). There may be additional services available under some circumstances.
Diabetic Services.	
Durable Medical Equipment (DME).	
Emergency Care Services.	
Enteral Nutrition Products.	• For adult members age 21 or older, medically necessary enteral nutrition products that given through a feeding tube. • For members who are less than 21 years of age, enteral nutrition products even if they are not given through a feeding tube.
Family Planning Services.	• Health education and counseling you need to help you make informed choices and to understand contraceptive methods. • Limited history and physical examination. • Laboratory tests if medically indicated as part of your decision-making process for deciding what contraceptive methods you might want to use. • Contraceptive pills, devices, and supplies. • Follow-up care for complications associated with the contraceptive methods provided or prescribed by the family health planning provider. • Pregnancy testing and counseling, including counseling and surgical procedures for pregnancy termination (abortion). • Tubal ligation (for females). • Vasectomies (for males). • Diagnosis and treatment of a sexually transmitted disease if medically indicated. • Screening, testing and counseling of at risk individuals for HIV and referral for treatment.

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<table>
<tr><td>HIV Testing and Counseling.</td><td></td></tr>
<tr><td>Home Health Services.</td><td></td></tr>
<tr><td>Hospice Care.</td><td>Benefits Limits
• Two 90-day periods, beginning on the date of hospice election, followed by unlimited 60-day periods
• A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends.
• Member is certified as terminally ill with a life expectancy of 12 months or less if the illness runs its normal course.

For Recipients Younger Than Age 21:
• Recipient younger than 21 years of age and certified by a care provider as having a life expectancy of six months or less may elect to concurrently receive hospice care in addition to curative treatment of the hospice related diagnosis.
• Non-hospice providers will be able to bill Medi-Cal for medically necessary, curative treatments provided within their scope of practice and are considered a benefit under the Medi-Cal program. All services are subject to current utilization review mechanisms.</td></tr>
<tr><td>Hospital Care.</td><td>Requires prior authorization except for emergencies or urgent care services. Care providers are required to notify UnitedHealthcare Community Plan of an admission within one business day. Hospital services are not covered outside of the United States, except for emergency services requiring hospitalization while in Canada or Mexico.</td></tr>
<tr><td>Laboratory Services.</td><td></td></tr>
<tr><td>Mastectomy.</td><td></td></tr>
<tr><td>Maternity Care.</td><td>We cover these maternity care services:
• Prenatal care.
• Postpartum care.
• Nutrition counseling.
• Labor and delivery care.
• Diagnostic testing.
• Genetic testing.
• Inpatient care for 48 hours after normal vaginal deliveries. Longer stays must be authorized.
• Inpatient care for 96 hours after a delivery by Cesarean section (C-section). Longer stays must be authorized.</td></tr>
</table>

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Minor Consent Services.	Minor Consent Services are available for Members under the age of 18 without permission or consent from their parent or guardian. Minor Consent Services are services related to: • Sexual assault, including rape. • Drug or alcohol abuse for children 12 years of age or older. • Pregnancy. • Family planning. • Sexually transmitted diseases (STD) for children 12 years of age or older. • Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.
Newborn Care.	
Obstetrical/Gynecological (OB/GYN) Care.	Female Members do not need a referral or permission from their PCP or from us to see an OB/GYN who contracts with us (also called an In-Network provider). If you have questions, please call our Member Services department toll-free at 866-270-5785, TTY: 711.
Occupational Therapy.	Up to two visits for occupational therapy, speech therapy, audiology, or podiatry (combined) in any one calendar month are covered.
Pharmacy.	See Pharmacy Services section
Provider Office Visits.	• All routine visits, exams, treatments, and immunizations • Specialty Care – Some services may require prior authorization.
Physical Therapy.	
Podiatry Care Services.	Podiatry care services are services for your feet. Podiatry care services are limited to two services in any one calendar month and must be provided at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). Prior Authorization is required, unless it is an emergency. Unless it is an emergency, only these Members are eligible to receive podiatry care: a. Pregnant women if it is part of their pregnancy-related care or for services to treat a condition that may cause problems in pregnancy. b. Children or young adults who are 20 years old and younger and receive full scope Medi-Cal. c. People who live in a licensed nursing home such as a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), ICF for the Developmentally Disabled (ICF-DD) and Sub-Acute Facility. d. If you are 21 years of age or older and began a course of treatment before you turned 21, your benefit may be continued. Your podiatrist must order the treatment. Check with your podiatrist or your Primary Care Provider.

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Reconstructive Surgery Services.	Contact Provider Services for more information.
Skilled Nursing Facility (SNF) Services.	Benefits limited to the month of admission and the month following.
Speech Therapy.	Up to two visits for occupational therapy, speech therapy, audiology, or podiatry (combined) in any one calendar month are covered.
Medical Transportation Services.	• Emergency medical transportation (ambulance) services • Non-emergency medical transportation services: Non-emergency medical transportation services to a medical facility when the member cannot use regular transportation because their medical or physical condition. To schedule transportation, call Member Services at 866-270-5785 at least three business days prior to the appointment.
Vision Services.	• Eye Examinations Medi-Cal will pay for eyeglasses or contact lenses services if the member is 21 years of age or older and • Pregnant and the primary care provider states not having the service will be harmful to the baby or pregnancy, or • Lives in a nursing home
X-Ray Services.	Services not covered by UnitedHealthcare Community Plan or Medi-Cal: • All services excluded from Medi-Cal under state or federal law. • Circumcision (routine), unless Medically Necessary. • Cosmetic surgery with the exception of approved reconstructive surgical procedures. • Eye appliances. • Experimental and investigational services. See the Appeals and Grievances section for more information. • Immunizations for sports, work or travel. • Infertility. • Personal comfort items while in the hospital.

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Enrollment

How to enroll

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

Newborns

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

Recertification

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

Disenrollment/Changing Health Plans

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

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

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Chapter 4: California (managed care) for Adults

4.1 24/7 Access to Care

After Hours Coverage

Providers are required to provide 24/7 access to care for their patients. This may be provided through covering care providers or the use of an after-hours call service.

UnitedHealthcare Community Plan also provides it members with access to NurseLine[SM], a 24/7 service that helps our members make confident health care decisions and facilitate the provision of care in the right setting.

NurseLine

NurseLine services give members:

- Immediate answers to your health questions any time, from anywhere — 24 hours a day
- Access to caring registered nurses who have an average of 15 years' clinical experience
- Trusted, care provider-approved information to guide health care decisions

When a member calls, a caring nurse can help our members to:

Choose appropriate medical care.

- Understand a wide range of symptoms.
- Determine if the emergency room, a doctor visit or self-care is right for his/her needs.

Find a doctor or hospital.

- Find doctors or hospitals that meet his/her needs and preferences.
- Locate an urgent care center and other health resources.

Understand treatment options.

- Learn more about a diagnosis.
- Explore the risks, benefits and possible outcomes of treatment options.

Achieve a healthful lifestyle.

- Get tips on how nutrition and exercise can help the member maintain a healthful weight.
- Learn about important health screenings and immunizations.

Ask medication questions.

- Explore how to save money on prescriptions.
- Learn how to take medication safely and avoid interactions.

Members can call a NurseLine nurse any time for health information and support — all at no cost — at 866-270-5785

4.2 Online Resources

Members also have access to a wealth of information online. Members can visit **UHCCommunityPlan.com** for health and well-being news, tools, resources and more. Members can even chat with a nurse any time about health questions or concerns.

4.3 Pharmacy Services

UnitedHealthcare Community Plan will cover medically necessary drugs through our Prescription Drug List (PDL). This was developed to assist providers in selecting medically appropriate, high quality, and cost-effective drugs for members. The PDL applies only to medications dispensed by contracted pharmacies to outpatient members; it does not apply to inpatient medications.

If a non-preferred medication is required for a member's treatment, the provider must call the Pharmacy Prior Authorization Service at 800-310-6826, or fax a Pharmacy Prior Notification Request form (available on **UHCCommunityPlan.com**) to 866-940-7328 to make the request. The request will be promptly reviewed and the provider will be notified of the decision.

Providers may also initiate requests to add a drug to the PDL. To submit a PDL addition request for consideration, the prescriber should complete the PDL Change Request Form, sign it, and follow the instructions on the form to send it in. The requests will be considered at the Pharmacy and Therapeutic Committee meeting. Results of the review will be sent to the requesting provider.

PDL information, including updates when changes occur, will be provided in advance to providers and a summary of changes posted to **UHCCommunityPlan.com**.The PDL, pharmacy prior notification request form and PDL Change Request Form can be found on the Health Plan's website at **UHCCommunityPlan.com**.

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To obtain a print copy of the PDL, contact Provider Services.

Specialty pharmacy medications

UnitedHealthcare Community Plan administers a Specialty Pharmacy Management Program that 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's used by a small number of people
- It treats rare, chronic, and/or potentially life-threatening diseases
- It has special storage or handling requirements such as needing to be refrigerated
- It may need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- It may not be available at retail pharmacies
- It 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.

You can also visit the plan website at **UHCCommunityPlan.com** to see the list of specialty pharmacy medications in the program, as well as information on the network specialty pharmacies.

4.4 SBIRT

Screening, brief interventions, and referral to treatment (SBIRT) services are covered when provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.

SBIRT services are covered for determining risk factors that are related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.

SBIRT screening will occur during an E/M exam and is not billable with a separate code. A brief intervention may be provided on the same day as a full screen in addition to the E/M exam. Brief interventions may also be performed on subsequent days. Brief interventions are limited to four sessions per patient, per provider per calendar year.

What is included in SBIRT?

Screening: With just a few questions on a questionnaire or in an interview, practitioners can identify patients who have alcohol or other drug (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: Individuals whose screening indicates a severe problem or dependence should be referred to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.**

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

- The billing provider and servicing provider are SBIRT certified.
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is V65.42
- The treatment or brief intervention does not exceed the limit of four (4) encounters per client, per provider, per year
- The SBIRT assessment, intervention, or treatment takes places in one of the following places of service:
  - Office
  - Urgent care facility
  - Outpatient hospital
  - Emergency room – hospital
  - Federally qualified health center (FQHC)
  - Community mental health center
  - Indian health service – free standing facility
  - Tribal 638 free standing facility
  - Homeless shelter

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Chapter 5: Medical Management

UnitedHealthcare Community Plan does not process or require formal referrals to participating providers.

5.1 Referral Guidelines

Providers caring for our members are generally responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of their practice. Providers are expected to monitor the progress of referred members' care and ensure that members are returned to their care as soon as medically appropriate. We require prior authorization of all out-of-network referral with the exception of emergency/urgent care or family planning service. The request is generally processed like any other authorization request. 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 generally approved for, but not limited, to the following circumstances:

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

It is the expectation providers will maintain a referral tracking log that indicates authorized, denied or modified referrals. This log must be made available to UnitedHealthcare Community Plan of California on request for auditing purposes.

Standing Referrals

The Primary Care Provider is encouraged to set up "Standing Referrals" with specialty care providers when ongoing care over a period of time is necessary. Referrals of up to six months with designated frequency are appropriate. When referred by in network provider to in network specialty, no referral is needed when using the same criteria as standard referrals. Out of network referrals continue to require authorization.

For a complete and current list of services requiring prior authorizations, go to **UHCCommunityPlan.com**. or call 866-270-5785. Submit your prior authorization request at **UnitedHealthcareOnline.com**, or via fax to 855-432-2828. Out-of-network referrals are monitored on an individual basis and trends related to individual care provider or geographical locations are reported to Network Management to assess root causes for action planning.

Emergency Department Referrals

For services requiring notification during and after business hours, providers may call UHC notification toll free number at 866-604-3267. These calls will be routed to the Inpatient Nurse Care Manager 24 hours a day/seven days a week.

The Emergency Department should remind United Medi-Cal members that they have access to NurseLine 24/7, where they can get advice from specially trained nurses who will triage the call and provide treatment options including referral to the Emergency Room when an emergency condition exists. The Nurses will assist the member in locating resources and provide support to help the member make informed healthcare decision. Members can call a NurseLine nurse any time for health information and support — all at no cost — at 877-543-3409.

5.2 Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services. Emergency care should be rendered at once, with notification of any admission to the Prior Authorization Department at 866-270-5785 or fax your Prior Authorization Form to 855-432-2828 by 5 p.m. the next business day. Nurses in the Health Services Department review emergency admissions within one working day of notification. UnitedHealthcare Community Plan uses evidence based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials or provide financial incentives that encourage under-utilization. The criteria is available in writing upon request or by calling 866-270-5785. Admission to inpatient starts at the time the order is written by a care provider that a member's condition has been determined to meet an acute inpatient level of stay.

Care in the Emergency Room

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

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

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

5.3 Admission Authorization and Prior Authorization Guidelines

All UnitedHealthcare Community Plan admission authorizations must contain the following information:

- Patient name and ID number;
- Facility name and Tax Identification Number (TIN) or National Provider Identification (NPI);
- Admitting/attending care provider name and TIN/NPI;
- Description for admitting diagnosis or ICD-10 or its successor, diagnosis code; and
- Admission date.

All UnitedHealthcare Community Plan prior authorizations must contain the following information:

- Customer 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 or its successor, diagnosis code for which the service is requested;
- Anticipated date(s) of service;
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable;
- Service setting; and
- Facility name and TIN/NPI, when applicable.

The Prior Authorization Fax Request Form is at UHCCommunityPlan.com > Health Professionals > California > Provider Forms.

If you have questions, please contact Prior Authorization Intake at 866-270-5785.

Administrative Days

The facility is required to bill SNF,ICF and residential level of care administrative days on a separate claim with the appropriate Occurrence Span Code and the range of dates. A separate authorization is required.

Services Requiring Prior Authorization

- Inpatient acute, sub-acute, rehab, and Skilled Nursing Facility (SNF) admissions require prior authorization.
- All non-participating services require prior authorization unless performed in an emergency/urgent care setting or for family planning services.
- Prior notification is not required for emergency services; however, hospitals must provide notification within one business days of inpatient admission.

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 receipt of request.	Within three days of the request.	Within three days of the request.
Concurrent Review	Within 24 hours or next business day following	Practitioner notified within 24 hours of determination	Practitioner notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Practitioner within 24 hours of determination and member notification within two business days

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Medical policies and coverage determination guidelines can be found at **UHCCommunityPlan.com** > For Health Care Professionals > California > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.

5.4 Determination of Medical Necessity

We evaluate medical necessity according to the following standard. Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, 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 or causes suffering or pain or results in illness or infirmity;
- Prevent the deterioration of a condition;
- Promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capabilities that are appropriate for individuals of the same age;
- Prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member.

The services provided, as well as the type of provider and setting, must reflect the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the member and not solely for the convenience of the member or provider of service. In addition, the services must be in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective.

Experimental services or services generally regarded by the medical profession as unacceptable treatment are considered not medically necessary. These specific cases are determined on a case-by case basis.

The determination of medical necessity must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance. In the case of pediatric members, the standard of medical necessity shall include the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily covered services for other members, are (a) appropriate for the age and health status of the individual, and (b) will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

5.5 Care Management

Our Care Management program is guided by the principles of the UnitedHealthcare Personal Care Model. We developed the Personal Care Model to address the needs of medically underserved and low-income populations. The Personal Care Model places emphasis on the individual as a whole, to include the environment, background and culture. If you need to directly refer a member who is not currently in the Care Management program, you may call 866-270-5785.

Identifications and Stratification

The Health Risk Assessment and our predictive modeling and stratification system are the primary tools for identifying members for the Care Management Program. The Health Plan will utilize Health Information Form (HIF)/Member Evaluation Tool (MET) data to assist with member stratification.

Health Risk Assessment

The Health Risk Assessment is an initial assessment tool used for new and existing members, to identify a member's health risks. Based upon the member's response to a series of question, the tool will assign a score that corresponds to a level. These levels are as follows:

- Level 1: Low-risk members who are typically healthy, stable or only have one medical condition that is well managed.
- Level 2: Moderate-risk members who may have a severe single condition, or multiple conditions issues across multiple domains of Care Management.
- Level 3: High-risk members who are medically fragile, have multiple co-morbidities and need complex Care Management.

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Stratification

Our multi-dimensional, episode-based predictive modeling tool, compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services.

On a monthly basis, the system uses algorithms to identify members for Care Management and stratify them into risk levels by severity of disease and associated co-morbidities. The algorithm takes into consideration inpatient and emergency room (ER) use. An “Overall Future Risk Score” is assigned to each member and represents the degree to which the Care Management program has the opportunity to impact members’ health status and clinical outcomes. This assists Case Managers in identifying members who are most likely to benefit from interventions.

Outreach and other Identification Processes

While Health Risk Assessments and retrospective data are the first line of identification of new members in the UnitedHealthcare Care Management Program, we have developed an extensive outreach program that supports real- time identification and referral for our Care Management services. Through community partnerships and relationships, our staff encourages and educates providers, ER staff, and hospital discharge planners to refer program members for a greater intensity and frequency of Care Management interventions when the situation requires it.

We supplement the Health Risk Assessment and the stratification tool identification process through several other methods. One of these approaches is an extensive outreach program that supports real-time identification and referral for our Care Management services. Our staff encourages and educates providers, ER staff, and hospital discharge planners to refer program members for a greater intensity and frequency of Care Management interventions when the situation requires it. We also rely on partnering programs and agencies to identify those members most at need. Our Care Management staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners, and fiduciary entities in order to identify members. Finally, in addition to claims and pharmacy data, we integrate authorization and pre-certification information into the Care Management software system. This data provides real-time identification of members experiencing health care barriers and self-care deficits.

Care Management Interventions

After a member has been identified, the Case Manager contacts the member’s parent or caregiver by telephone and sends program and health education materials targeted to the member’s specific care opportunities. The accompanying letter informs the member’s parent or caregiver on how the member became eligible to participate in the program, how to use the Care Management services, and how to opt out if they do not wish to participate.

Because our Care Management program provides benefits and quality-of-life improvements that ultimately impact the overall costs in care, our enrollment staff makes every attempt to enroll members in the Case Management program. We employ a number of strategies to locate and contact the member’s parents or caregivers, including after hour calls; searching for updated member information by contacting the PCP/ specialist office and reviewing prior authorization information; and sending written correspondence. We document and track contacts to ensure that all options have been exhausted prior to reporting failure to contact.

Once a member agrees to enroll in the Care Management program, the Care Manager performs a comprehensive health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history, and environmental risk factors. This information is used to augment and validate the risk stratification of members. We also institute disease specific assessments to augment the Health Risk Assessment when the caretaker is contacted. We have developed evidence-based interventions for our Care Management program. The following general interventions have been structured to improve members’ health status:

- Health Risk Assessment;
- Health review phone calls;
- Provide assigned Case Manager’s phone number to the member/family;
- Ongoing monitoring of claims and other tools to re-assess risk and needs;
- Access to program website;
- Episodic educational interventions, as needed;
- Post-hospitalization and emergency room assessment;
- Educational materials sent to the member;

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- Letter sent to the provider identifying the member's involvement, intervention and point of contact for the Care
- Management Program;
- Additional and/or specific interventions conducted to individualize the plan of care.

Plan of Care

Our Care Management Program is part of the Personal Care Model in which we pioneered a member-centric approach to the development of the plan of care for program participants. Our unique Personal Care Model features direct member, parent and caregiver contact by clinical staff who work to build a support network for high risk chronically and acutely ill members involving family, providers, and community-based organizations. The goal is to employ practical solutions to improve members' health and keep them in their communities with the resources they need to maintain the highest possible functional status.

The goals of the plan of care implementation are two-fold: 1) Case Manager interventions support self-management/ self-efficacy and patient education; and 2) Case Manager interventions are defined to ensure appropriate medical care referrals and assure appointments are kept, immunizations are received, and the member is connected with available and appropriate community support groups, for example, nutrition programs or caregiver support services. When the plan of care is implemented, our goals are:

- To help ensure the member is leveraging personal, family, and community strengths when able
- To ensure we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities
- To modify our approach or services based on the feedback from the member, family, and other health care team members
- To document services and outcomes in a way that can be captured and modified in order to continually improve
- To communicate effectively with the primary care provider/specialist and other providers involved in the member's care
- To monitor member satisfaction with services, adjusting as needed.

The Case Manager develops and implements an individualized plan of care for members requiring services, reviews the member's progress and adjusts the plan of care, as necessary, to ensure that the member continues to receive an appropriate level of care. The Case Manager will involve the provider caring for our member in the plan of care development process and assist them in directing the course of treatment in accordance with the evidence-based clinical guidelines that support our Care Management program. The plan of care addresses the following areas of care:

- Psychosocial adjustment,
- Nutrition,
- Complications,
- Pulmonary/cardiac rehab,
- Medication,
- Prevention,
- Self-monitoring of symptoms and vital signs,
- Emergency management/co-morbid condition action plan,
- Appropriate health care utilization.

Health Education

Our Medi-Cal health education program is led by our qualified, full-time health education manager. Providers are encouraged to collaborate with the health plan to ensure comprehensive health education services are provided to members. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.
The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes

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- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

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

Programs are based upon the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs of our members in San Diego and Sacramento Counties. Following is an overview of several health education programs we are prepared to offer based on need.

Healthy First Steps. Our Healthy First Steps (HFS) maternity management program promotes healthy birth outcomes for pregnant members, especially those with high-risk pregnancies. Education topics include normal pregnancy, recognition and reporting of signs and symptoms of potential complications, lifestyle and preventive health counseling, and increased awareness of community resources. HFS emphasizes activities that help prevent pregnancy-related complications, enhance the practitioner-patient relationship and promote the member's compliance with his/her plan of care. We provide HFS supports that increase member compliance with behaviors that lead to healthy outcomes for the mother and baby. An example of a tool for pregnant members that promotes healthy birth outcomes is Baby Blocks.

Baby Blocks. Baby Blocks encourages pregnant women and new mothers to attend their prenatal, postpartum and well-baby appointments. It uses online/mobile tools to remind and encourage pregnant members to keep their wellness appointments and is offered to all newly identified pregnant members.. Information about the Baby Blocks program is shared with pregnant members through mailings, brochures delivered through OBs and our HFS program. Interactive tools, delivered online or through a smartphone, remind and encourage pregnant members to keep their wellness appointments based upon their due date. We reward members for achieving key milestones, such as their six-month prenatal visit, eight-month prenatal visit, postpartum visit, their baby's six-month wellness visit and completion of their baby's blood lead screening. At each milestone, the new mom can select a reward.

Diabetes Health Education Program. Our diabetes health education program seeks to reduce unnecessary hospitalizations and health care costs by improving the health of adult and pediatric members who have diabetes. The program provides information, interventions and other resources to help members such as:

- Managing diabetes through daily monitoring of key findings for weight and symptom changes and for symptom-specific management
- Adhering to care provider treatment plans and drug therapy regimens
- Managing risk factors and co-morbidities
- Improving physical activity tolerance and reduce or eliminate health risk factors, such as excess weight, obesity and smoking
- Understanding diabetes and how to receive the most clinically appropriate, cost-effective and timely diagnostics and procedures

Asthma Health Education Program. Our asthma health education program helps reduce unnecessary hospitalizations and health care costs, missed days of work or school and seeks to improve an individual's quality of life. The program provides information, condition-specific materials, comprehensive assessments, nurse coaching, interventions and other resources to help participants such as

- Identifying and avoiding triggers that induce or aggravate asthma attacks
- Reducing or eliminating risk factors (e.g., smoking or smoke exposure)
- Managing asthma through adherence to medication, peak flow meter use, use of an asthma action plan and other care provider treatment plans
- Monitoring asthma to recognize attack warning signs and take appropriate actions to take
- If school-aged, ensuring that other entities that interact

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with the member, such as the school or athletic organizations, know about and participate in the member's plan of care

Self-Service Health Education Tools. Several innovative resources and tools to help members manage their conditions, provide health and wellness information, healthy lifestyle tips, tools that help members manage their conditions and reminders about important topics. Some of the tools are listed below and more information can be obtained by contacting the health plan.

1. **KidsHealth Online Support Center**, part of the Nemours Foundation Center for Children's Health Media, is an online resource offering more than 200 videos and 10,000 articles that provide support on a range of physical, emotional and behavioral issues that affect children and teens, such as nutrition, asthma, stress and coping strategies.
2. **uhclatino.com,** our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.
3. **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.
4. **NurseLine,** provides 24 hours a day, seven days a week support to members. The NurseLine audio knowledge library provides members with self-service access to hundreds of recordings on specific conditions and health and wellness-related topics
5. **UnitedHealthcare MyHealthLine,** through the Federal SafeLink program, we provide free cellphones to members, which include 250 voice minutes per month, unlimited texting and a pre-programmed member services number that does not count against the minutes. We enroll members in the Connect4Health texting program, which offers checkup reminders and tips to live healthier. Texts are based upon a child's age and development, baby due date and provide a personalized health profile for adults. Topics include exercise, fitness and nutrition, labor and delivery, car seat safety and breastfeeding.
6. **Annual member newsletter,** provides members with articles addressing asthma, coronary artery disease, COPD, diabetes, heart failure and healthy living.

5.6 Coordination of Care with Providers

Each member is encouraged to select a medical home for community-based health and preventive services. Providers caring for our members receive reports regarding the health status of members participating in our Care Management Program. As this link is established, we involve the provider in the plan of care development process and assist them in directing the course of treatment in accordance with evidence-based clinical guidelines.

The Case Manager collaborates with the member's provider on an ongoing basis to ensure integration of physical and behavioral health issues. In addition, the care manager will ensure the plan of care supports the member's/caregiver's preferences for psychosocial, educational, therapeutic and other non-medical services. The Case Manager ensures the plan of care supports providers' clinical treatment goals and builds the plan of care to reflect personal, family and community strengths.

The Case Manager and member will review the member's compliance with the treatment during each assessment cycle. Treatment, including medication compliance, is established as a health care goal with interventions and progress towards that goal documented in each assessment session. At any point that the care manager recognizes that the member is non-compliant with part or all of the treatment plan, the care manager will:

- Work to identify and understand the member's barriers to success;
- Problem solve for alternative solutions with the member;
- Report non-compliance to the treating provider/specialist, offer potential solutions and integrate provider feedback;
- Facilitate agreement for change between all parties and monitor progress of the change.

As the member's medical home, the provider caring for our member is continuously updated on the member's participation in the Care Management Program, the member's compliance with the plan of care and any unscheduled hospital admissions and emergency room visits. The provider receives notifications of when members are enrolled and disenrolled from the Care Management Program the assigned Care Manager for the Case Management Program, and how to contact the Case Manager. In addition, the provider receives notification of members who have generated care opportunities related to the Care Management Program. These evidence-based medical

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guidelines are generated from our multi-dimensional, episode-based predictive modeling tool.

We also distribute clinical practice guidelines upon the provider's request and provide training for providers and their staff on how best to integrate practice guidelines into everyday care provider practice. When a provider demonstrates a pattern of non-compliance with clinical practice guidelines, the Medical Director may contact the provider by phone or in person to review the guideline and identify any barriers that can be resolved.

5.7 Case Management

We use retrospective and prospective methods to ensure potential high-risk members are identified as early as possible. To identify members who meet criteria for Care Management, we continuously forecast risk through predictive modeling of our claims data. To supplement our retrospective, claims-based approach, we perform an automated, mini Health Risk Assessment. In addition, we also review authorization requests, hospital and ER use, pharmacy data and referrals from providers, members and their family/caregivers, as well as UnitedHealthcare Community Plan clinical staff. Individuals identified for possible Care Management go through a more in-depth, scored comprehensive assessment and are routed to the Care Management Program based on the outcome of that scoring.

Prospective Identification—UnitedHealthcare Community Plan uses numerous data sources to identify members with a diagnosis that qualifies them for the Care Management Program, as well as those whose utilization reflects high-risk and/or complex conditions (Level 3). These data sources include but are not limited to:

- The Health Plan will utilize the HIF /MET data to assist with member stratification.
- Completed Health Risk Assessments for members with a Pediatric Risk of Mortality (PRISM) score of 1.5 or greater.
- Short Health Risk Assessments conducted during new member welcome calls;
- Member-reported health needs in calls made to our Member Services Department;
- Pharmacy and lab data indicating the incidence of a specific condition (for example, insulin or inhalers);
- ER utilization reports, hospital inpatient census reports, authorization requests and transitional care coordination requests;
- Care provider referrals;
- Referrals from health departments, rural health clinics and Federally Qualified Health Centers (FQHC);
- UnitedHealthcare Community Plan clinical staff referrals.

Risk Stratification—All identified members complete a Health Risk Assessment that scores them into risk categories. Based on the actionable population and aid categories of each Health Plan and state program, we determine the specific threshold for each case and Care Management level. As previously mentioned, members are stratified **into one of three levels** and are assigned to the appropriately qualified staff.

5.8 Clinical Practice Guidelines

UnitedHealthcare Community Plan adopts clinical practice guidelines as the clinical basis for our Care Management program. Clinical guidelines are systematically developed, evidence-based statements that help providers make decisions about appropriate health care for specific clinical circumstances. We adopt clinical guidelines from recognized sources as defined by the National Committee on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC).

UnitedHealthcare Community Plan uses nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including MCG Care Guidelines, Behavioral Health Level of Care Guidelines, and CMS policy guidelines. MCG Care Guidelines is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best-practice care templates, and key milestones for the best possible treatment and recovery. Our Behavioral Health Level of Care Guidelines provide objective and evidence-based admission and continuing stay criteria for mental health and substance abuse services. These guidelines are integrated into our clinical system.

For specific state benefits or services not covered under national guidelines, we develop criteria through the review of current medical literature and peer reviewed publications, Medical Technology Assessment Reviews and consultation with specialists.

The clinical practice guidelines are reviewed and revised annually. The UnitedHealthcare Executive Medical Policy Committee (EMPC) reviews and approves nationally recognized clinical practice guidelines. The guidelines are

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then distributed to the National Quality Management Oversight Committee (NQMOC) and the Health Plan Quality Management Committee.

Medical guidelines are available and shared with providers upon request and are available on the provider website, **UHCCommunityPlan.com**. Policies and guideline updates are communicated through provider notices prior to implementation.

For pharmacy management, use of guidelines helps to ensure appropriate use at the initiation of therapy. OptumRx implements and manages a preferred product listing, which lends itself to standardization, consistency and cost savings. In addition, they offer a case review process, which includes clinical pharmacist review of the clinical progress of the patient, any pertinent labs, and patient compliance to evaluate continuation of a medication.

A provider may call UnitedHealthcare Community Plan Utilization Management at 866-270-5785 to answer any questions about Utilization Management or denials. Someone is available to take your call 24 hours a day, seven days a week.

5.9 Family Planning

Family planning services are covered when provided by care provider or practitioners to members who voluntarily choose to delay or prevent pregnancy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Members have a choice to receive services from their UnitedHealthcare PCP/PCCM clinic or go directly to a local health department or family planning clinic. Members do not need a referral (permission) from the Health Plan for the services below:

- Family Planning services and birth control
- Pregnancy testing and counseling
- Tubal ligation and vasectomies (see Sterilization section)
- Immunizations
- HIV and AIDS testing
- TB screening and follow-up care
- Sexually transmitted disease treatment and follow-up care

5.10 Maternity Care

Pregnant members should receive care from UnitedHealthcare Community Plan participating providers only. UnitedHealthcare Community Plan will consider exceptions to this policy if 1) the woman was in her second trimester of pregnancy when she became an UnitedHealthcare Community Plan member, and 2) if she has an established relationship with a non-participating obstetrician.

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

You need to contact Healthy First Steps by submitting an American College of Gynecology or any initial prenatal visit form to Healthy First Steps via fax 855-432-2828. Care providers with questions regarding Healthy First Steps should call 866-270-5785. See more information about Healthy First Steps below.

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

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

An obstetrician does not need approval from the member's provider for prenatal care, testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription to present at any of the UnitedHealthcare Community Plan participating radiology and imaging facilities listed in the provider directory. Midwives and home deliveries are a covered benefit. Maternity services provided by midwives and home delivery are a covered benefit without authorization.

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5.11 Healthy First Steps (Maternity Case Management) and Neonatal Resource Services (NICU Case Management)

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, the Healthy First Steps program uses early identification to:

- Help overcome common social and psychological barriers to prenatal care;
- Increase member understanding of the importance of early prenatal care;
- Increase the mother's self-efficacy by identifying and building the mother's support system, including referral to appropriate community resources such as the Women, Infants, and
- Children Program (WIC) services program;
- Ensure appropriate postpartum and newborn care;
- Develop the care provider/member partnership and relationship before and after delivery.

Women, Infants and Children Supplemental Nutrition Program ("WIC") Program

WIC is a federally funded health and nutrition program for women, infants, and children. WIC helps families by providing nutrition education, issuing checks for healthy supplemental foods, and making referrals to healthcare and other community services, nutrition counseling and breastfeeding support. Participants must meet income guidelines and be pregnant women, new mothers, infants, or children under age five (or guardians thereof).

Eligibility Requirements

As a part of a member's initial health assessment or as part of the initial evaluation of pregnant member, providers must refer and document the referral of pregnant, breastfeeding, or postpartum members, or a parent/guardian of a child under the age of five to the WIC Program. Program services include nutrition assessment and education, referral to health care, and monthly vouchers to purchase specific food needed to promote good health for low-income pregnant, breast-feeding, and postpartum women, infants, and children under five years of age with a medical/nutritional need. Members are eligible if they meet one of the following criteria:

- Pregnant women (eligible as soon as there is a positive pregnancy test)
- Breast-feeding women up to one year after childbirth
- Post-partum women up to six months after childbirth
- Parent or guardian of child under the age of five who is determined to be at nutritional risk by a health care professional such as the PCP

Required Lab Testing

As part of the referral process, providers must make available to the WIC Program a current hemoglobin or hematocrit laboratory value. Providers shall also document laboratory values and the referral in the member's medical record. Laboratory values must be provided within 90 days of enrollment and within 90 days of each succeeding six-month certification period except for a child whose blood value was within normal limits at the previous certification. For these children, Hgb/Hct values are required every 12 months. For children under nine months of age, height/length and weight must be submitted and dated within 60 days of enrollment and with each six-month re-certification period.

Other

All medically necessary Medi-Cal covered services will be provided to eligible members including enteral nutrition products. Formula and enteral nutrition products can be eligible to be covered under the pharmacy benefit if medical necessity is met. Formula and enteral nutrition products covered under Women, Infants, and Children's (WIC) Program are not covered under the pharmacy benefit.

Resources

WIC has local offices all over California that may be located by calling 888-WIC-WORKS (888-942-9675) or accessing the online search site: m.wic.ca.gov/WICMobile/Clinics/ClinicSearch.aspx

- Sacramento County – **saccountywic.net**
  - For lactation support and assistance:
- English – 916 875 2120 or Spanish – 916 875 2121

5.12 Delivery Admissions

Authorization for delivery is required for normal delivery past two days and C-Section delivery past four days. Please call 866-604-3267 or fax the following information for the newborn to UnitedHealthcare Intake at 855-554-2152:

- Date of birth
- Birth weight

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- Gender
- Delivery type
- Gestational age

5.13 Newborn Admissions

The hospital must notify us prior to or upon the mother's discharge, if the baby stays in the hospital after the mother is discharged. Healthy First Steps (HFS) will conduct concurrent review of the newborn's extended stay. The hospital should make available the following information:

- Date of birth
- Birth weight
- Gender
- Any congenital defect
- Name of attending neonatologist

5.14 Minor Consent Services

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

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

Eligible Members can receive these services from any qualified Medi-Cal provider, including providers who are not in the UnitedHealthcare Community Plan network.

5.15 Sterilization

You must comply with the procedures outlined below prior to obtaining an authorization* and performing the sterilization service. A completed Federal Consent Form must be submitted with claims for all voluntary sterilization procedures. Additionally, federal consent requirements for voluntary sterilization require:

- The recipient to be at least 21 years of age at the time consent is signed.
- The recipient to be mentally competent.
- Consent is to be voluntary and obtained without duress.
- 30 days, but not more than 180 days, must pass between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- At least 72 hours must have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery.
- The informed consent must be given at least 30 days before the expected date of delivery in the case of premature delivery.
- The person securing the informed consent and the care provider performing the sterilization procedure are required to sign and date the consent form.
- Copy of the signed Federal Consent Form must be submitted by each provider involved with the hospitalization and/or the sterilization procedure.
- That sterilization consents may not be obtained when an eligible recipient:
  - is in labor or childbirth.
  - is seeking to obtain or obtaining an abortion.
  - is under the influence of alcohol or other substances that affect that recipient's state of awareness.

5.16 Sterilization Consent Form

If the provider is performing a sterilization procedure, which may only be performed on patients 21 years of age and older and who are mentally competent, the Department of Health Services' Consent Form (PM 330). The PM 330 form is available for download from the Medi-Cal website located at **medi-cal.ca.gov**.

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Federal government auditors closely monitor the proper and timely completion of the consent form and UnitedHealthcare Community Plan is required to insist on proper adherence to the requirements. You must wait 30 days between the patient signing the consent form and performance of the procedure, except in the case of premature delivery or emergency abdominal surgery. The consent expires 180 days from the member's date of signature. A new consent form is required if the procedure is to be performed after the 180-day period.

5.17 Concurrent Review

We perform concurrent review on all hospitalizations for the duration of the stay based on contractual arrangements with the hospital. We perform fax, telephonic or onsite utilization reviews at the facility.

We use evidence based, nationally accepted, clinical criteria guidelines for determinations of appropriateness of care.

The Inpatient Case Manager may certify extension of the length of stay, but may not deny any portion of the stay. Only a medical director or care provider advisor can deny an extension of the length of stay.

We notify the facility when the Inpatient Case Manager refers a hospital stay for review by a medical director or care provider advisor. If a medical director or care provider advisor determines the extended stay is not justified, we notify the facility by phone and fax within 24 hours. Members are notified in writing within two business days.

The attending care provider or facility caring for the member may appeal any adverse decision with written member consent, according to the procedures in the Complaints and Grievances section.

5.18 Inpatient Concurrent Review: Clinical Information

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

Your cooperation is required with all our requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. 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). UnitedHealthcare Community Plan uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

5.19 Discharge Planning and Continuing Care

The Inpatient Case Manager contacts the care provider caring for the member, the attending care provider, the member, and member's family to assess needs and develop a plan for continuing care beyond discharge, if medically necessary. UnitedHealthcare Inpatient Case Managers facilitate coordination of care across multiple sites of care. The Inpatient Case Managers work with the member, family members, care provider, hospital discharge planners, rehabilitation facilities, and home care agencies. They evaluate the appropriate use of benefits, oversee the transition of patients between levels of care, and refer to community-based services as needed.

5.20 Preventive Health Care Standards

Our goal is to partner with providers to ensure that members receive preventive care. UnitedHealthcare Community Plan endorses and monitors the practice of preventive health standards recommended by recognized medical and professional organizations. Preventive health care standards and guidelines are available at **UHCCommunityPlan.com**. Standards such as well child, adolescent and adult visits, childhood and adolescent immunizations, lead screening, and cervical and breast cancer screening are included in the website. Education is provided to both members and providers related to preventive health services and members are offered assistance with gaining access to these

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services if needed. Members may self-refer to all public health agency facilities for medical conditions treated by those agencies.

5.21 Recommended Childhood Immunization Schedules

The childhood and adolescent immunization schedule and the catch-up immunization schedule have been approved by Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP).
Government Childhood and Adolescent Immunizations Guide:
cdc.gov/vaccines/recs/schedules/childschedule.htm

Government Quick Reference Guide:
cdc.gov/vaccines/recs/schedules/

Source: CDC and Advisory Committee on Immunization Practices

5.22 Tuberculosis (TB) Screening and Treatment; Direct Observation Therapy (DOT)

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

PCP Responsibilities:

Identification – The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all individuals at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. Providers will coordinate and collaborate with Local Health Departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the Local Heath Department (LHD). The PCP must report known or suspected cases of TB to the LHD TB Control Program within one (1) day of identification.

Referral – Individuals determined to be at risk of non-compliance with TB drug therapy are referred to the LHD for direct observation therapy (DOT). Directly Observed Therapy (DOT) is a technique of delivering TB treatment to ensure timely completion of treatment, prevent further TB transmission, and prevent development of drug resistance. National guidelines recommend DOT as standard treatment for TB disease. Rates of relapse and development of acquired drug resistance have decreased when DOT is used.

Follow-up – The PCP ensures that a follow-up appointment is scheduled to develop and implement the ongoing plan of care. Members who fail to keep follow-up appointments are contacted by telephone and/or letter and these follow-up contacts documented in the member record. The PCP also notifies the LHD TB Control program when members show a pattern of missing follow-up appointments.

5.23 Transplant Services

Major organ transplants are a covered benefit of the Medi-Cal program. Member undergoing transplants are disenrolled with the exception of cornea and kidney transplants for which UHC maintains responsibility.

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

Authorization Request – If the transplant center physician considers the member to be a suitable candidate, the health plan shall submit a Prior Authorization Request to either the DHCS San Francisco Medi-Cal Field Office (for adults) or the California Children Services Program (for children) for approval.

Disenrollment – Once each of the above steps is completed and the member is approved for transplant, the health plan initiates the disenrollment process.

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

If it is determined that the member is not a candidate for a major organ transplant or DHCS denies authorization for a transplant, the member is not disenrolled and the health plan covers the cost of the evaluation performed by the Medi-Cal approved transplant center.

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5.24 Access and Referral to Waiver Programs

Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) HCBS Waiver Program

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

Identification – Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The health plan Care Coordinator or the PCP may identify members potentially eligible for the waiver program. The member is informed of the availability of waiver program services.

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

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

Other Federal Waiver Programs

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

5.25 Carve-out Services

Medi-Cal covers services that are not part of the UnitedHealthcare Community Plan managed care benefit. This includes the following services/program:

- California Children Services (CCS)
- Child Health and Disability Prevention Program (CHDP)
- Women, Infants and Children (WIC) Program
- Comprehensive Perinatal Services Program (CPSP)
- Dental Services
- Alcohol and Drug Services

Members may access these services while continuing to be enrolled with UnitedHealthcare Community Plan.

Major organ transplants are a covered benefit of the Medi-Cal program. Member undergoing transplants are disenrolled with the exception of kidney and cornea transplants for which UHC maintains responsibility.

Child Health and Disability Prevention (CHDP) Program

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

The CHDP Health Assessment includes the following:

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

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The CHDP Provider should also coordinate referrals to other programs/services as needed including the following:

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

CHDP providers delivering care to members eligible for the CHDP program must submit a complete PM160 INF (Information Only) Form. This form is used to monitor the quality of and compliance with CHDP screening requirements. Copies of the form should be handled as follows:

- Copy 1 (white/brown) Send to:
  UnitedHealthcare Community Plan of California
  PO Box 31341
  Salt Lake City, UT 84131
- Copy 2 (yellow) Send to the Local County CHDP office. Please ensure the PCP (service site) address, number, and county code are completed in the lower left-hand corner of the form.
- Copy 3 (white) is stored in the member's medical record file
- Copy 4 (pink) is given to the member or parent/guardian at the time of the CHDP visit.

UnitedHealthcare Community Plan must submit all complete CHDP forms to DHCS within 30 days from the end of the month in which services were rendered. Please contact Provider Services at 866-270-5785 to order PM160 INF forms or visit **UHCCommunityPlan.com**.

5.26 Dental Screening and Referral

PCP responsibility

Dental services are not a covered benefit; however, members are entitled to an annual dental screening as part of initial and periodic health assessments completed by the PCP. A dental screening should include, at a minimum, documentation of the dental history, examination of the teeth and gums and dental education. For members under the age of 21 years, the dental screening is performed as part of every periodic assessment and annual dental referrals to appropriate Medi-Cal dental providers are made beginning at age three or earlier if necessary.

Covered Medical Services

Covered medical services are those services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered prescription drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure, including facility fees and anesthesia services for both inpatient and outpatient services. For children under 6 years of age, topical application of fluoride up to three times in a 12-month period is a Medi-Cal Managed Care Plan benefit. When the procedure follows a protocol established by the attending care provider, then nurses and other appropriate personnel may apply fluoride varnish.

Referral Process

Members or providers may contact the Medi-Cal Dental Program via the Beneficiary Telephone Service Center at 800-322-6384. The call is free. Medi-Cal dental program representatives are available 8:00 a.m. to 5:00 p.m., Monday through Friday to provide assistance.

5.27 Targeted Case Management

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

PCP Responsibility – Perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS eligible medical condition and collaborate with the local LEA or RC in the development of the IEP or IFSP to determine the appropriate strategies and services required based on the unique identified needs of the child

Identification – The five target populations include:

- Children under the age of 21 at risk for medical compromise
- Medically fragile individuals
- Individuals in frail health, over the age of 18 and at risk of institutionalization
- Individuals in Jeopardy of negative health or psychosocial outcomes

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- Individuals infected with a communicable disease, including tuberculosis, HIV/AIDS, etc., or individuals who have been exposed to communicable diseases, until the risk of exposure has passed

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

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

5.28 Early Start Program

The Early Start Program provides early intervention services to infants and toddlers with disabilities and their families.

PCP Responsibility – Perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS eligible medical condition and collaborate with the local LEA or RC in the development of the IEP or IFSP to determine the appropriate strategies and services required based on the unique identified needs of the child

Identification – The PCP should use appropriate screening and assessment tools to identify infants and toddlers with a disability that continues, or can be expected to continue indefinitely, and that constitutes a substantial handicap. Infants and toddlers from birth to age 36 months may be eligible for early intervention services through Early Start if, through documented evaluation and assessment, they meet one of the criteria listed below:

- Have a developmental delay of at least 33 percent in one or more areas of either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- Have an established risk condition of known etiology, with a high probability of resulting in delayed development; or
- Be considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel

Referral – The PCP will refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once the need for services has been identified. The PCP will provide information as requested to complete the referral process. If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these impairments, the Local Education Agencies (LEA) should be contacted for evaluation and early intervention services. After contacting the regional center or local education agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility. Some children may be eligible for both Early Start and CCS in which case both the RC and CCS agencies should be notified (see section 5.29).

Continuity of Care –The PCP will support the development of the Individual Family Service Plan (IFSP) developed by the Early Start Program through either the Regional Center (RC) or Local Education Agency (LEA). The assigned Care Coordinator will collaborate with the local Regional Center or local Early Start Program and the PCP to ensure provision of all medically necessary covered diagnostic, preventive and treatment services identified in the individual family service plan (IFSP). The health plan continues to provide collaborative case management and care coordination to the member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the individual family service plan (ISFSP) developed by the Early Start Program, with PCP participation.

5.29 California Children's Services (CCS)

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

PCP Responsibility - Perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS eligible medical condition and collaborate with the local LEA or RC in the development of the IEP or IFSP to determine the appropriate strategies and services required based on the unique identified needs of the child

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

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

Referral – The PCP or specialist care provider refers eligible members to the CCS program for comprehensive case management. Referral may be made by telephone, same-day mail or fax, if available. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program. Referrals may only be made to CCS paneled providers and CCS-approved hospitals within the contracted network effective from the date of referral.

Contact Information:
Sacramento County CCS: 916-875-9900
San Diego County CCS: 619-528-4000

Continuity of care – The Health Plan continues to provide all Medically Necessary Covered Services for the member's CCS eligible condition until CCS eligibility is confirmed. Once eligibility for the CCS program is established for a member, the Health Plan shall continue to provide all medically necessary covered services unrelated to the CCS eligible condition and shall monitor and help ensure coordination of services and joint case management between its Primary Care Providers, the CCS specialty providers, and the local CCS program. If the local CCS program does not approve eligibility, the health plan remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, the Health Plan remains responsible for obtaining the service, if it is medically necessary, and paying for the service if it has been provided.

5.30 Development Disability Services and Coordination with Regional Centers

Developmental disabilities are severe and chronic disabilities attributable to a mental or physical impairment that begins before the individual reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions closely related to intellectual disability or requiring similar treatment. The California Department of Developmental Services (DDS) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children over the age of 36 months to adulthood.

PCP Responsibility – Perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS eligible medical condition and collaborate with the local LEA or RC in the development of the IEP or IFSP to determine the appropriate strategies and services required based on the unique identified needs of the child.

Identification – The PCP or Care Coordinator identify members who may benefit from the DDS program, for example, in-home supportive services. The PCP will coordinate the developmental, psychological, and psychiatric assessment as appropriate. The Care Coordinator will assist in obtaining records necessary in the determination of the need for supportive services.

Referral – If it is determined supportive services would be of benefit, a referral is made to DDS for approval and assignment of a Regional Center Case Manager who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the Regional Center Interdisciplinary Team. While the Regional Center does not provide overall case management for their clients, they must assure access to health, developmental, social, and educational services from birth throughout the lifespan of 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 Care Coordinator. The Care Coordinator and PCP continue to provide and manage primary care and medically necessary services. Should the member not meet criteria for the program or placement is not currently available, the health plan will continue care coordination as needed to support the screening, preventive, medically necessary, and therapeutic covered services required by the member.

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5.31 Chronic Condition Management

Educational materials and newsletters are used to remind members to comply with 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 educational materials are based upon evidence-based guidelines or standards. All printed materials are written at a fifth grade reading level and are available in English and Spanish and other prevalent non-English languages. The materials are designed to support members as they begin to take responsibility for their health and provide them with the information necessary to manage their condition as successfully as possible 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 provide support to members and caregivers with conditions common to children with special health care needs and help them manage their illness.

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

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

5.32 Long Term Care

Sacramento County Only – Long-Term Care (LTC) coverage is limited to the month of admission and the following month after which members return to the Fee-for-Service (FFS) Medi-Cal program for continued LTC coverage. Upon admission, the health plan designee will assess the health care needs of the member and estimate the potential length of stay. If the member requires care for longer than the month of admission plus one month, a disenrollment request will be submitted to DHCS. This does not include hospice services that are covered services and are not long-term care services regardless of the member's expected or actual length of stay.

San Diego County Only – Long Term Care (LTC) is a covered benefit for members residing in San Diego County. The Health Plan will cover Medically Necessary LTC from the time of admission into an appropriate facility to either the member's release from the facility or to the member electing to receive hospice services. The health plan ensures that a member in need of LTC is placed in a facility that provides the level of care most appropriate to the member's medical needs. These health care facilities include SNF/NF, sub-acute facilities, and Intermediate Care Facilities.

5.33 Community Based Adult Services

CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CBAS services include: an individual assessment; professional nursing services; physical, occupational and speech therapies; mental health services; therapeutic activities; social services; personal care; a meal; nutritional counseling; and transportation to and from the participant's residence and the CBAS center.

Identification: Current SPD members or family members, care providers and HP case managers may identify members potentially eligible for CBAS services. SPD members/family or the PCP may contact the UnitedHealthcare Community Plan case manager to determine eligibility.

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

Continuity of Care: The health plan maintains responsibility for providing primary care and prevention services including CBAS-eligible services. The case manager will work collaboratively with the PCP and CBAS case manager to ensure delivery of eligible services.

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5.34 Long Term Support Services

In-Home Supportive Services (IHSS) is a State mandated, county-administered program that is intended to provide consumer directed care for eligible recipients. The IHSS Program is an alternative to out-of-home care (such as nursing homes) and will help pay for services provided to individuals so that they can remain safely in their own home. The types of services that can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. IHSS is a consumer-directed model for eligible members, which allows them to self-direct care through selection, hiring, supervising, training and terminating caregivers(s).

Eligibility. To be eligible, members must be over 65 years of age, or disabled, or blind and in some cases, disabled children are also eligible for IHSS. Additional eligibility requirements include:

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

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

Contact information for referrals to AIS is:

- Telephone Number: 800-510-2020 Representatives are available Monday through Friday, 8 a.m. – 5 p.m. Calls received after hours will be returned the next business day.
- AIS Web Referral (Attachment C): **aiswebreferral.org/**
  - Available 24 hours a day, 7 days a week

Assessment and Approval: The County Social Worker will schedule a face-to-face assessment with the member to complete a comprehensive needs assessment to determine need. The Social Worker will authorize the service hours for which a member is eligible. The member will be notified by the county if services are approved or denied and, if denied, the reason for denial. United Healthcare Community Plan of California will pay for IHSS hours for which an enrollee has been deemed eligible by the county IHSS agency.

5.35 Multipurposes Services Program (MSSP)

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

Eligibility. MSSP site staff makes this certification determination based upon Medi-Cal criteria for placement. Individuals can only be enrolled in one HCBS waiver at any a time and the services must be within the cost limitations of the program (they may not exceed the cost of care within a nursing facility). Eligibility requirements include:

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

Eligible Services include:

- Adult day care
- Housing assistance
- Chore and personal care assistance
- Protective supervision
- Care management

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- Respite
- Transportation
- Meal services
- Social services
- Communications services

Referral and Coordination of Services. The member's family, PCP or the case managers may make a referral to the MSSP program. The Case Manager and PCP collaborate with the MSSP Waiver Case Management Team to coordinate appropriate services. The MSSP Case Management Team will conduct a case conference if MSSP services are indicated. Contact information for the local MSSP sites is included below:

- Sacramento County – California Health Collaborative: **healthcollaborative.org/** - 916-374-7739
- San Diego County – Aging and Independent Services: **sandiegocounty.gov/hhsa/programs/ais/** - 800-510-2020

5.36 Women, Infants and Children Supplemental Nutrition Program (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides Federal grants for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

Eligibility

- Pregnant women as soon as there is a positive pregnancy test
- Women who have been pregnant within the previous six months
- Breastfeeding women
- Children under the age of five

Referral: Referrals to the WIC program should be made as a part of the initial health assessment of a pregnant, breastfeeding, or postpartum woman and children under the age of five. As a part of the referral process, 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:

- Sacramento
  - 916-876-5000
  - **saccountywic.net**
- Breastfeeding and Lactation support
  - 916-875-2120 (English)
  - 916-875-2121 (Spanish)
- San Diego
  - **sdsuwic.org**

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Chapter 6: Complaints and Grievances

UnitedHealthcare Community Plan maintains a timely and organized process using established policies and procedures to ensure prompt resolution of informal and formal complaints and grievances filed by members and providers. Our system includes member and provider appeals processes and a provider payment dispute process. UnitedHealthcare Community Plan has a specialized grievance and appeal department. We allocate qualified and trained personnel to establish, implement and maintain this process.

Our grievance and appeals system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies.

Upon enrollment, members receive written information which clearly explains the grievance system requirements. These member materials were developed in accordance with federal regulations and the California Administrative Code regarding content, timing and translation of such information. They are provided in each prevalent non-English language occurring within each service area. Members are informed that grievance system information is available in prevalent non-English languages upon request, how to obtain it and via oral interpretation services in any language. Providers are informed of the member grievance and appeal process through the UnitedHealthcare Provider Manual and **UnitedHealthcareOnline.com**. Materials are available in hard copy and on our website.

The information includes a description of: the right to administrative hearing, the method for obtaining an administrative hearing, the rules that govern representation at the hearing, the right to file grievances, the requirements and timeframes for filing grievances and appeals, the availability of assistance in the filing process, the toll-free numbers that the member can use to file a grievance or appeal by phone, that benefits will continue when requested by the member in an appeal or administrative hearing request concerning certain actions which are timely filed, that the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the member, and that a provider or appointed representative may file an appeal on behalf of a member with the member's written consent.

6.1 Second Opinion

Member materials also explain the member's right to obtain a second opinion at no cost to the member when they disagree with the initial provider's recommended treatment plan. This information is available to the member via the New Member Welcome packet, online through the UnitedHealthcare Community Plan website. and in other written materials including information on how to contact UnitedHealthcare Community Plan to request a second opinion.

6.2 Filing a Member Grievance

Members or their authorized representative may file a grievance with UnitedHealthcare Community Plan by calling Member Services toll-free or by mailing a written grievance to the address provided in their Member Handbook. Welcome packet materials and the Member Handbook state that grievances should be filed directly with UnitedHealthcare and encourages members to follow the grievance process appropriately. Members may contact the Department of Managed Care (DMHC) if the grievance has not been satisfactorily resolved or remains unresolved for more than 30 days. UnitedHealthcare date stamps written grievances, enters them into the grievance tracking system and creates a case file. Verbal grievances are entered into the tracking system on the date of receipt and a case file created. UnitedHealthcare acknowledges receipt of each member grievance and logs and tracks member name/ identification number; date grievance received/grievance acknowledged; grievance description code; staff assigned for disposition; disposition; and disposition date. UnitedHealthcare will send a written acknowledgement of the grievance received within five calendar days.

6.3 Process for Resolving a Grievance

Member Services receives calls 24 hours a day, seven days a week to address various issues, including member grievances. Not all calls received by Member Services are logged into ETS. Only those calls not resolved by Member Services and qualify as grievances will be forwarded to A&G team for entry into ETS. The majority of member grievances are resolved during the initial call to UnitedHealthcare Community Plan. The information is sorted to identify any potential quality of care issues.

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The Grievance Coordinator conducts preliminary research to verify the appropriate path of the grievance. The Grievance Coordinator will research and processes the grievance for resolution. If it is necessary to involve other departments, the Grievance Coordinator triages the grievance to the appropriate department and oversees the process until resolution is attained. The Grievance Coordinator will close the case file in ETS with all applicable data. Members generally receive notification of the grievance resolution within 30 calendar days. Expedited grievances will be resolved within 72 hours.

6.4 Member Appeal Process

When UnitedHealthcare Community Plan makes a decision to deny or issue a limited authorization of a service authorization request, or reduces, suspends or terminates a previously authorized service, we mail a Notice of Action to the member. You are also informed via written notice of the decision to deny or reduce a service authorization request. We provide a Notice of Action to the member as expeditiously as his/her health condition requires, but not later than 14 days following the receipt of the authorization with a possible extension of up to 14 days if the member or provider requests an extension, or if we establish a need for additional information and delay is in the member's best interest. If UnitedHealthcare Community Plan does not make a decision within the applicable timeframes, a decision is made on the date that those timeframes expire.

6.5 Filing an Appeal

A member or a representative authorized in writing to act on the member's behalf may file an appeal in response to the actions described above. The member has 60 calendar days from the date of the Notice of Action to file an appeal. UnitedHealthcare Community Plan will accept appeals in writing or verbally. A standard oral appeal will be followed with a signed written appeal. UnitedHealthcare Community Plan date stamps an appeal received, enters the pertinent information into the appeals tracking system and creates an appeal case file to include available and relevant information associated with the appeal. The Appeals staff acknowledges the receipt of each standard member appeal within five calendar days. Appeals staff makes an effort to notify members verbally within one calendar day for cases not accepted as expedited appeals that the case will be reclassified as standard and resolved within 30 calendar days from initial received date. Notification in writing will be mailed within two calendar days for reclassified standard appeals.

6.6 Timeliness for Resolving an Appeal

We resolve standard appeals and appeals for termination, suspension, or reduction of previously authorized services within 30 calendar days after receipt of the appeal. We may request an extension of up to 14 days and will provide the member with a written notice of the extension and the reasons for the delay. However, the extension will not delay the decision beyond 30 calendar days of the request for appeal without the informed written consent of the enrollee. We will expedite resolution of an appeal if, according to the information provided by the member or as indicated by a provider filing an appeal on the member's behalf, the standard resolution timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Under such circumstances, We will resolve the expedited appeal within 72 hours. We may request an extension of up to 14 days and will provide the member with a written notice of the extension and the reasons for the delay. If the expedited appeal request is denied, the appeal will be transferred to the standard appeal process. We will make every effort to contact the member orally to notify them of the denial and provide written notice of denial within two calendar days, including the member's right to file a grievance regarding our denial of a request for expedited resolution.

6.7 Process for Resolving an Appeal

After the appeal has been logged into the tracking system and the acknowledgment letter has been sent, the appeal is assigned to an Appeals Representative.

No punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal. UnitedHealthcare provides each member, or member's representative, a reasonable opportunity to present evidence and allegations of fact or law in person or in writing. The member is informed of the limited time available in cases involving expedited resolution. Any information received during the resolution process is date stamped and incorporated into the case file. UnitedHealthcare provides members an opportunity to examine the appeal file, including medical records and other documents considered by UnitedHealthcare Community Plan during the resolution process. Unless the appeal involves a denial based on lack of medical necessity or otherwise involves clinical issues, the Appeals Representative researches and adjudicates the appeal. For clinical appeals, the Appeals Representative assembles relevant background information from our prior authorization and claims systems, obtains relevant clinical information and forwards the matter to a health care professional

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with clinical expertise in treating the enrollee's condition or disease that was not involved in any decision-making or previous review surrounding the action or appeal.

If the matter requires review by another UnitedHealthcare Community Plan department, the Appeals Representative requests that a designated subject matter expert in the department address specific issues necessary to resolve the appeal. The Appeals Representative may contact the member or the member's treating provider to obtain information necessary to resolve the appeal. Upon completion of this process, the Appeals Representative or designee provides verbal notice of our decision for an expedited resolution and issues a written Notice of Appeal Resolution for both expedited and standard resolutions.

The Notice of Appeal Resolution contains the date of resolution, reasons for the determination in easily understood language, and a written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the Utilization Management clinical review or decision making criteria; and for appeals not resolved wholly in favor of the member:

1. The member's right to request an administrative hearing (including the requirement that the member must file the request for a hearing in writing no later than 90 calendar days from the date of the Notice of Appeal Resolution) and how to make the request;
2. Include information on the enrollee's right to receive services while the hearing is pending and how to make the request

6.8 Request for State Fair Hearing

Members have the right to request a Fair Hearing from the State of California Department of Social Services at any time during the grievance process. The member may request a Fair Hearing even if a formal grievance has not been submitted to UnitedHealthcare Community Plan. The State Fair Hearing can only be requested within 120 calendar days from the date of a Notice of Action. If a member is currently receiving a medical service that is going to be reduced or stopped, they may continue to receive the same medical service until the hearing if the hearing is requested within ten days from the date the denial letter was postmarked or personally delivered.

The member or their provider may request an Expedited State Fair Hearing by calling, writing or faxing the Department of Social Services, Expedited Hearing Unit. The member may also call Member Services to assist with requesting an expedited State Fair Hearing.

6.9 Request for Independent Medical Review (IMR)

The member may request an Independent Medical Review (IMR) of a disputed healthcare service from the DMHC. A "disputed healthcare service" is any healthcare service eligible for coverage and payment that has been denied, modified, or delayed by UnitedHealthcare Community Plan or one of its contracted providers, in whole or in part because the service is not medically necessary. UnitedHealthcare Community Plan will provide the member with an IMR application form with any disposition letter that denies, modifies, or delays healthcare services.

The following requirements are reviewed by the DMHC to determine if the request for an IMR is appropriate:

- The provider has recommended a health care service because it is medically necessary and it is denied
- The member received urgent or emergency services determined to be necessary and it was denied; or
- The member was seen by a network provider for the diagnosis or treatment of the medical condition (even if the health care service was not recommended by a network provider);
- The disputed health care service is denied, changed or delayed by UnitedHealthcare Community Plan based in whole or in part on a decision that the health care service is not medically necessary
- The member filed a grievance with UnitedHealthcare Community Plan and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 days.
- It has been six months from the date of denial.

The DMHC will submit the dispute to an IMR Organization. The DMHC must provide a determination within 30 days of receipt of the application or three business days if the case is deemed urgent. Examples of urgent cases include:

- Severe pain

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- Potential loss of life, limb, or major bodily function
- Immediate and serious deterioration of your health

External Independent Review (EIR)

A member can request an EIR through the DMHC when a medical service, drug or equipment is denied because it is experimental or investigational in nature. This request may be filed within six months from the date of denial.

The member may provide information to the EIR panel. The EIR panel will provide a written decision within 30 days from when the request was received. In urgent cases the EIR panel will provide a decision within three business days from the time your information is received.

The following requirements must be met to file an EIR:

1. The member has a very serious condition that is "life-threatening" or "debilitating" (for example, terminal cancer).
2. The care provider must certify that:
   - the standard treatments were not or will not be effective; or
   - the standard treatments were not medically appropriate; or
   - the proposed treatment will be the most effective.
3. The care provider will certify in writing that the drug, equipment, procedure, or the requested therapy is likely to work better than standard treatment.
4. The member has been denied a drug, equipment, procedure, or other therapy requested by your doctor.
5. The care provider certified in writing, based on certain medical and scientific evidence that, the requested treatment is likely to be more beneficial for you than any standard treatment.
6. The treatment would have been covered as a benefit, but we have determined that it is experimental and investigational.

For more information or help with the IMR or EIR process or to request an application form, please contact us.

6.10 Processes Related to Reversal of Our Initial Decision

If the State Fair Hearing, IMR or EIR reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, UnitedHealthcare Community Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. If the decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, UnitedHealthcare will pay for those services as specified in policy and/or regulation.

Managed Care Ombudsman Program

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman Program assists in the mediation of disputes between Medi-Cal Managed Care members and their health plans as well as care providers, and to attempt to resolve these disputes informally outside of the formal grievance and appeal processes. If you wish to use the services of the DHCS to address your concerns, complaints, or grievances, please call the Medi-Cal Managed Care Ombudsman program toll free at **888-452-8609**, Monday through Friday, between the hours of 8 a.m. and 5 p.m. (Pacific Standard Time). You can also call the DMHC HMO Consumer Service toll free telephone number at **800-400-0815**.

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Chapter 7: Behavioral Health

7.1 Access to Behavioral Health Services

Outpatient Mental Health Services

UnitedHealthcare Community Plan offers the following mental health services to members meeting medical necessity or Early Periodic Screening Diagnosis and Treatment (EPSDT) and/or members with mild to moderate distress or impairment of mental, emotional, or behavioral functioning:

1. Individual and group mental health evaluation and treatment (psychotherapy)*
2. Psychological testing when clinically indicated to evaluate a mental health condition*
3. Psychiatric consultation for medication management*
4. Applied Behavioral Analysis (BHT) for children under age 21 with a confirmed diagnosis of Autism*
5. Screening and Brief Intervention (SBI)
6. Outpatient laboratory, supplies and supplements
7. Drugs (excluding anti-psychotic drugs which are covered by Medi-Cal Fee-For-Service)

Services one through three (*) above will be provided through Optum Behavioral Health by providers contracted with OptumHealth Behavioral Solutions of California. Certain mental health services require prior authorization. Care providers may contact UnitedHealthcare Community Plan at 866-270-5785 for information on referring patients for these behavioral health services. Members should also be referred to the Optum Behavioral Health phone number to access behavioral health care services.

Primary care providers (PCP) are responsible for screening and brief intervention (SBI) and performing evaluations needed to develop a diagnosis before referring the member to Optum Behavioral Health, County Mental Health, or other programs. Outpatient laboratory, supplies, supplements and eligible drugs are administered through the member's medical benefits. Screening tools are available on the DHCS website and our provider website, and include the Individual Health Education Behavioral Assessment (IHEBA).

The following services for members with Serious Mental Illness (SMI) and/or Severe Emotional Disturbance (SED) condition(s) are not covered by UnitedHealthcare Community Plan, however, will continue to be covered through the **County Mental Health system**:

Outpatient services for Members with SMI/SED

- Mental health services, including assessments, plan development, therapy and rehabilitation, and collateral
- Medication support
- Day treatment services and day rehabilitation
- Crisis intervention and stabilization
- Targeted case management
- Therapeutic behavior services
- Residential services
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services
  - Acute psychiatric inpatient hospital services
  - Psychiatric inpatient hospital professional services
  - Psychiatric health facility services

In addition, alcohol and drug treatment services are not covered under UnitedHealthcare Community Plan. However, coverage may be available through County Alcohol and Other Drug (AOD) programs.

OptumHealth Behavioral Solutions of California Provider Network Information

The remainder of Chapter 7 applies to behavioral health providers contracted with U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California). In the event this chapter conflicts with other chapters in this manual, this chapter will control.

7.2 Joining the Behavioral Health Network

If you are interested in joining the OptumHealth Behavioral Solutions of California (Optum) network, you can start the application process by going to the "Join Our Network" section of the provider website, *Provider Express*, at **providerexpress.com** and following the instructions for California providers.

Optum Provider Credentialing and Recredentialing

Optum uses the Universal Provider Data Source®, developed by CAQH®, to obtain the data needed for credentialing and

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recredentialing of our network clinicians, and many clinicians who are contracted with us through a group practice, unless otherwise required by law. The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online. This free service for healthcare professionals is available 24 hours a day, 365 days a year. The online application allows you to save your work and return later to finish the process. Once completed, CAQH stores the application online and enables you to make updates to your information as needed. By keeping your CAQH information current, future recredentialing is quick and easy.

Once your application is completed with CAQH, Optum may utilize Aperture, a National Committee for Quality Assurance (NCQA) certified Credentials Verification Organization (CVO), to review the application packet for completeness and collect any missing or incomplete information.

Clinician Credentialing

Optum credentials clinicians according to rigorous criteria that reflect professional and community standards as well as applicable laws and regulations. These criteria include, but are not limited to, satisfaction of the following standards:

- Independent licensure or certification in your state(s) of practice, except as required by applicable law
- License is in good standing and free from restriction and/or without probationary status
- Board Certification or Board Eligibility (to complete prior to the recredentialing cycle) for psychiatrists
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in the state of California
- Professional Liability Coverage: a minimum of $1 million occurrence/$1 million aggregate for master's-level and doctoral-level clinicians and a minimum of $1 million/$3 million for care providers (exceptions to these required insurance amounts may be made as required by applicable law)
- Free from any exclusion from government programs

For a more specific list of criteria, please refer to the **Credentialing Plan**, available on *Provider Express*.

[1]U. S. Behavioral Health Plan, California, doing business as OptumHealth Behavioral Solutions of California

You will be asked to sign a release of information granting Optum and its agents access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. Obtaining and reviewing this information is necessary to complete the credentialing process. Failure to provide such a release will preclude completion of your credentialing and prevent your participation in the network.

Optum has specific requirements for identified specialty areas. A comprehensive list of specialty areas is available on the **Clinician Expertise/Specialty Attestation** form, which can be found in the "Forms" section at *Provider Express*. If you request recognition of a specialty area, an attestation statement may be required, documenting the specific criteria met for the identified specialty. Current competency of a designated specialty may be randomly audited to ensure that network clinicians remain active and up-to-date in their specialty field attestations.

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaint investigations, etc.), and information regarding disciplinary action, up to and including termination of participation in the network. The Credentialing Plan is available at **Provider Express**, or you may request that a paper copy be mailed to you by contacting Network Management.

Clinician Recredentialing

In accordance with our commitment to the highest quality of clinical treatment, we re-credential clinicians every 36 months unless applicable law or client policies require a different recredentialing cycle. During recredentialing, we will access your information through your CAQH application, unless otherwise required by law. In addition, you will be required to provide your current copy of:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for the state of California
- Controlled Dangerous Substances (CDS) certificate (if applicable)
- Professional and general liability insurance
- Curriculum vitae

You may also be asked to:

- Attest to your areas of clinical specialty, language fluency,

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and appropriate training supporting the identified specialties

- Sign a release of information granting access to information pertaining to your professional standing. This is required for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. Failure to provide such a release will preclude completion of your re-credentialing and prevent your continued participation in the network.

You are required to provide a copy of all professional documents whenever they renew or change.

Organizational Provider Credentialing and Recredentialing
Optum follows the guidelines of the NCQA for credentialing and recredentialing unless otherwise required by law. As part of the credentialing and recredentialing process, organizational providers are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes, but is not limited to:

- Current copies of all licenses required by your state for the services you offer
- Current copy of accreditation certificate and/or letter from accrediting body
- General and professional liability insurance certificates (Professional Liability Coverage for acute care: a minimum of $5 million occurrence/$5 million aggregate; and, for non-acute services: a minimum of $1 million/$3 million. Exceptions to these required insurance amounts may be made as required by applicable law)
- W-9 forms
- Disclosure Ownership Form (if applicable)
- Signed malpractice claims statement/history
- Staff roster, including attending care providers
- Daily program schedules
- Program description
- Facility Billing Information Form

In the event that the organizational provider is not accredited by an entity recognized by Optum, an on-site audit will be required prior to credentialing and again prior to recredentialing (see "Audits of Sites and Records" in the "Quality Management and Improvement" chapter of this Manual for more information).

The Credentialing Plan addresses the requirements for participation, continued participation (maintaining unrestricted license, cooperating with complaints investigation, etc.), and information regarding disciplinary action, up to and including termination of participation in the network. The **Credentialing Plan** is available at *Provider Express* or you may request that a paper copy be mailed to you by contacting Optum Network Management.

Board Certified Behavior Analyst and Applied Behavior Analysis Agencies
Optum includes two provider types to its network to provide Behavioral Health Treatment, specifically Applied Behavior Analysis (ABA) and Intensive Behavior Therapies (IDT) in the treatment of enrollees diagnosed with Autism Spectrum Disorders (ASD).

Qualified Board Certified Behavior Analysts (BCBAs) are eligible to apply for participation in this unique Applied Behavior Analysis Network. BCBA applicants must demonstrate expertise by meeting the minimum requirements of 6 months supervised experience or training in the treatment of ASD, in addition to active BCBA certification from the national Behavior Analyst Certification Board, and must meet the requirements as a Qualified Autism Service Provider (California Health and Safety Code 1374.73).

In addition, Applied Behavior Analysis organizations (ABA Agencies), which are directed and supervised by a qualified BCBA or a California independently licensed behavioral health clinician and meet the requirements as Qualified Autism Service Providers (California Health and Safety Code 1374.73), are eligible to apply for participation in the Applied Behavior Analysis Network. ABA Agency applicants must demonstrate expertise by meeting the minimum requirement for their supervisors of 6 months supervised experience or training in the treatment of ASD and active BCBA certification and/or applicable licensure, as well as the successful completion of an agency medical record and site review.

Credentialing and Recredentialing Rights and Responsibilities
As an applicant to the Optum network, or as a network Provider in the process of recredentialing, you are entitled to:

- Be informed of your rights
- Be informed of credentialing or recredentialing status

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upon request

- Review information submitted to support your credentialing or recredentialing application; excluding personal or professional references, internal Optum documents, or other information that is peer-review protected or restricted by law
- Make corrections to erroneous information identified by Optum in review of credentialing or recredentialing application

In addition to the above rights, you have the responsibility to submit any corrections to your credentialing or recredentialing application in writing within 10 business days of your notification by Optum.

Psychological Assistants and Interns

The services you provide must be provided directly by you for all members. Participating clinicians may not submit claims in their name for treatment services that were provided by a psychological assistant, intern, or another clinician.

7.3 Behavioral Health Provider Resources

UnitedHealthcareOnline.com Online Resources

All online electronic functionality such as member eligibility, claim status, claim submission and electronic remits for UnitedHealthcare Community Plan members are accessible through **UnitedHealthcareOnline.com**. If you are not registered on **UnitedHealthcareOnline.com**, you may do so directly on the website.

UnitedHealthcareOnline.com offers an innovative suite of online health care management tools. Use of this website is intended for approved Community Plan providers, facilities and medical administrative staff and offers the convenience of online support 24-hours-a-day, seven-days-a-week and offers these electronic functions:

UnitedHealthcareOnline.com:

- Patient Eligibility and Benefits
- Claim Submissions
- Claim Status
- Claim Reconsiderations
- Electronic Payments and Statements (EPS)
- Notification/Prior Authorization Submission & Status
- Care provider Directory
- Tools & Resources
  - EDI Education
  - Health Resources for Patients
  - Health Literacy and Cultural Competency
  - News and Network Bulletin
  - Cardiology Notification Submission & Status
  - Medical Policies

ProviderExpress.com Online Resources

Optum's provider website, **providerexpress.com**, allows providers to:

- Update practice information
  - Add NPI
  - Add Taxonomy Code(s)
  - Update languages spoken
  - Update e-mail address
  - Update expertise
  - Manage address locations, including practice, remit, credentialing and admitting privileges
  - Make demographic changes
- Download standard forms
- Review behavioral health clinical guidelines
- Locate current and archived issues of Network Notes, the Optum provider newsletter
- Find Network Management contact information

To ensure proper processing of claims, it is important to promptly contact Optum if you change your Tax ID number.

Additional Resources

UHCCommunityPlan.com:

- Provider Information
- Claims and Member Information
- Pharmacy Program
- Bulletins
- Medicare Part D Education Materials
- Billing and Reference Guides
- Clinical Practice Guidelines

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- Cultural Practice Guidelines

UnitedHealthcare Provider Services: 866-270-5785
This is an automated system. Please have your National Provider Identifier and Tax ID numbers or the member ID ready, or hold to speak to a representative. The call center is available to:

- Answer general questions
- Verify member eligibility
- Check claim status

Claims and Customer Service
Providers can access Claims information on **UnitedHealthcareOnline.com** or by calling UnitedHealthcare Provider Services at 866-270-5785.

To ensure proper processing of claims, it is important to promptly contact Optum if you change your Tax ID number.

For Further Assistance
For general information and contractual questions, contact Optum Network Services at 877-614-0484.

7.4 Behavioral Health Provider Requirements

Written Notification of Status Change

Providers are contractually required to notify us in writing within 10 calendar days of any changes to:

- The status of the practice, including changes in practice location, billing address, or telephone/fax numbers
- Changes in facility, agency or group ownership
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, debarment from any government program, monitoring or any other adverse action
- The status of professional liability insurance
- Potential legal standing (any malpractice action or notice of licensing board complaint filing)
- Tax Identification (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Registered users of *Provider Express*, except organizational providers, are encouraged to use the "My Practice Info" function to update this information. Otherwise, clinicians and group practices should submit changes in writing, using fax or mail, to your state-specific Network Management Team. Organizational providers should submit their changes, in writing, using fax or e-mail, to the Network Manager or Facility Contract Manager.

Provider Initiated Unavailable Status

Individual clinicians may request to be made unavailable for new referrals at one or more of your practice locations for up to six months. You are required to notify Network Management within five business days of your lack of availability for new referrals. If you become available for new referrals, you are required to notify Network Management within five business days of your availability. You may make these notifications through secure "Transactions" on **Provider Express** or by contacting Network Management. You will be sent a letter confirming that your request has been processed.

When you have been on unavailable status for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. You may contact Network Management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected, you may update your status on **Provider Express** or notify Network Management.

Some common reasons for requesting unavailable status are: extended illness, vacation or leave plans, and lack of available appointments. Please note that while on unavailable status your Agreement remains in effect.

Group practices and organizational providers that wish to be made unavailable should contact Network Management within five business days of their lack of availability for new referrals. If the group, facility/agency becomes available for new referrals, they are required to notify Network Management within five business days of their availability.

If you are not accepting new members and are contacted by a member or potential member seeking to become a new patient, you are required to direct the individual to both Optum and to the Department of Managed Health Care ("DMHC") to report any inaccuracy with the Optum directory.

Periodic Validation of Data

In accordance with California Health and Safety Code ("HSC"), Section 1367.27, Optum reviews and updates our entire California provider directory annually. Individually contracted clinicians are notified at least once every six months and group

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practices, facilities and agencies are notified at least annually. Notification includes:

- The information in the provider directory about the provider
- A statement that failure to respond to the notification may result in a delay of payment or reimbursement of a claim
- Instructions on how the provider can update the information in the directory

You must acknowledge receipt of the notification within 30 business days, either confirming that the information in the directory is current and accurate, or, alternatively, updating the information in the directory through secure "Transactions" on Provider Express or by notifying Network Management. Failure to respond to the notification or outreach by Optum to confirm your directory information may result in your removal from the directory and evaluation of your status as a participating provider.

On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to members in emergency situations 24 hours a day, seven days a week. You should inform members about your hours of operation and how to reach you after-hours in case of an emergency. In addition, any after-hours message or answering service must provide instructions to the members regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating clinician.

Termination or Restriction of Network Participation

Your participation with Optum can end for a variety of reasons. Both parties have the right to terminate the Agreement upon written notice, pursuant to the terms of your agreement. If you need clarification on how to terminate your agreement, you may contact Network Management or your Facility Contract Manager.

In some cases, you may be eligible to request an appeal of an Optum initiated termination or restriction of your participation. If you are eligible for an appeal, Optum will notify you of this in writing within 10 calendar days of the adverse action. The written request for appeal must be received by Optum within 30 calendar days of the date on the letter which notified you of any adverse action decision. Failure to request the appeal within this timeframe constitutes a waiver of all rights to appeal and acceptance of the adverse action.

The appeal process includes a formal hearing before at least three clinicians, appointed by Optum. The Appeal Committee members are not in direct economic competition with you and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. You may be represented by a person of your choice at the appeal hearing, including legal counsel. At the conclusion of the hearing, you have five business days to submit further documentation for consideration. The Appeals Committee's decision is by a majority vote of the members. The decision of the Committee is final and may uphold, overturn, or modify the recommendation of Optum. Correspondence regarding the decision is sent to you via First Class mail, postage prepaid and properly addressed, overnight delivery, facsimile, or email, within 30 calendar days after the due date of your submission of any final written statements to the Appeals Committee.

Continuation of Services after Termination

Network Clinicians, Group Practices and Agencies who withdraw from our network are required to notify us, in writing in accordance with your Agreement, 90 calendar days prior to the effective date of termination, unless otherwise stated in your Agreement or required by state law. With the exception of terminations due to quality-related issues, suspected fraud, waste or abuse, change in license status or change in ability to participate in federal programs, clinicians are obligated to continue to provide treatment for all members under their care. The timeline for continued treatment is up to 90 calendar days from the effective date of the contract termination, or as outlined in your Agreement or until one of the following conditions is met, whichever is shortest:

- The member is transitioned to another contracted clinician
- The current episode of care has been completed
- The member's UHCCP benefit is no longer active

7.5 Care Advocacy and Authorization

The Care Advocacy team is responsible for the administration of benefits including authorization of benefits when authorization is required. In addition, the Care Advocacy Center (CAC) focuses on activities that impact a member's stabilization and recovery, and promote active participation in their care. This approach consists of targeted interventions intended to

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facilitate member services, identify members who may be at risk, and assist you in the coordination and delivery of care to Members. This approach supports a collaborative relationship between you and the Care Advocate. Care advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating providers involved in a member's care
- Using the information on the Wellness Assessments to identify members who may be at-risk
- Proactively reaching out to providers to discuss a member's care when the individual has been identified as being at-risk
- Offering clinical consultations with Optum clinical staff
- Reaching out to members in some circumstances to educate, evaluate risk, and offer assistance
- Supporting members to actively participate in treatment and follow-up care
- Referencing web-based and written information for members and treating care providers regarding behavioral health conditions, designed to support informed decision-making

Affirmative Incentive Statement

Care advocacy decision making is based only on the appropriateness of care as defined by the **Coverage Determination Guidelines, Level of Care Guidelines, Psychological and Neuropsychological Testing Guidelines**, the member's benefit plan, and applicable law. The Level of Care Guidelines were developed to produce consistency in decision-making by the Care Advocacy and medical staff and to help you reach optimal clinical outcomes. You will find these, along with the **Best Practice Guidelines, Medicare Coverage Summaries and the Supplemental and Measurable Guidelines** at **Provider Express** or you can receive a paper copy from Network Management.

Optum expects all treatment provided to members to be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Optum does not reward its staff, providers or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

Routine Outpatient Services

Authorization or Notification for Mental Health Benefits

In accordance with the Agreement and many Benefit Plans, some in-network outpatient behavioral health services require an initial pre-authorization or notification. Clarification of these requirements may be obtained through a telephone contact between the member or member representative and our staff. The member website is another avenue for members to request authorization. However, if a required pre-authorization has not been issued or notification has not been made at the time you are inquiring about eligibility, then you need to initiate it. Eligibility inquiries can be made through **UnitedHealthcareOnline.com** or by calling Provider Services at 866-270-5785. Authorization requests may be made by calling 866-270-5785. Be prepared to provide the following information: the member's name, address, and identification number, as well as the subscriber's name and date of birth.

When a member calls seeking referrals, our staff will collect demographic information, request coordination of benefits information, explain the services available under the member's benefit plan, and obtain a brief description of the presenting problem(s). Referrals are based on the clinical, linguistic, cultural, and geographic needs of the member. The member is responsible for contacting you to schedule an appointment. The member is advised of the number of sessions available under the benefit plan and any deductible, copayment, and/or coinsurance amount for which he or she will be financially responsible. The member will be given multiple care provider names and numbers from which to choose to schedule an appointment. Routine authorization or approval letters are mailed directly to the member. The approval of benefits is valid for any participating Optum network care provider for routine outpatient services.

When pre-authorization or notification is required, members are instructed to bring the letter to their initial session. This document includes member information needed to check benefits and limits of coverage through **UnitedHealthcareOnline.com**. If the member does not bring the letter to the session, you should contact **UnitedHealthcareOnline.com** to ensure that an authorization or approval has been issued. This initial session is also the time to initiate the ALERT® process with the administration of the first Wellness Assessment. For greater detail about ALERT, please see "Clinical Outcomes Model: ALERT" and "Wellness Assessments" in this chapter of the Manual. There is also an **ALERT** page on *Provider Express* that provides additional information.

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This authorization or notification will be valid for one year from the date of issue subject to the member's continued eligibility and terms of the benefit plan. We expect all treatment provided to members to be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. If the member is still in treatment when the authorization or notification expires, you will need to request continued authorization through **UnitedHealthcareOnline.com** or by calling Provider Services at 866-270-5785.

Clinical Outcomes Model: ALERT®

Optum is committed to partnering with our network to achieve optimal therapeutic outcomes for the individuals we mutually serve. This approach focuses on assisting the network to make consumer-directed, outcomes-based, cost-effective and clinically necessary treatment decisions. With that goal in mind, we have developed the ALERT model, which includes an authorization or notification process, when required.

ALERT stands for ALgorithms for Effective Reporting and Treatment. The system utilizes Member responses to a validated tool, the one-page Wellness Assessment (WA), along with claims data. Both WA and claims information are analyzed through a set of algorithms to determine a member's behavioral health status and potential risks. In addition, the algorithms identify cases that may benefit from a review. Such reviews may include consideration of **Best Practice Guidelines, Coverage Determination Guidelines**, or Level of Care Guidelines. The ALERT algorithms offer opportunities for earlier intervention on potential treatment complications. Care Advocacy will use a combination of letters and/or calls to inform you about any targeted risk or the requirement to complete a review. This allows us to work together more efficiently, focusing on those members with the greatest potential for benefit from such collaboration.

The WA is completed at multiple points rather than at a single point in treatment. This offers more immediate feedback on changes in health status and functioning which may inform further treatment planning, including level of care changes or coordination with medical professionals.

Psychiatrists and prescribing nurses are not required to submit Wellness Assessments, unless they wish to view data related to their outcomes on **Provider Express**. Please note that claims-based ALERT algorithms do apply to prescribing providers and may require Care Advocacy reviews, as noted above.

Wellness Assessments (WA)

The WA includes a range of questions to measure symptom severity and overall well-being, and screens for functional impairment, substance use disorder risk and medical co-morbidity risks. The following process is for members who are receiving routine MH outpatient services.

- Member contacts Optum, either online or by phone, to request authorization when required by the benefit plan for outpatient treatment. If not required by the benefit plan, the member may still call for referrals.
- Optum provides referrals to in-network providers based on clinical and geographic needs. If required, an authorization is generated, allowing the member to see any Optum network clinician for routine outpatient psychotherapy services.
  - Member calls the clinician directly to schedule an appointment. When applicable, the member brings a copy of the authorization to the initial appointment. To determine if a member's plan requires authorization, go to **UnitedHealthcareOnline.com** or call Provider Services at 866-270-5785. Failure to obtain a required authorization may result in denial of claim payment.
- At the first session, you provide the one-page WA to each new member, or to the parent/guardian of a child or adolescent patient.
- You promptly return each completed WA to Optum as instructed on the form.
- A second WA is administered between sessions three and five. Optum reviews the WA and alerts you if a targeted risk is identified. You will either be notified by letter, or contacted by a Care Advocate to discuss the case and/or assist in coordinating additional services.
- A follow-up WA will also be sent by Optum directly to the member approximately four months after the initial evaluation.

The information contained in the WA is confidential and will not be shared with the member's employer, medical benefit plan or medical providers without the member's consent. A member may also decline to participate in ALERT. If this occurs, submit a WA to Optum by completing the provider and Member demographic sections and filling in the "MRef" (Member refusal) bubble located in the top demographic section of the WA. In the case of members who are minors (except for those who are emancipated or able to consent to their own treatment under the laws of your state), the parent or guardian should be asked to complete the form.

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The two versions of the WA, Adult and Youth, are available in Spanish. WA forms can be obtained from **Provider Express**. You may go to **Provider Express** for detailed information about **completing and downloading WAs.**

Practice Management

Practice Management, a clinical team, in coordination with other Optum departments, works with network and out-of-network providers on the following key elements:

- Managing outliers, through the identification of practice patterns that appear to fall outside typical patterns, including the measurement of improvement over time
- Identifying and resolving potential practice patterns that may constitute Fraud, Waste and/or Abuse (see “Fraud, Waste and Abuse” section in this chapter).
- Evaluating compliance with Care Advocacy processes and contractual obligations

Practice Management employs intervention strategies to address practice patterns. Interventions may include, but are not limited to, a direct conversation with the care provider, education, peer-to-peer reviews, and site and/or treatment record audits.

Potential results of a Practice Management intervention may include ongoing monitoring, Corrective Action Plans, referral to Peer Review, non-coverage (adverse) benefit determinations, referral to the Credentialing Committee or Payment and Network Integrity (PNI).

For additional information, please see the “Fraud, Waste and Abuse” and “Treatment Record Documentation Requirements” in this chapter of the Manual.

Applied Behavior Analysis (ABA) Services

Coverage for ABA services requires prior authorization by an Optum Autism Care Advocate. Please be aware that not all Benefit Plans provide coverage for ABA services and, prior to beginning care, network Board Certified Behavior Analysts (BCBA) and ABA Agencies must contact Optum to verify eligibility, review treatment plans and obtain authorization.

Authorization of Benefit for Non-Routine Outpatient Services

Non-routine outpatient services, including, but not limited to psychological testing or extended sessions, 53 minutes or more (90837/+90838 or successor codes), require ongoing authorization prior to providing services. To pursue this authorization, please call the number on the back of the member’s ID card. Authorizations for non-routine outpatient services are specific to the care provider. The care provider will receive a copy of this authorization. For an unforeseen crisis, for which there may be an unanticipated need for an extended office visit, you should use the new crisis code 90839 to bill for the first 30-74 minutes of psychotherapy. Prior authorization is not required for crisis sessions.

Psychological Testing

Psychological testing must be pre-authorized for outpatient services.

Psychological testing is considered after a standard evaluation (including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairment that may affect functioning or interfere with the patient’s ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction

In some cases where a member in need of testing has already received sufficient evaluation to conclude testing is necessary, it is permissible to conduct initial interview intake on the same day of service as testing. Generally, psychological testing purely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. Also not covered are tests performed routinely as part of an assessment. We recommend that you contact Optum pre-service to determine authorization requirements and procedures.

For more information regarding coverage for testing, interpretation and report writing, see the current Optum **“Psychological/Neuropsychological Testing Guidelines”** and the **“Neuropsychological Testing – Frequently Asked Questions”**. Both documents may be found at **Provider Express**: Home page > Guidelines/Policies > Psychological/ Neuropsychological Testing.

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7.6 Timely Access to Outpatient Mental Health (MH) Care

As part of our Quality Management and Improvement Program, and to help ensure that all members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. Optum requires that services be provided in a timely manner appropriate for the nature of the member's condition consistent with good professional practice, and that the network has adequate capacity and availability to offer member appointments within certain timeframes. Thus, Optum requires that the network adhere to specific access standards, which are outlined as follows:

- Respond verbally within 24 hours to a member or provider request for routine outpatient care
- An initial MH appointment must be offered within 10 business days of the request
- Urgent appointments must be offered within 48 hours
- Non-life-threatening emergencies must be offered an appointment within six hours
- An immediate appointment must be offered for any life-threatening emergencies
- An MH outpatient appointment must be offered within seven days of an acute inpatient discharge

If more stringent time frames are required by applicable law, we require that the network adhere to the more stringent time frames.

Optum expects that members will generally have no more than a 15 minute wait time for their appointment in your office. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice.

In cases where a member is being discharged from acute inpatient care, Optum expects a follow-up outpatient appointment to occur within seven days from the discharge date. This appointment should be included in the facility discharge plan.

If you are unable to take a referral, immediately direct the member to the number on the back of his or her ID card so that he or she can obtain a new referral.

Compliance with these standards will be monitored by, but not limited to, the administration of an annual provider survey to solicit perspective and concerns regarding compliance with the standards; tracking network capacity and availability; evaluating accessibility, availability, and continuity of care at least quarterly; and conducting site reviews of high volume providers.

Your recognition and incorporation of these standards into your practice illustrates your shared commitment to ensuring that members are always able to receive clinically appropriate and timely access to care.

7.7 Language Assistance Program

The OptumHealth Behavioral Solutions of California Language Assistance Program includes assessment of the language needs of members, provision of free language assistance services, and monitoring of compliance with the program. Language assistance services are available at no cost to you or to covered members. Oral interpretation services are available for all language assistance needs. Written translation of vital documents is available for members whose identified language preference is a Threshold Language. We maintain documentation of a member's specified language preference, if available, and that information is relayed to providers upon inquiry or during referral discussions with our customer service or care advocacy staff.

You are required to post written notice in your waiting room regarding the availability of free language services. In addition, you are required to offer interpretation services to Limited English Proficiency (LEP) members at the time of their initial assessment. This assistance must be offered even if you have self-attested to your ability to conduct treatment in the member's language and/or when the member is accompanied by a family member or friend who can interpret on their behalf. The offer of interpretation services, as well as the member's acceptance or declination of that assistance, must be documented in the treatment record. It is also important that you have a process in place for your staff to identify members who desire language assistance in all contacts.

To access language assistance services for an identified LEP member, contact us at **866-270-5785**. Our staff will connect you and the member with the interpretation services vendor, where certified interpreters are available to provide telephonic interpretation services.

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Upon member request, you are also required to provide grievance documents in the member's identified Threshold Language. English and pre-translated Grievance Forms for UHCCP members are available at **Provider Express**. Applications for Independent Medical Review are available on the websites of the California Department of Managed Health Care (DMHC), **dmhc.ca.gov**, and the California Department of Insurance (CDI), **insurance.ca.gov**, as applicable to the member's benefit plan, and include instructions about the member's right to file a grievance with the DMHC or the CDI. The member may also contact us to obtain a hard copy of these forms.

Optum monitors network compliance with the Language Assistance Program through site visits, treatment record reviews, and the member grievance process. Any deficiencies noted require a corrective action plan from the provider to ensure future compliance.

7.8 Communication with Primary Care Providers and Other Health Care Professionals

When a member is receiving services by more than one professional, it is critical that the service providers collaborate and coordinate effectively in order to ensure that care is comprehensive, safe and effective. We expect care providers to make a "good faith" effort at coordinating care with other behavioral health clinicians or facilities and any medical care professionals who are treating the member.

To coordinate and manage care between behavioral health and medical professionals, we expect that you will request the member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary care providers, medical specialists) and/or other behavioral health clinicians (e.g., psychiatrists, therapists). Coordination and communication should take place:

- At the time of intake
- During treatment
- At the time of discharge or termination of care
- At the point of transition between levels of care, and
- At any other point in treatment that may be appropriate

We believe that coordination of services improves the quality of care to members in a number of ways:

- Allows behavioral health and medical providers to create a comprehensive care plan
- Allows a primary care provider to know his or her patient followed through on a behavioral health referral
- Minimizes potential adverse medication interactions for members who are being treated with psychotropic and/or non-psychotropic medication
- Allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- Promotes a safe and effective transition from one level of care to another
- Reduces the risk of relapse

The following guidelines are intended to facilitate effective communication among all behavioral health and medical professionals involved in a member's care:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate behavioral health and medical professionals who are providing treatment
- After the initial assessment, provide other behavioral health and medical professionals with the following information within two weeks:
  - Summary of member's evaluation
  - Diagnosis
  - Treatment plan summary (including any medications prescribed)
  - Primary clinician treating the member
- Update other behavioral health and medical professionals when there is a change in the member's condition or medication(s)
- Update other behavioral health and medical professionals when serious medical conditions warrant closer coordination
- At the completion of treatment, send a copy of the discharge summary to the other behavioral health and medical professionals
- Attempt to obtain all relevant clinical information that other behavioral health and medical professionals may have pertaining to the member's mental health or substance use problems

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It is understood some members may refuse to consent to release information to other behavioral health and medical professionals. We expect you to discuss the benefits of sharing information and the potential risks of not sharing information, and to document the discussion in the member's clinical record.

7.9 Treatment Record Documentation Requirements and Audits

For your agreement, you are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. You must maintain these records in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

To perform required utilization management, practice management, payment and quality improvement activities, we may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its payors, customers, clinicians, and facilities.

We may review your records during a scheduled on-site audit or may ask you to submit copies of the records to us for review. An on-site audit and/or Treatment Record Review may occur for a number of reasons, including, but not limited to:

- Reviews of facilities without national accreditation such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or other agency approved by us
- Audits of services and programs, including, but not limited to, Applied Behavioral Analysis (ABA), Supervisory Protocol and Peer Support Services
- Audits of high-volume clinicians
- Routine audits
- Audits related to claims, coding or billing issues
- Audits concerning quality of care issues
- Audits related to a member complaint regarding the physical environment of an office or facility

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatments records and/or accuracy of billing and coding. We have established a passing performance goal of 85% for both the Treatment Record Review and on-site audit. On-site audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of the implementation of the CAP. However, in some cases, a requesting committee may require a CAP and/or re-audit regardless of the scores on the audit tools.

Billing records should reflect the member who was treated, the rendering clinician and the modality of care. Audits related to claims, coding or billing issues may require corrective action.

Treatment Record – Content Standards

When billing services for more than one family member, separate treatment records must be maintained.

We require that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following:

- The member's name or identification number on each page of the record
- The member's address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information
- An indication of whether or not the member is of Limited English Proficiency (LEP); if determined to be LEP, the record indicates that the member was offered language interpretation services and whether the member accepted or declined those services
- The date of service, either start and stop time or total time in session (for time based services), Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/Revenue (REV) code billed, notation of session attendees, the rendering clinician's name, professional degree, license, and relevant identification number as applicable

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- Treatment records entries should be made on the date services are rendered and include the date of service; if an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry, and a notation that this is a late entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the member has no relevant medical history, this should be prominently noted
- Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the patient from the onset of care through discharge includes the following (applicable for all prescribers):
  - Standing, P.R.N. and STAT orders for all prescription and over-the-counter medications
  - The date medications are prescribed along with the dosage and frequency
  - Informed member consent for medication, including the member's understanding of the potential benefits, risks, side effects, and alternatives to the medications
  - Changes or rationale for lack of changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes
  - Discharge summaries should specify all medications and dosages at the time of discharge
- A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the member's medical and psychiatric status, and the source of such information
- Prominent documentation (assessment and reassessment) of special status situations, when present, including, but not limited to, imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential (for all overnight levels of care). It is also important to document the absence of such conditions
- A medical and psychiatric history including previous treatment dates, clinician or facility identification, therapeutic interventions and responses, sources of clinical data, and relevant family information
- The behavioral health history includes an assessment of any history of abuse the member has experienced
- For adolescents, the assessment documents a sexual behavior history
- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic)
- For members 12 years of age and older, documentation includes past and present use of nicotine or alcohol, as well as illicit, prescribed or over-the-counter medications
- Documentation of a DSM diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Continue to list medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition
- Treatment plan documentation needs to include the following elements:
  - Specify symptoms and problems related to the identified diagnosis of the treatment episode
  - Critical problems that will be the focus of this episode of care are prioritized; any additional problems that are deferred should be noted as such
  - Relates the recommended level of care to the level of impairment
  - Member (and, when indicated, family) involvement in treatment planning
  - Treatment goals must be specific, behavioral, measurable and realistic
  - Treatment goals must include a time frame for goal attainment
  - Progress or lack of progress toward treatment goals
  - Rationale for the estimated length of the treatment episode
  - Updates to the treatment plan whenever goals are achieved or new problems are identified
  - If the member is not progressing towards specified goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals and interventions as needed
- Progress notes include:
  - Signature of the practitioner rendering services
  - The date of service

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  - Member strengths and limitations in achieving treatment plan goals and objectives
  - Treatment interventions that are consistent with those goals and objectives noted in the treatment plan
  - Dates of follow-up visits
  - Documentation of missed appointments, including efforts made to outreach to the member
  - For time based services only, either start and stop time or total time in session
- Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
  - Criteria for discharge
  - Identification of barriers to completion of treatment and interventions to address those barriers
  - Identification of support systems or lack of support systems
- A discharge summary is completed at the end of the treatment episode that includes the following elements:
  - Reason for treatment episode
  - Summary of the treatment goals that were achieved or reasons the goals were not achieved
  - Specific follow up activities/aftercare plan
- Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities, or consultants. If the member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
  - At the initiation of treatment
  - Throughout treatment as clinically indicated
  - At the time of transfer to another treating clinician, facility, or program
  - At the conclusion of treatment
- Documentation of referrals to other clinicians, services, community resources, and/or wellness and prevention programs

Records related to billing must include all data elements required for submission of the claim **The Fraud, Waste, Abuse, Error and Payment Integrity** information page on *Provider Express* includes additional resources to support documentation requirements.

Guidelines for Storing Member Records

The following are additional guidelines for completing and maintaining treatment records for members.

- Practice sites and facilities must have an organized system of filing information in treatment records
- Records for members who desire interpretation services must be identified in a manner so office or facility staff is aware of the need for language assistance in all contacts
- Treatment records must be stored in a secure area and the site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations, including HIPAA
- The site must have a process in place to ensure that records are available to qualified professionals if the treating clinician is absent
- Treatment records are required to be maintained for a minimum period of seven years from the date of service, or in accordance with applicable state or federal laws or regulations, whichever is longer. Termination of the Agreement has no bearing on this requirement
- Financial records concerning covered services rendered are required to be maintained from the date of service for 10 years, or the period required by applicable state or federal law, whichever is longer. Termination of the Agreement has no bearing on this requirement
- Providers with electronic health records must have an established procedure to maintain a backup copy of all electronic health records

Audits of Sites and Records

On-site and record-only audits may occur with any contracted provider. Both types of audits involve reviewing a sampling of treatment records. The on-site audit also involves a review of policies and procedures, including policies related to hiring and supervision of staff, discussion of services that are offered and a tour of the facility or office site.

Our representatives conduct site visits at clinician offices, agencies such as community mental health centers (CMHCs), facilities, and group provider locations. On-site audits are routinely completed with CMHCs and facilities without national accreditation. In addition, audits are completed to address specific quality of care issues or in response to member complaints about the quality of the office or facility environment.

Facilities and CMHCs that hold national accreditation through organizations such as the Joint Commission, CARF, COA,

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HFAP, NIAHO, CHAP, and/or AAAHC receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process. The plan may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations. When it is determined that a service or program is not part of the accreditation, we will audit that particular service or program.

Facilities and CMHCs that are not accredited will be required to participate in an on-site audit prior to credentialing and a recredentialing audit prior to their specified recredentialing timeframe. Any facility or CMHC, regardless of accreditation, may be subject to an on-site audit for any member complaints or suspected quality of care concerns brought to our attention.

During on-site and record-only audits for all types of care providers, chart documentation is reviewed, including, but not limited to, the assessment (which is distinct from any questionnaire the member may complete), diagnosis, treatment plan, progress notes, monitoring risk issues, coordination of care activities, and discharge planning. This process also verifies that services were provided to members. You are expected to maintain adequate medical records on all members and document in the record all services that are provided. Prior to the audit, you will be notified of the specific types of charts that will be reviewed. Failure to adequately document services that are rendered and/or dates of services may lead to a request for a Corrective Action Plan (CAP). Please see the "Treatment Record Documentation Requirements" section of for more information.

The audit tools are based on NCQA, the Joint Commission and Optum standards. These forms are used during audits and are available at **Provider Express** for reference: Home page > Clinical Resources > Forms > Optum Forms - Administrative > Site Audit Tools.

7.10 Compensation and Claims Processing

The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, less any applicable copayments, coinsurance and deductibles due from the member, or (2) the contracted fee maximum, less any applicable copayments, coinsurance and deductibles due from the member. Fee maximums can vary based on different insurance plans and are available upon request.

The contracted rate for facilities is referenced in the Payment Appendix of the facility agreement and defines rates applicable to inpatient and/or outpatient care through that facility. When the contracted rates include care provider fees, the facility is responsible for payment of all treating care providers and notifying the care providers payment will be made by the facility and not us.

Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the Agreement has no bearing on this legal obligation.

Balance Billing for Covered Services Is Prohibited

Under the terms of the Agreement, you may not balance bill UHCCP members for covered services provided during eligible visits, which means you may not charge members the difference between your billed usual and customary charges and the aggregate amount reimbursed by us and member expenses.

Claims Submission and Payment

All information necessary to process claims must be received by UHCCP no more than 90 calendar days from the date of service, or as allowed by applicable law or specific member benefit plans. Claims received after this time period may be rejected for payment at the discretion of UHCCP and/or the payor. You may not bill the member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim.

Submit claims as directed by UHCCP. We strongly recommend that you keep copies of all claims for your own records. You permit UHCCP, on behalf of the payer, to bill and process forms for third-party claims or for third-party payers, and execute any documents reasonably required or appropriate for this purpose. In the event of insolvency of the member's employer or UHCCP, your sole redress is against the assets of UHCCP or the applicable payer, not the member. You must agree to continue to provide services to members through the period for which premiums have been paid. Any termination of the agreement has no bearing on this requirement.

Generally, claims that contain all of the required information and match the authorization, if applicable, will be paid within 30 calendar days after receipt, or as required by applicable law. This may exclude claims that require Coordination of Benefits

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(COB) determinations. Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the plan. You will be paid for covered services by UHCCP and must not, under any circumstances, seek payment through UHCCP for plans for which UHCCP is not the payor or administrator.

UHCCP may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the manual, the Credentialing Plan, the Agreement, and applicable law. UHCCP may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law. The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable law.

EDI/Electronic Claims

Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (care provider, psychologist, social worker) and a Payor (UHCCP). You may choose any clearinghouse vendor to submit claims through this route. When sending claims electronically, routing to the correct claim system is controlled by the Payer ID. For UnitedHealthcare Community Plan claims use Payer ID #87726.

Coordination of Benefits (COB)

Some members are eligible for coverage under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s). It is the provider's responsibility to inquire and collect information concerning all applicable health plans available or verifying member enrollment. All providers should verify member eligibility and insurance coverage prior to providing services.

You may not bill members for the difference between your billed usual and customary charge and the amount paid by the primary plan(s) and us.

7.11 Anti-Fraud, Waste and Abuse

Overview

Optum believes you are an integral part of our program of integrity work. Protecting clients, providers and stakeholders through the prevention, early detection, investigation and ultimate resolution of potential Fraud, Waste and Abuse (FWA) issues is a fundamental component of quality care and sound clinical practice. Please refer to Section 8.11 of this Manual for information about the UHCCP Fraud and Abuse prevention program.

7.12 Provider Dispute Resolution Mechanism

A Provider Dispute is a contracted care provider's written notice to OptumHealth Behavioral Solutions of California (Optum) requesting claim review or reconsideration that has been denied, adjusted or contested; or seeking resolution of a billing determination or other contract dispute; or disputing a request for reimbursement of an overpayment of a claim. Provider Disputes are resolved through the Dispute Resolution Mechanism.

Disputes must be submitted in writing and must include the following:

- Provider's name;
- Provider's identification number;
- Provider's contact information;
- If about a claim, specific claim information including claim number, dates of service, procedure codes, amounts, etc.;
- If not about a claim, a detailed explanation of the issue;
- If about a member, the name and identification number of the member and a detailed explanation of the issue.

Send a written dispute to the OptumHealth Behavioral Solutions of California Appeals Department:

OptumHealth Behavioral Solutions of California
Attn: Appeals and Grievances Department
P. O. Box 30512
Salt Lake City, UT 84130-0512
Telephone: **800-999-9585**
Fax: 855-312-1470

You may contact Network Management for guidance with the Dispute Resolution Process. Providers have up to 365 days from the date of Optum's action, inaction or incident causing dissatisfaction to submit a dispute. Optum will send written acknowledgment to the provider within 15 working days of receiving the dispute. Optum will send written notice of the resolution to the provider within 45 working days of receiving the dispute.

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Any dispute submitted by a treating clinician on behalf of an enrollee is handled through Optum's member grievance and appeals system according to our policy and procedure. In such cases, the provider is deemed to be assisting the enrollee within the context of California Health and Safety Code, §1368.

Providers are offered one level of dispute review unless otherwise required by applicable law or regulation or contractual requirement. The outcome of the dispute is Optum's final determination.

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Chapter 8: Quality Management

8.1 Provider Participation in Quality Management

UnitedHealthcare Community Plan has a Quality Management Committee (QMC), chaired by the CEO or designee of the CEO, which meets monthly and has oversight responsibility for issues affecting health services delivery. The QMC is composed of UnitedHealthcare Community Plan management staff and reports its recommendations and actions to the UnitedHealthcare Board of Directors. The QMC has three standing sub-committees:

- **Provider Advisory Committee** reviews and recommends action on topics concerning credentialing and recredentialing of providers and facilities, peer review activities, and performance of all participating providers. Participating providers give UnitedHealthcare Community Plan advice and expert counsel in medical policy, quality management, and quality improvement. A Medical Director chairs the Provider Affairs Subcommittee.
- **Health Care Quality and Utilization Management Committee** reviews statistics on utilization, provides feedback on Utilization Management and Case Management policies and procedures, and makes recommendations on clinical standards and protocols for medical care.
- **Service Quality Improvement Committee** reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees member and provider intervention for quality improvement activities as needed.
- **Seniors and Persons with Disabilities Advisory Council (SPDAC)** provides a collaborative forum for SPDAC caregivers to share successes, bring issues and ideas from SPDAC enrollees, work together opportunities for community outreach, identify common ground around legislative issues, obtain feedback on new and future initiatives.

8.2 Quality Improvement Program

The Quality Improvement program at UnitedHealthcare Community Plan is a comprehensive program under the leadership of the Chief Executive Officer and the Chief Medical Officer. A copy of our Quality Improvement program is available upon request. The Quality Improvement program consists of the following components:

- Quality improvement measures and studies
- Clinical practice guidelines
- Health promotion activities
- Service measures and monitoring
- Ongoing monitoring of key indicators (e.g., over and under-utilization, continuity of care)
- Health Plan performance information analysis and auditing (e.g., HEDIS®)
- Care Coordination℠
- Educating members and care provider
- Risk management
- Compliance with all external regulatory agencies

Your participation is an integral component of UnitedHealthcare's Quality Improvement program.

As a participating care provider, you have a structured forum for input through representation on our Quality Improvement Committees and through individual feedback via your Network Account Manager. We require your cooperation and compliance to:

- Participate in quality assessment and improvement activities.
- Provide feedback on our Care Coordination℠ guidelines and other aspects of providing quality care based upon community standards and evidence-based medicine.
- Advise us of any concerns or issues related to patient safety.
- Protect the confidentiality of patient information.
- Share information and follow-up on other providers of care and UnitedHealthcare Community Plan to provide seamless, cohesive care to patients.
- Use the Physician Data Sharing information we provide you to help improve delivery of services to your patients.

8.3 Provider Satisfaction

On an annual basis, UnitedHealthcare Community Plan conducts ongoing assessments of provider satisfaction

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as part of our continuous quality improvement efforts. Key activities related to the assessment and promotion of provider satisfaction include:

- Annual Provider Satisfaction Surveys and Targeted Improvement Plans;
- Regular visits to providers;
- Provider town meetings.

Objectivity is our utmost concern in the survey process. To this end, UnitedHealthcare Community Plan works with Survey Research Solutions, a product of our sister segment, OptumInsight and the Center for Study Services (CSS) to conduct our annual provider satisfaction survey(s). CSS draws the survey samples of eligible care providers working within our networks from lists provided by OptumInsight.

Survey results from all UnitedHealthcare Community Health Plans are aggregated annually and reported to our National Quality Management Oversight Committee. The results are compared by the Health Plan year over year and also in comparison to other UnitedHealthcare Community Health Plans across the country. The survey results include key strengths, secondary strengths, key improvement targets and secondary improvement targets.

8.4 Credentialing Standards

UnitedHealthcare Community Plan will credential and re-credential all participating providers according to the regulations mandated by the accrediting body, the National Committee of Quality Assurance (NCQA). The following key elements are required to begin the credentialing process:

- A completed Credentialing Application including Attestation Statement
- Current Medical License;
- Current DEA Certificate;
- Current Professional Liability Insurance;

Information from primary sources regarding licensure, education and training, board certification, and malpractice claims history will be verified as part of the credentialing process.

8.5 Credentialing and Recredentialing Process

UnitedHealthcare Community Plan's credentialing and recredentialing process is to determine the provider's competence and suitability for initial and continued inclusion in UnitedHealthcare Community Plan's provider network. All individual contracted providers are subject to the credentialing and recredentialing process before they can evaluate and treat our members.

Types of Providers Subject to Credentialing and Recredentialing

UnitedHealthcare Community Plan credentials and recredentials the following types of practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- PA's (Physician Assistants)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists) Excluded from the credentialing and recredentialing process are practitioners who:
- Practice exclusively within an inpatient setting
- Hospitalists who are employed solely by the facility

Health Facilities

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

Facilities must meet the following requirements or verification:

- Meet State and Federal licensing and regulatory requirements and NPI number. Current unrestricted license to operate
- Confirm the provider has been reviewed and approved by an accrediting body
- Malpractice coverage/liability insurance that meets contract minimums
- Site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency
- No Medicare/Medicaid sanctions

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

Credentialing and Recredentialing activities are completed by our National Credentialing Center (NCC). Applications are retrieved from the Council for Affordable Quality Healthcare (CAQH) website. First time applicants will need to contact the National Credentialing Center (VETTS line) at 877-842-3210 to obtain a CAQH number in order to complete the application on line.

8.6 Peer Review

Credentialing Process

All applicants are reviewed by the Provider Advisory Committee (PAC). Decisions are final and binding and not subject to appeal if they relate to mandatory participation criteria at the time of initial credentialing. The practitioner is notified in writing of the credentialing determination within 60 calendar days of the committee decision.

Recredentialing Process

UnitedHealthcare Community Plan recredentials practitioners every three years to assure that time-limited documentation is updated, that changes in health and legal status are identified, and that practitioners comply with our guidelines, processes, and provider performance standards. Practitioners are notified prior to their next credentialing cycle to complete their application on the CAQH website. Failure to respond to UnitedHealthcare's request for recredentialing information will result in administrative termination of his/her privileges as a UnitedHealthcare participating provider. The practitioner will be afforded multiple opportunities to respond to our request for recredentialing information before action is taken to terminate participation privileges.

Provider Performance Review

As part of the recredentialing process, UnitedHealthcare Community Plan queries its Quality Management database for information regarding provider performance. This includes but is not limited to:

- Member complaints
- Quality of care issues
- Utilization Management
- Performance Measure Rates

Applicant Rights and Notification

Practitioners have the right to review the information in support of their credentialing/ recredentialing applications and to request the status of their application. This review is at the practitioner's request and is facilitated by the credentialing staff. The credentialing staff notifies practitioners of any information obtained during the credentialing or recredentialing process that varies significantly from the information given to UnitedHealthcare Community Plan by the practitioner. Practitioners have the right to correct erroneous information of the request for clarification by the credentialing staff.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

8.7 Resolving Disputes

Contract Concern or Complaint

If you have a concern or complaint about your agreement with us, send a letter containing the details to: UnitedHealthcare Central Escalation Unit, P.O. Box 5032, Kingston, NY, 12402-5032. A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your applicable Provider Agreement.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare Community Plan procedures, such as the credentialing or Care Coordination process, we will follow the procedures set forth in those plans to resolve the concern or complaint. After following those procedures, if you remain dissatisfied, please follow the dispute resolution provisions of your applicable Provider Agreement.

If we have a concern or complaint about our agreement with you, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions with you, please follow the dispute resolution provisions of your applicable Provider Agreement.

In the event a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the member's handbook, and this Provider Administrative Guide.

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8.8 HIPAA Compliance – Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the health care system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight health care fraud and abuse were the core goals of the Act, the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the health care industry. UnitedHealthcare Community Plan is a “covered entity” under the regulations as are all health care providers who conduct business electronically.

1. **Transactions and Code sets**
   These provisions were originally added because of the need for national standardization of formats and codes for electronic health care claims to facilitate electronic data interchange (EDI). From the many hundreds of formats in use prior to the regulation, nine standard formats were adopted in the final Transactions and Code sets Rule. All providers who conduct business electronically are required to do so utilizing the standard formats adopted under HIPAA or to use a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare Community Plan.
2. **Unique Identifiers**
   HIPAA also requires the development of unique identifiers for employers, health care providers, Health Plans and individuals for use in standard transactions. (See National Provider Identifier section.)
3. **Privacy of Individually Identifiable Health Information**
   The privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that Health Plans, pharmacies, hospitals and other covered entities can use patients’ personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

   The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information; also, to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.
4. **Security**
   The Security Regulations require covered entities to meet basic security objectives.
   - Ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates, receives, maintains and transmits;
   - Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
   - Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
   - Ensure compliance with the Security Regulations by the covered entity’s workforce.

UnitedHealthcare Community Plan expects all participating providers to be in compliance with the HIPAA regulations that apply to their practice or facility within the established deadlines. Additional information on HIPAA regulations can be obtained at **cms.hhs.gov**.

8.9 Member Rights and Responsibilities

Privacy Regulations

HIPAA Privacy Regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The Privacy Regulations also create certain individual patient rights.

- **Access to Protected Health Information**
  UnitedHealthcare Community Plan members have the right to access information in a designated record set held at the provider’s office or at the Health Plan. Members may make this request to UnitedHealthcare for claims and data used to make medical treatment decisions. They may also make a request of the provider of service to obtain copies of their medical records.
- **Amendment of PHI**
  UnitedHealthcare Community Plan members have the right to request information held by the provider or Health Plan be amended if they believe the information to be inaccurate or incomplete. Any request for amendment of PHI must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member.
- **Accounting of Disclosures**
  UnitedHealthcare Community Plan members have the right to request an Accounting of Disclosures of his or

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her PHI made by you or the Health Plan. This accounting must include disclosures by business associates.

- **Right to Request Restrictions**
  Members have the right to request restrictions to the provider or Health Plan's uses and disclosures of the individual's PHI. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented.
- **Right to Request Confidential Communications**
  Members have the right to request that communications from the provider or the Health Plan be received at an alternative location or by alternative means. A provider must accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A Health Plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the NCQA are:

1. A responsibility to supply information (to the extent possible) that the organization and its providers need in order to provide care
2. A responsibility to follow plans and instructions for care that they have agreed to with their providers
3. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

The following is a list of member rights and responsibilities:

Members have the right to:

- Be treated with respect and dignity by everyone who works with UnitedHealthcare Community Plan of California, Inc.
- Not be treated badly or disrespectfully by us, your doctors, or the Department of Health Care Services for acting on these rights and when making decisions about your care.
- Receive information about your health plan, our doctors, our other providers, our services, and your rights and responsibilities.
- Choose your Primary Care Provider from our network. Members can change their PCP at any time. Members can see their old or new PCP without waiting for the change to take effect. We do not interrupt claims payment or access to care regardless of the current effective status of the PCP on file. The only requirement we have is the PCP is in network and performed services are covered under Medi-Cal.
- Receive information about your health and to have your questions about your health answered.
- Receive information about all of your treatment options if you are sick, regardless of benefit coverage or cost.
- Talk with your doctor about your care and treatment options, help make decisions about your treatment, regardless of your benefit coverage or costs, and ask for a second opinion.
- Decide to not be treated for your illness.
- Decide in advance how you want to be cared for in case you have a life-threatening illness or injury.
- Have your medical records kept private and confidential, receive a copy of your medical records, and ask us to make corrections to your medical records (to the extent allowed by State and Federal law).
- If you are a minor, receive certain services without the permission of your parents or guardian.
- Complain about UnitedHealthcare Community Plan of California, Inc., your care, and the providers we work with without being afraid of losing your benefits. We will help you with this process, and if you do not agree with our decision, you have the right to ask for a review of the decision (this review is also called an appeal. You can also request a State Fair Hearing and to get information on how to get a State Fair Hearing quickly.
- Disenroll from UnitedHealthcare Community Plan of California, Inc. at any time.
- Request an interpreter free of charge if you want to speak a language that is not English, and be asked to use a family member or friend to interpret for you.
- Get this handbook, information about your providers, your health, or us in the language that you want or in another format, such as Braille, audio, or larger font within a reasonable time and in accordance with State laws.
- Receive emergency or urgent services, family planning services, and sexually transmitted disease services from providers that are outside of UnitedHealthcare Community Plan of California, Inc.'s network.

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- Receive information about your rights and responsibilities.
- Make recommendations about these rights and responsibilities.

Members have the responsibility to:

- Treat your doctor, all providers, and their staff with courtesy and respect.
- Be on time for your appointments.
- Call your doctor at least one day before your scheduled appointment when you have to cancel or reschedule the appointment.
- Give the correct information, and give as much information as you can, to your doctor, other providers who treat you, and to us.
- Get regular checkups with your doctor, and tell your doctor about your health problems as soon as possible.
- Talk to your doctor about your health care needs and discuss your treatment choices. Follow your doctor's instructions and the treatment plans that you and your doctor have agreed to.
- Learn about your health benefits and ask any questions you might have. You can ask us or your doctor.
- Use the Emergency Room only when you feel it is necessary or when you have been told to do so by your doctor.
- Report health care fraud or wrong doing by calling us. You can report without giving your name.

8.10 National Provider Identifier

NPI is the standard unique identifier (a 10 character number with no imbedded intelligence) for health care providers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which covered entities must accept and use in standard transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) and should be shared by the provider with all impacted trading partners such as providers to whom you refer patients, billing companies, and Health Plans.

The NPPES assists providers with their application, processes the application and returns the NPI to the provider.

There are two entity types for the purposes of enumeration. A Type 1 entity is an individual health care provider and a Type 2 entity is an organizational provider, such as a hospital system, clinic, or DME providers with multiple locations. Type 2 providers may enumerate based on location, taxonomy or department.

Only providers who are direct providers of health care services are eligible to apply for an NPI. This creates a subset of providers who provide non-medical services who will not have an NPI.

Taxonomy

Taxonomy codes are 10-character federally established alpha numeric codes which health care professionals use to identify their unique specialty areas. They are a combination of Provider Type and Provider Specialty that are self- declared by health care providers during the National Provider Identifier (NPI) enumeration process. The Health Care Provider Taxonomy code set is developed by the Centers for Medicare & Medicaid Services (CMS) and is published twice a year in July and January.

NPI Compliance

HIPAA mandates the adoption and use of NPI in all standard transactions (claims, eligibility, remittance advice, claims status request / response, and authorization request / response) for all health care providers who conduct business electronically. **Additionally, most state agencies are requiring the use of the NPI on paper claims – we will require NPI on paper claims also in anticipation of encounter submissions to the state agency.**

NPI will be the only health care provider identifier that can be used for identification purposes in standard transactions for those covered health care providers.

How to get an NPI

Health care providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan & Provider Enumeration System - Home Page and apply online at nppes.cms.hhs.gov/NPPES.
- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.

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- Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:
  - Phone: 800-465-3203 or TTY: 800-692-2326
  - Mail: NPI Enumerator
    P.O. Box 6059
    Fargo, ND 58108-6059
  - Email: **customerservice@npienumerator.com**

How to share your NPI with us

Once you have NPI, it is imperative that it be communicated to UnitedHealthcare Community Plan immediately by visiting **UnitedHealthcareOnline.com**. There you will find downloadable forms for you to fill in the appropriate information. NPI information can be faxed to 855-773-3156, Attn: Provider Demographics. To assist us in expediting this process, please also include your provider name, address, and TIN.

8.11 Fraud and Abuse

Fraud and abuse by care providers, members, Health Plans, employees, etc. hurts everyone. Your assistance in notifying us about any potential fraud and abuse that comes to your attention and cooperating with any review of such a situation is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.

Definitions of Fraud and Abuse

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse: Care provider practices inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the program or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the program.

Examples of fraud and abuse include:

Misrepresenting Services Provided

- Billing for services or supplies not rendered
- Misrepresentation of services/supplies
- Billing for higher level of service than performed

Falsifying Claims/Encounters

- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Administrative or Financial

- Kickbacks
- Falsifying credentials
- Fraudulent enrollment practice
- Fraudulent third party liability reporting

Member Fraud or Abuse Issues

- Fraudulent/Altered prescriptions
- Card loaning/selling
- Eligibility fraud
- Failure to report third party liability/other insurance

Reporting Fraud and Abuse

If you suspect another care provider or a member has committed fraud or abuse, you have a responsibility and a right to report it. Reports of suspected fraud or abuse can be made in several ways.

- Call us at 866-242-7727.

For provider-related matters (e.g. doctor, dentist, hospital, etc.), please furnish the following:

- Name, address and phone number of provider
- Provider number
- Type of care provider (physician, physical therapist, pharmacist, etc.)
- Names and phone numbers of others who can aid in the investigation
- Dates of events
- Specific details about the suspected fraud or abuse

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For member-related matters (beneficiary/recipient), please furnish the following:

- The person's name, date of birth, Social Security number, ID number
- The person's address
- Specific details about the suspected fraud or abuse

8.12 Ethics & Integrity

Introduction

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with members, care providers, suppliers and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other health care providers, regulators and others has never been greater. It's not only the right thing to do, it is necessary for our continued success and that of our business associates.

Compliance Program

As a business segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Compliance program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity. The UnitedHealthcare 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 education of employees;
- Assessing compliance by monitoring and auditing;
- Responding to allegations or information regarding violations;
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for employees, managers and others 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 located in each Health Plan. In addition, each Health Plan has an active Compliance Committee, consisting of senior managers from key organizational functions. The Committee provides direction and oversight of the program with the Health Plan.

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare Community Plan employee which comes to the attention of a care provider should be reported to a UnitedHealthcare Community Plan senior manager in the Health Plan or directly to the Compliance Officer.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important component of the Compliance program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by providers and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities. To facilitate the reporting process of any questionable incidents involving plan members or providers, call 866-242-7727. Please refer to the Fraud and Abuse section of this Manual for additional details about the UnitedHealthcare Fraud and Abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews and audits to ensure compliance with law, regulations, and policies/contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within the plan or by our providers, UnitedHealthcare will conduct an appropriate investigation. Providers are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by your applicable provider agreement and this manual) and access to provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

If a care provider becomes the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to the provider's operations (other than a routine request for documentation from a regulatory agency), the provider must advise the UnitedHealthcare Community Plan of the details of this and of the factual situation which gave rise to the inquiry.

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Extrapolation Audits of Corporate-wide Provider Billing

UnitedHealthcare Community Plan will work with HCA to perform “individual and corporate extrapolation audits” and this may affect all programs supported by dual funds (state and federal funding), as well as state-funded programs, as requested by HCA, including California programs and state employee health plans.

Record Retention, Reviews and Audits

You must agree to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. You must maintain for a period of not less than six years from the close of the program agreement between the state and UnitedHealthcare Community Plan, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the disposition of records under review or inspection.

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

You must cooperate with the state or any of its duly authorized representatives, the Department of Managed Health Care (DMHC), , the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency prior-approved by the state, at any time during the term of your applicable Provider Agreement.

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

All reviews and audits will be performed that will not unduly delay your work. If you refuse to allow access to all documents, papers, letters, or other materials, this will constitute a breach of your applicable Provider Agreement.

You must keep records for a period of six years after final payment under your applicable Provider Agreement, unless the state authorizes in writing their earlier disposition. You agree to refund to the state any overpayment disclosed by any such audit.

However, if any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the six-year period, you agree to retain the records until completion of the action and resolution of all issues which arise from it and for one year thereafter. The state shall also retain the right to perform financial, performance, and other special audits on such records maintained by the provider during regular business hours throughout the term of your applicable Provider Agreement.

Delegating and Subcontracting

If you delegate or subcontract any function, the subcontract or delegation must include all requirements of your applicable Provider Agreement and this Guide.

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Chapter 9: Claims

9.1 Claims Billing Procedures

Electronic claims reduce errors and shorten payment cycles. For electronic claims submission requirements, please see our companion documents located at **UHCCommunityPlan.com**. You should share this documentation with your software vendor.

To obtain more information regarding electronic claims, please refer to the EDI section of this manual or the provider section of the website at **UHCCommunityPlan.com**, or you may call our EDI Customer Service at 800-210-8315.

If a claim must be submitted on paper, you should send claims to the following address:

UnitedHealthcare
P.O. Box 30884
Salt Lake City, UT 84130

9.2 Claims Format

All claims for medical or hospital services must be submitted using the standard CMS1500 (formerly known as HCFA 1500), UB04 (also known as CMS1450), 5010 format or respective electronic format. We recommend the use of black ink when completing a CMS 1500. Black ink on a red CMS 1500 form will allow for optimal scanning into the claims processing system. No matter which format you use to submit the claim, ensure that all appropriate secondary diagnosis codes are captured and indicated for line items. This allows for proper reporting on encounter data.

9.3 Claim Processing Time

Please allow 30 days before inquiring about claims status. The standard turnaround time for clean claims is 10 business days, measured from date of receipt.

9.4 Claims Submission Rules

You must submit claims to UnitedHealthcare Community Plan within 180 days from the date of service in accordance with "clean claim" submission requirements.

You MUST submit the following claims on paper due to required attachments:

- Timely filing reconsideration requests
- Correct Coding Initiative (CCI) edit reconsideration
- Unlisted procedure codes if sufficient information is not sent in the notes field

Please do not send claims on paper or with attachments unless requested by the Health Plan. Paper claim specific rules include:

- Corrected claims may be submitted electronically; however the words "corrected claim" must be in the notes field. Your software vendor can instruct you on correct placement of all notes.
- Unlisted Procedure Codes may be submitted with a sufficient description in the notes field. Your software vendor can instruct you on correct placement of all notes. If sufficient information cannot be submitted in the notes field, paper must be submitted. X-ray, lab and drug claims with unlisted procedure codes should be submitted electronically with notes.
- OT/ST/PT/Dialysis/MHSA claims require the Date of Service by line item. The Health Plan does not accept span dates for these types of claims.

9.5 Tax Identification Numbers/Provider IDs

Please submit standard transactions using your tax identification number and your NPI. To ensure proper claims adjudication, please use the ID that best represents the Health Care Professional that performed the service. If you have any questions about IDs, please contact your local office or EDI Customer Service at 800-210-8315.

9.6 Coordination of Benefits

If you are aware the member has other creditable insurance coverage, you should notify UnitedHealthcare Community Plan of the potential coverage. Please submit claims with other insurance remittance advice as needed.

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9.7 Electronic Claims Submission and Billing

All documents, frequently asked questions and other information regarding electronic claims submission can be found at **UHCCommunityPlan.com** under Physicians, EDI Services.

Please share this information with your software vendor. Your software vendor can help in establishing electronic connectivity. Please note the following:

- Clearinghouse connectivity is OptumInsight at **OptumInsight.com/connectivity** for our Payer ID 87726.
- All claims are set up as "commercial" through the clearinghouse.
- Our Payer ID is 87726.
- Clearinghouse Acknowledgement Reports and Payer specific Acknowledgment Reports identifying claims failing to successfully transmit electronically.
- We follow CMS National Uniform Claim Committee (NUCC) Manual guidelines for placement of data for both HCFA 1500 & UB04.

Address questions to EDI Customer Service at 800-210-8315.

Importance & Usage of EDI Acknowledgment/ Status Reports

Software vendor reports only show that the claim left the provider's office and either was accepted or rejected by the vendor. Your software vendor report **does not** confirm claims have been received or accepted at clearinghouse or by the Health Plan. Acknowledgement reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached the Health Plan for payment or if claim(s) have been rejected for an error or additional information.

Providers must review their reports, clearinghouse acknowledgement reports and the Health Plan's status reports to eliminate processing delays and timely filing penalties for claims that have not reached the Health Plan.

How do I get these reports?
Your software vendor is responsible for establishing your connectivity to our clearinghouse **OptumInsight at OptumInsight.com/connectivity**, and will instruct you in how your office will receive Clearinghouse Acknowledgement Reports.

How do I correct errors?
If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing later.

IMPORTANT: If a claim is rejected and corrections are not received by the Health Plan within 90 days from date of service or EOB from primary carrier, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

EDI Companion Documents

The Health Plan's Companion Guides are intended to convey information that is within the framework of the ASC X12N Implementation Guides(IG) adopted by HIPAA. The companion guides identify the data content being requested when data is electronically transmitted. The Companion Documents are located on our website at **UHCCommunityPlan.com**.

The Health Plan utilizes the Companion Guides to:

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

Section 1 provides general information.

Section 2 provides specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

As the Health Plan makes information available on various transactions, we will identify our requirements for those transactions in Section 2 of the Companion Guide. Additional comments may also be added to Section 1 as needed. Changes will be included in Change Summary located in each section of the Companion Document.

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e-Business Support

UnitedHealthcare Community Plan offices will be staffed and open during normal business hours 8 a.m. to 5 p.m., Monday through Friday. e-Business support is available for the following EDI issues:

EDI Claims Issues	800-210-8315
	ac_edi_ops@uhc.com
EDI Log-on Issues	800-842-1109
	UnitedHealthcareOnline.com

Contacting your software vendor and/or clearinghouse prior to contacting UnitedHealthcare Community Plan should be considered.

Electronic Payments and Statements (EPS)

Optum's Electronic Payments and Statements (EPS) is a free electronic funds transfer (EFT) and electronic remittance advice (ERA) service brought to you by UnitedHealthcare Community Plan. It is the standard for receiving UnitedHealthcare Community Plan payments and explanation of benefits (EOBs)/ remittance advice.

EPS delivers electronic payments and provides online remittance advice and 835 files to physicians, hospitals and other health care professionals. Electronic payments may be made by direct deposit/EFT into an organization's bank account or by Virtual Card Payment (VCP). With VCP, your bank account information is not needed as you process payments like a credit card transaction.

If VCP is available to you and you are receiving paper checks and remittance advice, you will be required to elect your preferred claim payment method: EPS with direct deposit, EPS with VCP, or paper checks and remittance advice. You will receive a deadline and instructions for making your election. If you do not take action by your given deadline, your tax identification number (TIN) will default to Virtual Card Payments. If you choose to continue receiving paper, you will need to confirm your election annually.

EPS with direct deposit: No credit card processing fees

While funds are deposited to your account, UnitedHealthcare Community Plan will not debit or deduct claim adjustments from your checking or savings account. You can also contact your bank to ensure that you have appropriately placed controls over the electronic funds transfers to and from your account. Posting and balancing with direct deposit:

1. Receive email notifications when payments are deposited to your designated bank account(s).
2. Log on to EPS and view, save or print remittance advice to post payments manually to your practice management system, or auto-post using the free electronic remittance advice 835/ERA.

Note: Enroll with your clearinghouse if you would like to receive the 835 file from them.

EPS with Virtual Card Payments

Virtual Card Payments can be processed using the same method leveraged by your organization to process credit card transactions. Please note, your current credit card processing fees will apply. Please confirm those rates with your bank of choice directly. Banking information is not shared outside your organization.

Posting and balancing with Virtual Card Payment:

1. Your practice will receive one or more virtual card numbers (a card number is issued for each payer) in the mail and this card number should be retained in a secure location as you will need it for future payments.
2. You will be notified of new claim payments via email.
3. Log on to EPS and view, save or print remittance advice to post payments manually to your practice management system, or auto-post using the free electronic remittance advice 835/ERA.

Note: you should enroll with your clearinghouse if you would like to receive the 835 file from them.

EPS Registration

To learn more about EPS and register, visit **WelcometoEPS.com**. If you have questions about EPS, direct deposit, Virtual Card Payments or enrollment, call us at (866) 842-3278 and select option 5, to speak with an EPS representative.

9.8 Span Dates

Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS1500, Box 45 of the UB04, or the remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

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9.9 Effective Date/Termination Date

Coverage will terminate on the date the member's benefit plan terminates with UnitedHealthcare Community Plan. If a portion of the services or confinement take place prior to the effective date, or after the termination date, an itemized split bill will be required. If a member is covered by us upon the date of admission, termination does not occur until:

1. The member is discharged from a facility to home or a community residential setting.
2. The member 's eligibility to receive Medicaid services ends.
3. Aging and Long Term Services Administration (ALTSA) determines the member is eligible for custodial care.

Please be aware that effective dates for members are frequently revised, as individual members recertify their Medi-Cal eligibility through the state. You should verify eligibility at each visit, to ensure coverage for services.

9.10 Overpayments

If an overpayment has been made, please include reference to the claim number or member ID number and date of service. The best way to handle a potential overpayment is to call a Provider Services Representative.

9.11 Subrogation

The Health Plan may override timely filing denials based on decisions received from third-party carriers on subrogation or workers' compensation claims. At the time of service, please submit all claims to the Health Plan for processing.

Through recovery efforts, we will work to recoup dollars related to subrogation and workers' compensation. In addition, if your office receives a third-party payment, notify Provider Services at 866-270-5785 and the overpayment will be recouped.

9.12 Provider/Member Cost Sharing Responsibilities

UnitedHealthcare Community Plan Medi-Cal members do not have any cost sharing responsibility for covered services. You may not bill a member for covered services. If you have questions about whether a service is covered or not or when it may or may not be appropriate to bill a member, please contact us.

9.13 Timely Filing and Late Bill Criteria

Please refer to your contract for your timely filing and late billing criteria.

9.14 Reconsideration Requests

If you have questions relating to claims payments please contact Provider Services at 866-270-5785. A Provider Services Representative may be able to assist you without requiring additional administrative work. If you are requested to submit a payment reconsideration, requests can be forwarded to:

UnitedHealthcare
P.O. Box 31341
Salt Lake City, UT 84131

A copy of the claim and supporting documentation will be required for review.

It is important to mark the claim as a "Payment Reconsideration" to make sure the claim is routed to the appropriate area for review. An indication of "appeal" may result in the claim being forwarded to the Member Appeal area of the Health Plan and potential delays in the claim review process.

9.15 Provider Complaints and Claims Payment Disputes

Provider Claims Adjustment Request

If you believe you were underpaid by UnitedHealthcare Community Plan, you can simplify the submission of requests for claim adjustments and receive efficient resolution of claim issues by using **UHCCommunityPlan.com**. Submit a single claim or submit claim batches of 20 or more claims that are in a paid or denied status directly to UnitedHealthcare Community Plan for research and reconsideration online.

You may also call Provider Services at 866-270-5785 and select the correct prompts, including opting to speak with a Provider Phone Representative (PPR). The PPR is trained to address your inquiry and handle initial claim related calls. During the call, if the PPR is unable to resolve the issue, they will put the care provider in contact with a Rapid Resolution Expert (RRE). The RRE is trained to manage more complex and escalated claim service issues. The Rapid Resolution program is designed to make more highly-skilled claims resolution experts readily accessible and to improve the overall call center experience for care provider.

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We may make claim adjustments without requesting additional information from you. You will see the adjustment on the Provider Remittance Advice. When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination.

Provider Formal Claim Appeals

Formal claim appeals are appeals of any payment decision that DOES NOT involve our determination of medical necessity or obtaining from the care provider information pertinent to a determination of medical necessity. Formal claim appeals may be made for claims that are:

- Denied in entirety
- Denied in part
- Paid at a rate asserted to be inconsistent with contracted rates

Some of the common reasons for formal claim appeals include, but are not limited to, disputes concerning the following reasons:

- Failure to obtain required prior authorization
- Untimely submission
- Reimbursement disputes

All formal claim appeals must be filed within 365 days of the date of the UnitedHealthcare Community Plan provider remittance. To file a formal claim appeal, the care provider should send a written appeal via regular mail to:

UnitedHealthcare
Attention: Formal Claim Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

The cover letter should state that a formal claim appeal is being made. Several claims with the same reasons for appeal may be combined in a single appeal letter, with an attached list of claims. State the specific reason for denial as stated on the remittance. UnitedHealthcare Community Plan does not accept appeals that fail to address the reason for the denial as stated on the remittance. For appeals of payment rates, state the basis for the dispute and enclose all relevant documentation, including but not limited to contract rate sheets and fee schedules. If you are appealing a claim that was denied because filing was not timely, for:

- Electronic claims: include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.
- Paper claims: include a copy of a screen print from your accounting software to show the date you submitted the claim.

If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed.

Excluded Providers

As part of ongoing efforts to ensure compliance with federal and state requirements, UnitedHealthcare Community Plan performs monthly screenings of the Office of Inspector General (OIG) (**oig.hhs.gov/fraud/exclusions.asp**), the List of Excluded Individuals and Entities (LEIE) and System for Award Management (SAM), and other databases for individuals or entities who have been “excluded” or “debarred” from federal programs. Individuals or entities identified as excluded or debarred as a result of these screenings will be terminated from participation in the Apple Health programs, immediately, upon discovery. Payments made to “excluded” or “debarred” providers will be recovered retroactive to the date of exclusion.

9.16 The Correct Coding Initiative

The Health Plan performs coding edit procedures, based primarily on the CCI (Correct Coding Initiative) and other nationally recognized and validated sources.
The edits basically fall into one of two categories:

1. Comprehensive and Component Codes.

Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:

- Separate procedures. Codes that are, by CPT definition, separate procedures should only be reported when they are performed independently, and not when they are an integral part of a more comprehensive procedure.
- Most extensive procedures. Some procedures can be performed at different levels of complexity. Only the most extensive service performed should be reported.
- With/without services. It is contradictory to report code combinations where one code includes and the other

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excludes certain other services.

- Standards of medical practice. Services and/ or procedures that are integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
- Laboratory panels. Individual components of panels or multichannel tests should not be reported separately.
- Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported.

2. Mutually Exclusive Codes.

These edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same care provider. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

CCI guidelines are available in paper form, on CD ROM, and in software packages that will edit your claims prior to submission. Your CPT and /ICD-10 vendor probably offers a version of the CCI manual, and many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS's authorized distributor of CCI information is the U.S. Department of Commerce's National Technical Information Service, or NTIS. They can be reached at 800-553-NTIS (6847), or on the Web at **ntis.gov**.

9.17 Immunizations Billing for Children

The Health Plan must provide for administration of all mandated childhood immunizations according to the recommended schedule of the Advisory Committee on Immunization Practices (ACIP) standards, a current copy of which is included on **UHCCommunityPlan.com**.

All vaccines for children are provided through the California state Department of Health, which will distribute vaccines to providers who are willing to participate in the vaccine program.

The cost of the vaccine will not be billed to the Health Plan. The only cost associated with immunizations to be reimbursed under the policy shall be the cost to administer the vaccine. Vaccines may be administered by network providers, including school-based nurses, by a non-participating provider to whom UnitedHealthcare Community Plan has referred the member, or by the California State Department of Health. Providers administering vaccines must agree to participate in the state's Immunization Registry. UnitedHealthcare Community Plan must reimburse these providers on a fee- for-service basis for the cost of administering any immunizations they provide to members. Other non-routine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, shall be covered as any other covered service. UnitedHealthcare Community Plan shall submit a monthly report containing a list of providers, their contact information, claimant information and corresponding vaccine administrations to the California state Department of Health.

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Chapter 10: Care Provider Standards and Policies

Primary care providers (PCPs) are an important partner in the delivery of care. members have the freedom to seek services from any participating care provider and the program does not require members to be assigned to PCPs. While PCPs are not assigned, members are encouraged 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" that they can access to optimize their care.

10.1 Role of the Primary Care Provider

The Primary Care Provider plays a vital role as a care provider case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas—access, coordination, continuity, and prevention. The PCP is responsible for the provision of 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/seven-days coverage and backup coverage when he or she is not available.

UnitedHealthcare Community Plan expects all care providers involved in the member's care to communicate with each other and work to coordinate the member's care; this includes communicating significant findings and recommendations for continuing care.

Females have direct access (without a referral or authorization) to any of our network 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 providers to ensure that all participants understand, support, and benefit from the primary care case management system.

10.2 Responsibilities of the Primary Care Provider

In addition to the requirements applicable to all providers, the responsibilities of the PCP include:

- Offer access to office visits on a timely basis, in conformance with the standards outlined in the Timeliness Standards for Appointment Scheduling section of this Guide.
- Conduct a baseline examination during the member's first appointment. This should include an Initial Health Assessment (IHA) within 120 days of enrollment, which consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). These enable the PCP to comprehensively assess the member's current acute, chronic, and preventive physical and behavioral health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered by the Medi-Cal managed care benefit.

  The member's PCP is responsible for completing the assessment with the member in accordance with the SHA Periodicity Schedule, providing counseling assistance and follow up pursuant to the requirements and MMCD PL 13-001. The care provider is responsible for documenting all components of the IHA or any applicable IHA exemption in the members medical record in a timely manner- pursuant to MMCD PL- 08-003.

  The Staying Healthy Assessment Policy Letter, forms, and provider training materials are found here: **dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx**
- For members younger than age of 21, the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment must be completed concurrently with the IHA. The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the member under 21 years of age is up-to-date. If conditions are identified that justify referral to a program such as CCS, Early Start or DDS, the PCP should perform appropriate baseline

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health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS eligible medical condition. The PCP shall collaborate with the local LEA or RC in the development of the IEP or IFSP to determine the appropriate strategies and services required based on the unique identified needs of the child .

- Cooperate and coordinate with the California Department of Social Services (CDSS) for the care of a child who is receiving services from, or has been placed in the conservatorship of, CDSS including complying with all provisions related to covered services, including Behavioral Health Services
- Provide basic and complex case management services in collaboration with the health plan. The PCP should identify member conditions and circumstances where referral to community resources is required to meet the needs of the member (e.g. referral to California Children's Services (CCS) and Regional Centers).
- Coordinate with UnitedHealthcare Community Plan case managers to ensure members have access to specialty mental health services covered under the County Mental Health plan.
- Treat general health care needs of members. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced on **UHCCommunityPlan.com**.
- Consult with other appropriate health care professionals to assess and develop individualized treatment plans for enrollees with special health care needs that include the use of person-centered planning concepts.

When a contracted PCP does not have admitting privileges at a hospital, patients should be referred to the hospitalist program for inpatient management. The PCP should maintain communication with the patient and family throughout the hospitalization and during the hospitalization, decisions regarding care, consultation, admission, transfer, and discharge should be the sole responsibility of the hospitalist care provider in consultation with the patient and, as appropriate, the patient's family care provider and/or family members. When the patient leaves the hospital, he or she will return to a PCP for follow-up and continuing care.

- Ensure the integration of clinical and non-clinical disciplines and services in the overall plan of care for special needs members that include the use of person-centered planning concepts.
- Take steps to encourage all members to receive all necessary and recommended preventive health procedures in accordance with the Agency for Healthcare Research and Quality, US Preventive Services Task Force Guide to Clinical Preventive Services, **ahcpr.gov/clinic/uspstfix.htm**.
- Make use of any member lists supplied by the Health Plan indicating which members appear to be due preventive health procedures or testing.
- Be sure to timely submit all accurately coded claims or encounters.
- For questions related to member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc., call Provider Services at 866-270-5785.
- Provide all well baby/well-child services.
- Screen members for behavioral health problems, using the Behavioral Health Toolkit for the Health Care Professional found on our website, **UHCCommunityPlan.com**. File the completed screening tool in the patient's medical record.
- Coordinate each member's overall course of care.
- Be available personally to accept UnitedHealthcare Community Plan members at each office location at least 16 hours a week.
- Be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating Primary Care Physician or an answering machine directing the member to a live voice.
- Respond to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for urgent situations.
- Educate members about appropriate use of emergency services.
- Discuss available treatment options and alternative courses of care with members.
- Refer services requiring prior authorization to the Prior Authorization Department, Behavioral Health Unit, or Pharmacy Department as appropriate.

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- Inform UnitedHealthcare Case Management at 866-270-5785 of any member showing signs of end stage renal disease.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized.
- Respect the Advance Directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan.
- Provide culturally competent care and services. All providers must have a cultural competency program designed to educate and train its staff on addressing cultural and linguistic barriers to the delivery of health care services to members of all cultures.
- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Copies of members' medical records must be provided to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
- Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Advise enrollees about the availability of substance use disorder services, including a list of Substance Use Disorder
- Clinics and contact information located in the counties served by UHC.
- Advise enrollees on the availability of long-term care services including availability of home and community based services.
- Participate in educational opportunities for primary care providers, such as those produced by the California State Department of Health Collaborative, the California State Medical Association or the California State Hospital Association, etc.
- Evaluate and ensure services furnished to individuals with special health care needs are appropriate to the enrollee's needs.
- Refer all pregnant members to the Healthy First Steps Maternity Case Management Program.

California Commercial Benefit Plans

As of July 1, 2016, California Senate Bill 137 requires us to perform ongoing updates to our care provider directories, both online and hardcopy. As a participating medical group, IPA or independent physician, you are required to update UnitedHealthcare within five business days if there are any changes to your ability to accept new patients.

As a participating medical group, IPA or independent physician, if an enrollee or potential enrollee seeking to become a patient contacts you, and you are no longer accepting new patients, you must direct them to report any inaccuracy in our provider directory to both:

- UnitedHealthcare for additional assistance in finding a care provider, and, as applicable,
- Either the California Department of Managed Health Care or the California Department of Insurance.
  You shall cooperate with and provide the necessary information to us so we meet the requirements of Senate Bill 137.

We are required to contact all participating care providers, including, but not limited to, contracted medical groups/IPAs, on an annual basis, and independent physicians, every six months. This outreach includes a summary of the information that we have on record. It requires you to respond by either confirming your information is accurate or providing 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 make attempts for you to verify the information. If these attempts are unsuccessful, we will notify you that if you continue to be nonresponsive we will remove you from our provider directory after 10 business days.

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If the final 10 business day period lapses with no response from you, we may remove you from the directory. If we receive notification that the provider directory information is inaccurate, the provider group/IPA or physician may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we are required to make outreach if the plan receives a report of inaccuracy for any provider data in the directories. The plan is required to confirm your information is correct.

To help ensure we have your most current provider directory information, medical groups/IPAs or independent physicians can submit applicable changes to:

- **For Delegated providers,** email your changes to Pacific_DelProv@uhc.com or delprov@uhc.com.
- **For Non-delegated providers,** visit UnitedHealthcareOnline.com for the Provider Demographic Change Submission Form and further instructions.

Staying Healthy Assessment

The PCP must conduct a baseline examination during the member's first appointment. This should include an Initial Health Assessment (IHA) within 120 days of enrollment, which consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). These enable the PCP to comprehensively assess the member's current acute, chronic, and preventive physical and behavioral health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered by the Medi-Cal managed care benefit. The member's PCP is responsible for completing the assessment with the member in accordance with the SHA Periodicity Schedule, providing counseling assistance, appropriate follow up and documenting any exemptions pursuant to the requirements and MMCD PL 13-001 and MMCD PL 08-003.

IHA Components and Requirements

PCPs are responsible for reviewing each member's SHA in combination with the following relevant information:

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

Components

The IHA consists of the following:

A. Comprehensive History – must be sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes but is not limited to the following:

  a. History of present illness

  b. Past medical history

    i. Prior major illnesses and injuries

    ii. Prior operations

    iii. Prior hospitalizations

    iv. Current medications

    v. Allergies

    vi. Age appropriate immunization status

    vii. Age appropriate feeding and dietary status

  c. Social history

    i. Marital status and living arrangements

    ii. Current employment

    iii. Occupational history

    iv. Use of alcohol, drugs and tobacco

    v. Level of education

    vi. Sexual history

    vii. Any other relevant social factors

    d. Review of organ systems

  d. Review of organ systems

B. Preventive services

  a. Asymptomatic health adults – must adhere to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counselling services. Status of current recommended services must be documented.

  b. Members under 21 years of age – must provide preventive services as specified by the most recent American Academy of Pediatrics age specific guidelines and periodicity schedule. Preventive visits must include age specific assessment and services

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required by the Child Health and Disability Prevention Program (CHDP). When examinations occur more frequently using the AAP periodicity schedule rather than on the CHDP examination schedule, the IHA must follow the AAP periodicity schedule and the scheduled assessments and services must include all content required by the CHDP for the lower age nearest to the current age of the child.

c. Perinatal services for pregnant for pregnant members must be provided according to the most current standards of guidelines of the American College of Obstetrics and Gynecology (ACOG). A DHCS approved comprehensive risk assessment tool for all pregnant members that is comparable to the ACOG standard and the Comprehensive Perinatal Services Program (CPSP) standards per Title 22, CCR, Section 51348 that includes an individualized care plan. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up with appropriate interventions and documented in the medical record.

C. Comprehensive Physical and Mental Status exam must be sufficient to assess and diagnose acute and chronic conditions.

D. Diagnoses and Plan of Care – the plan of care must include all follow up activities

E. Individual Health Education Behavioral Assessment (IHEBA)

a. IHEBA requirement – an age specific IHEBA must be administered as part of the IHA. Assessment tolls used to complete the IHEBA must be approved by the Medi-Cal Managed Care Division (MMCD) prior to use. Since the “Staying Healthy” assessment tool was developed for MMCD health plans, it may be used without prior approval by MMCD. Please see MMCD Policy Letter 99-07 or the most current IHEBA Policy Letter for specific requirements and a schedule for re-administering the behavioral assessment.

b. Exceptions for transferring members – the IHEBA requirement for members transferring from an outside group may be met if the medical record indicates that in IHEBA tool or a behavioral risk assessment has been completed within the last 12 months. The age specific and age appropriate behavioral risk assessment should address the following areas:

i. Diet and weight issues

ii. Dental care

iii. Domestic violence

iv. Drugs and alcohol

v. Exercise and sun exposure

vi. Medical care from other sources

vii. Mental health

viii. Pregnancy

ix. Birth control

x. STIs/STDs

xi. Sexuality

xii. Safety prevention

xiii. Tobacco use an exposure

Requirements

Who Can Perform the IHA

A. The member’s PCP of record

B. Perinatal Care Providers

C. Primary Care Providers

D. Non-Physician Mid-Level Practitioners

Timelines for the Provision of the IHA

A. New Plan Members – within 120 calendar days of enrollment

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

IHA Visit Settings – an IHA may be performed in settings other than ambulatory care for members who are continuously enrolled for 120 days as follows:

A. Nursing Facility

B. Home Visits

C. Hospitals

Staying Health Assessment (SHA) Periodicity Schedule - each member must complete a SHA in accordance with the following guidelines and timeframes prescribed below and in the table below. A member’s refusal to complete the SHA must be

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documented on the appropriate age-specific form and kept in the member's medical record.

A. **New members** must complete the SHA within 120 days of the effective date of enrollment as part of the IHA. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System (MEDS) that a member is eligible to receive services from the MCP.

B. **Current members** who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-baby, well-child, well-woman exam), according to the SHA periodicity table

C. **Pediatric Members**
Members 0–17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group

   Adolescents (12–17 years) should complete the SHA without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible to increase the likelihood of obtaining accurate responses to sensitive questions. The PCP will determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

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

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

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Table 1: SHA Periodicity

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

Counseling, Assistance and Follow up

A. The PCP must review the completed SHA with the member and initiate a discussion with the member regarding behavioral risks the member identified in the assessment. Clinic staff members, as appropriate, may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.

B. The PCP must prioritize each member's health education needs and initiate discussion and counseling regarding high-risk behaviors.

C. Based on the member's behavioral risks and willingness to make lifestyle changes, the PCP should provide tailored health education counseling, intervention, referral, and follow-up. Whenever possible, the PCP and the member should develop a mutually agreed-upon risk reduction plan.

D. The PCP must review the SHA with the member during the years between re-administration of a new SHA assessment. The review should include discussion, appropriate patient counseling, and regular follow-up regarding risk reduction plans.

SHA Documentation by PCP:

A. The PCP must sign, print his/her name, and date the "Clinic Use Only" section of a newly administered SHA to verify that it was reviewed and discussed with the member.

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

C. The PCP must sign, print his/her name, and date the "SHA Annual Review" section of the questionnaire to document that an annual review was completed and discussed with the member.

D. A member's refusal to complete the SHA must be documented on the age-appropriate SHA questionnaire by:

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a. Entering the member's name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire.

b. Checking the box "SHA Declined by Patient."

c. Having the PCP sign, print his or her name, and date the "Clinic Use Only" section of the SHA.

d. Keeping the SHA refusal in the member's medical record.

E. The PCP may make notations in the "Clinic Use Only" column to the right of the questions, but this is not required

Bright Futures Assessment
Providers may use the American Academy of Pediatrics Bright Futures assessment without prior approval from MMCD, as long as they notify MMCD at least one month before they begin using the Bright Futures assessment, and the following conditions are met:

A. The most current version of the Bright Futures assessment is used and administered according to Bright Futures guidelines.

B. The notification must include the method/process to be used to document and verify the administration of the assessment and follow-up.

C. MCPs must indicate which providers or provider groups will be using the Bright Futures assessment and for which age groups.

D. The Bright Futures assessment must be translated into the threshold languages of their members and made available to MCP providers.

Exceptions from IHA Requirements – exceptions to the timeline requirements can only occur in the following situations and only if documented in the medical record:

A. All elements completed within the 12 months prior to enrollment

B. New plan members who choose their current PCP; however, if the patient has not had a physical exam within 12 months of enrollment and updated physical exam must be conducted

C. Member is not continuously enrolled

D. Disenrolled members

E. Member refuses IHA

F. Missed Scheduled Appointments – after initial and two additional documented attempt to reschedule have been unsuccessful

Resources

Assessment Forms and Provider Training Documents
The Staying Healthy Assessment Policy Letter, forms, and provider training materials are found here: **dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx**

Reference: MMCD Policy Letters 08-003 and 13-001

Panel Roster

PCPs may print a monthly Primary Care Provider Panel Roster by visiting **UnitedHealthcareOnline.com**.

Sign in to **UnitedHealthcareOnline.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 the 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 providers to ensure that all participants understand, support, and benefit from the primary care case management system. The coverage shall include availability of 24 hours, seven days per week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP's nurse triage) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems. Recorded messages are not acceptable.

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Assignment to PCP Panel Roster

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at **UnitedHealthcareOnline.com**. The portal requires a unique user name and password combination to gain access.

Sign in to **UnitedHealthcareOnline.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.

Proactive Notification of Changes

If you have received the upgraded My Practice Profile on **Link** and have been granted editing rights by your ID administrator, you can use Link to make many of the updates required in this section.

Physician/Health Care Professional Verification Outreach

UnitedHealthcare Community Plan is committed to providing our members with the most accurate and up-to-date information about our network. We are currently undertaking an initiative to improve our data quality. This initiative is called Professional Verification Outreach (PVO).

Your office may receive a call from us asking to verify your data currently on file in our care provider database. This information is confidential and is immediately updated in our database.

Provide Official Notice

You must send notice to us at the address noted in your agreement with us and delivered by the method required, within 10 calendar days of your knowledge of the occurrence of any of the following:

- Material changes to, cancellation or termination of liability insurance
- Bankruptcy or insolvency
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice. For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility
- Relocation or closing of your practice, and, if applicable, transfer of member records to another physician/facility.

Provide Timely Notice of Demographic Changes

PCPs are responsible for monitoring your office capacity based on member assignments and for notifying us if you have reached your maximum capacity. A self reporting tool is available for you to generate a PCP panel roster report at **UnitedHealthcareOnline.com** > Tools & Resources > Reports.

Notification of Changes Must be Proactive

You or an entity delegated to conduct credentialing activities on behalf of UnitedHealthcare (a “delegate”) are expected to review, update care provider records and attest to the information available to our members, including the information listed here, at least quarterly. If you or the delegate cannot attest to the information, you or the delegate must supply corrections to UnitedHealthcare online or through the Provider Service Center. At least 30 calendar days before the change is effective, you or the delegate must notify us of changes to all care provider information. This includes adding new information and removing outdated information, as well as updating the paragraph. Delegates are responsible for notifying us of these changes for all of the participating providers credentialed by the delegate.

You and the delegates are required to update all care provider information, including but not limited to the following:

- The status as to whether the participating care provider is accepting new patients or not
- The address(es) of the office locations where the participating care provider currently practices
- The phone number(s) of the office locations where the participating care provider currently practices
- The email address of the participating care provider
- Whether or not the participating care provider is still affiliated with listed care provider groups
- The hospital affiliation(s) of the participating care provider
- The specialty of the participating care provider
- The license(s) of the participating care provider

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- The tax identification number used by the participating care provider
- The NPI(s) of the participating care provider
- The languages spoken/written by the participating care provider or the staff
- The ages/genders served by the participating care provider
- Office hours
- In the event of a departure of health care providers from your practice, we ask that you notify us immediately to allow sufficient time for member notification.

To Change Status of Panel (Open/Closed)

If you wish to change your panel status (i.e., open to new patients, open to existing patients only, or closed), the request must be made in writing 30 days in advance and state that the change applies to all patients for all products, not only UnitedHealthcare Community Plan members. We may notify you in writing of changes in our panel status including closures based on state and/or federal requirements, current market dynamics and patient quality indicators. You can update your panel status online using the upgraded My Practice Profile on Link.

To change an Existing TIN or to add a Physician or Health Care Provider

To submit the change, please complete and fax the Provider Demographic Change Form to the appropriate fax number listed on the bottom of the fax form.

The Provider Demographic Change Form is available at **UnitedHealthcareOnline.com** > Tools & Resources > Forms. Alternatively, submit detailed information about the change and the effective date of the change on your office letterhead. This information can be faxed to the fax number on the bottom of the demographic change request form.

To Update Your Practice or Facility Information

As a registered health care provider, you can make all other updates to your practice information by :

1. Signing in to **UnitedHealthcareOnline.com** > Practice/ Facility Profile found on the global navigation at the top of any web page.
2. Submit your change by: completing the *Provider Demographic Change Form* and emailing the form to the appropriate email address listed on the bottom of the form; or
3. Calling our Enterprise Voice Portal at **877-842-3210.**

Administrative Terminations for Inactivity

We are committed to working with physicians and other health care providers to keep our network information and directories up to date. Up to date directories are a critical element of providing our members with the information they need to manage their health. In an effort to provide more accurate and up-to-date directories reflecting providers in our network who are actively treating our members, we began:

- Administratively terminating provider agreements for care providers who had not submitted claims for a period of one year on the basis that they are not actively treating UnitedHealthcare Community Plan members, and have voluntarily ceased participation in our Network, and
- Inactivating any TIN under which there have been no claims submitted for a period of one year on the basis that they are not in active use.

When physicians, other health care providers and practice administrators inform UnitedHealthcare Community Plan of practitioners leaving a practice, we make multiple attempts to obtain documentation of that change. Effective April 1, 2017, we will also begin to administratively terminate a care provider if:

- We receive oral notification that a practitioner is no longer with the practice, and
- No documentation confirming the practitioner's departure is obtained from the practice after three attempts, and
- The practitioner has not submitted claims under that practice's TIN(s) for a period of six months prior to our receipt of oral notification that the practitioner left the practice or the effective date of departure provided to us, whichever is sooner.

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10.3 Responsibilities of Specialist Care Providers

In addition to the requirements applicable to all providers, the responsibilities of specialist care providers include:

- Provide specialty care medical services to UnitedHealthcare members recommended by the member's PCP or who self-refer.
- Evaluate and ensure services furnished to individuals with special health care needs are appropriate to the enrollee's needs.
- Be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another network specialist care provider or an answering machine or voicemail service directing the member to a live voice.
- Provide the PCP copies of all medical information, reports, and discharge summaries resulting from the specialist's care.
- Communicate in writing to the PCP all findings and recommendations for continuing patient care and note them in the patient's medical record.
- Coordinate with UnitedHealthcare Community Plan case managers to help ensure members have access to specialty mental health services covered under the County Mental Health plan.
- Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital.

If inpatient admission is necessary to a hospital where the specialist care provider does not have admitting privileges, patients should be referred to the hospitalist program for inpatient admission and management. The specialist care provider should maintain communication with the hospitalist and consulting care providers throughout the hospitalization. When the patient leaves the hospital, he or she may return to the local specialty care provider for follow-up and continuing care as appropriate.

- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- Advise enrollees about the availability of substance use disorder services, including a list of Substance Use Disorder Clinics and contact information located in the counties served by UHC. Advise enrollees on the availability of long-term care services including availability of home and community based services.
- Evaluate and ensure services furnished to individuals with special health care needs are appropriate to the enrollee's needs.

Medical Residents in Specialty Practice

Specialists may use medical residents in specialty care in all settings supervised by fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

24-Hours, Seven-Days-a-Week Coverage

PCPs and obstetricians must be available to members by phone anytime or have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. A Medical Director or Physician Reviewer must approve coverage arrangements that vary from this requirement. PCPs and obstetricians are expected to respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Standard
Urgent care w/ no prior auth within 48 hours
Urgent care w/ prior auth within 96 hours
Non-urgent PCP visits within 10 business days
Non-Urgent Specialist within 15 business days
Non-urgent mental health within 10 business days
Non-urgent ancillary services within 15 business days
Urgent care w/ no prior auth within 48 hours
Urgent care w/ prior auth within 96 hours
Non-urgent PCP visits within 10 business days
Non-Urgent Specialist within 15 business days
Non-urgent mental health within 10 business days
Non-urgent ancillary services within 15 business days

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UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for 24/7 after-hours access. PCPs and obstetricians are required to participate in all activities related to these surveys.

10.4 Timeliness Standards for Appointment Scheduling

You should comply with the following appointment availability standards:

- UnitedHealthcare Community Plan of California, Inc. reports the rate of compliance separately for each of the time elapsed standards for each contracted provider group located in its service area by county in its Timely Access Annual Report filed with the DMHC.

*UnitedHealthcare Community Plan of California, Inc.'s current service area consists of one county, which is San Diego and Sacramento counties.
**Additional Provider Groups are added as needed.

10.5 Timeliness Standards for Notifying Members of Test Results

You should notify members of laboratory or radiology test results within 24 hours of receipt of results in urgent or emergent cases. You should notify members of non-urgent, non-emergent laboratory and radiology test results within 10 business days of receipt of results.

10.6 Allowable Office Waiting Times

Members with appointments should not routinely be made to wait longer than 30 minutes.

10.7 Provider Office Standards

UnitedHealthcare Community Plan requires a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards. Financial incentives for completing physical improvements to meet ADA accessibility standards are available to providers that qualify as small businesses (up to 30 FT employees or less than $1 million gross revenue). Tax credits are available for "access expenditures" ranging from $250 to $10,250 and tax deductions are available up to $15,000 per year for expenses associated with the removal of barriers. Provider Relations Representatives may conduct periodic site visits to identify PCP offices that meet ADA standards. If a PCP is planning to relocate an office, a Provider Relations Representative may perform a site visit before care can be rendered at the new location.

10.8 Language Assistance/Interpreter Services

We provide oral interpreter services 24 hours a day, seven days a week to our members free of charge. Services for over 240 non-English languages and services for the hearing impaired are available. If a UnitedHealthcare Community Plan member needs Interpreter Services, we prefer you use a professional interpreter. To access a professional interpreter during regular business hours, contact the Provider Call Center at 866-270-5785. After hours, you may contact 877-261-6608 and enter the Client ID 209677 (do not hit #). Press 1 for Spanish and 2 for all other languages.

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10.9 Medical Record Charting Standards

All participating UnitedHealthcare Community Plan care providers are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. As part of this process, you are required to participate in UnitedHealthcare Community Plan's quality review of medical records and meet the following requirements for medical record keeping.

Confidentiality	• The office has a policy & procedure in place that addresses the confidentiality of the patient medical record • Office staff receive initial and periodic training in maintaining the confidentiality of patient records • Medical records are released only to the patient and/or entities as designated in accordance with HIPAA regulations • Medical records are stored in a manner that ensures patient confidentiality. Records are kept in a secure area which is only accessible to authorized personnel
Organization	• Medical records are filed in a manner in which they are easily retrievable • Medical records are readily available to the treating care provider whenever the patient is seen at the site where they generally receive care • Medical records are sent promptly to specialty providers upon patient request. For urgent issues, records are made available within 48 hrs. • There is a policy for medical record retention • The contents of medical records must be organized in such a manner that reports, problem lists, immunization records, etc. are easily retrievable and are located in the same area in each record • There is one medical record per patient • Pages in the medical record are secure
Medical Record Documentation Standards	• The chart is legible • The chart contains at a minimum the following patient identifiers: name, sex, address, phone # and DOB • The patient name/ID # is located on each page of the medical record • Each entry is dated and signed by the treating provider(s) • An initial history & physical is present • Documentation of the presence or absence of allergies or adverse reactions is clearly noted • Screenings for high risk behaviors such as drug, alcohol and tobacco use are present • Screening for behavioral health issues including depression • Documentation of the presence or absence of an executed Advanced Directive

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Medical Record Documentation Standards (continued)	• An updated Problem List includes medical and psychological conditions • A Medication List includes current and past meds • Progress notes from each visit that document the reason for the visit, the physical findings, the diagnosis, and treatment plan • Documentation of need for follow-up visits • Documentation of member input and/or understanding of the treatment plan • Documentation that reflects compliance with EPSDT standards for all pediatric patients • Maintenance of a current immunization record for all pediatric patients • Tracking and referral for age appropriate preventive health screenings such as mammography, pap smears, colorectal screen and flu shots are noted • Appropriate use of lab testing (HBA1c, LDL, lead screen) • Results of lab, x-ray, and other tests as ordered by the provider including indication of care provider review • Notation of treating specialists (including behavioral health) as well as copies of consultant reports ordered by the provider • Continuity of care demonstrated by evidence of copies of Home Health Nursing reports, Hospital Discharge summaries, Emergency Room visits, and physical or other therapies as ordered by the provider • Use of Clinical Practice Guidelines or flowsheets for the management of chronic conditions (diabetes, asthma, etc.) • Mechanism for tracking and management of no shows
HIV/AIDS	• You are required to submit completed reportable disease reports for HIV and AIDS, as described in the California Code of Regulations, Title 17, Section 2465. • We recommend that you have procedures for documenting HIV status in the medical records that ensure member's confidentiality in compliance with state law. • We also recommend that you implement state compliant HIV screening protocols regarding obtaining consent for confidential testing, and obtaining consent for disclosure of HIV test results.

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Screening and Documentation Tools

Most of these tools were developed by UnitedHealthcare Community Plan with assistance from the Provider Affairs Subcommittee to help you comply with regulatory requirements and practice in accordance with accepted standards.

10.10 Medical Record Review

On a routine basis, UnitedHealthcare Community Plan will conduct a review of the medical records you maintain for our members. You are expected to achieve a passing score of 85% or better. Medical Records should include:

- Initial health assessment, including a baseline comprehensive medical history, which should be completed in less than two (2) visits and documented, and ongoing physical assessments documented on each subsequent visit.
- Problem list, includes the following documented data:
  - Biographical data, including family history
  - Past and present medical and surgical intervention
  - Significant illnesses and medical conditions with dates 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 are prominently noted. Also note if there are no known allergies or adverse reactions.
- Past medical history is easily identified and includes serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years or younger), past history relates to prenatal care, birth, operations and childhood illnesses.
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record
- Document tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of Advance Directive, or other document as allowed by state law, or a notation that patient 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 findings
- Lab and other studies as appropriate
- Patient education, counseling and/or coordination of care with other care providers or health care professionals
- Notation regarding the date of return visit or other needed follow-up care for each encounter
- Consultations, lab, imaging and special studies initialed by primary care provider to indicate review
- Consultation and abnormal studies including follow-up plans

Patient 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)

10.11 Advance Directives

Members have the right to make health care decisions for themselves, including the right to accept or refuse treatment and to execute an advance directive. An advance directive is a written instruction, such as a living will or a durable power of attorney for health care, that is recognized under state law and relates to the provision of health care when an individual is incapacitated. There may be several types of advance directives available to a member. You must comply with state law requirements regarding advance directives in the state(s) in which they practice.

Members are not required to have an advance directive and a provider cannot condition the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. Providers should document in a member's medical record whether or not the member has executed an advance directive. If a member does have an advance directive, a copy of it should be maintained in the member's medical record. The member (or the member's

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designee) should keep the original. Providers should 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, the member may file a complaint with the UnitedHealthcare Medical Director, the UnitedHealthcare Physician Reviewer, and/or the state survey and certification agency.

10.12 Protect Confidentiality of Member Data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members' health care experience. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records. You will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of member medical information. You agree specifically to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations, in addition to the applicable state laws and regulations. UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes policies and procedures governing administrative and technical safeguards of protected health information. Training is provided to all personnel on an annual basis and to all new employees within the first 30 days of employment.

10.13 Requirements for Morbidity Surveillance and Reporting

You are required to adhere to Title 17 California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions. These reporting requirements are available at **cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf**. Treatment plans, or other clinical information may be requested, You will need to cooperate with the treatment plan developed by the Local Health Department. Regular updates must be provided to the Local Health Department until treatment is completed. For members with known or suspected Tuberculosis (TB), referrals to the Direct Observation Therapy (DOT) program will be made as applicable.

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

Health Department Communicable Disease Contact Information:

Sacramento County
7001 A East Parkway, Suite 600
Sacramento, CA 95823
916-875-4069
916-875-5881
dhhs.saccounty.net

San Diego County
3851 Rosecrans St.
San Diego, CA 92110
Sexually Transmitted Disease (STD): 619-692-8541
TB: 619-692-5516
Epidemiology (Epi): 858-715-6458
stdsandiego.com
sdepi.org

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Chapter 11: Care Provider Communications and Outreach

The UnitedHealthcare Community Plan care provider education and training program is built on 27 years of experience with care providers and multi-state managed care programs and includes the following care provider training components:

- Website
- Forums/town hall meetings
- Office visits
- Newsletters and bulletins
- Manual

11.1 Care Provider Website

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. **UHCCommunityPlan.com** facilitates provider communications pertaining to administrative functions. Our interactive website enables providers to electronically determine member eligibility, submit claims, and ascertain the status of claims. UnitedHealthcare Community Plan has implemented an internet-based prior authorization system on **UHCCommunityPlan.com**, which allows providers who have internet access the ability to request their medical prior authorizations online rather than telephonically. The website also contains an online version of the Provider Administrative Guide, the Provider Directory, the Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements and educational materials such as newsletters, recent fax service bulletins and other provider information. UnitedHealthcare Community Plan also posts notifications regarding changes in laws, regulations and subcontract requirements to the portal.

A website is also available to members including access to the Member Handbook, newsletters, provider search tool and other important plan bulletins.

DHCS Provider Manual
files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

DHCS Managed Care
dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

11.2 Provider Office Visits

Care Provider Advocates visit primary care providers (PCP), specialist and ancillary provider offices on a regular basis. Each Care Provider Advocate is assigned to a geographic territory to deliver face-to-face support to our providers across the state. The prioritization and quantity of provider office visits by these staff is determined based on a variety of demographic factors, including size of member population, special cultural/linguistic needs, geography, and other special needs. Our primary reasons for face-to-face office visits are to create program awareness, promote program compliance, and minimize health care disparities.

11.3 Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces and distributes Practice Matters, a provider newsletter to the entire California network published four times a year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives, and other articles regarding health topics of importance. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements. UnitedHealthcare Community Plan uses electronic bulletins, posted on the **UHCCommunityPlan.com** website, to rapidly disseminate urgent information that impacts the entire network.

11.4 Provider Administrative Guide

UnitedHealthcare Community Plan publishes this guide online, which includes an overview of the program, toll free number to our provider services hotline, a removable quick reference guide, and a list of additional provider resources and incentives. Care providers without Internet access may request a hard copy of this guide by contacting your provider advocate.

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11.5 Provider Training Topics

- Mission/Vision
- Overview of UnitedHealthcare Community Plan of California/Medi-Cal
- Member Eligibility and Benefits
- Notification and Prior Authorization
- Pharmacy Services
- Doing Business with Us
- Care Provider Resources
- Your Physician Advocate

Additional information is available for you at **UHCCommunityPlan.com**

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Chapter 12: Glossary/Index of Terms

Action – The denial or limited authorization of a requested service, including the type, level or 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 contract.

Failure of the Contractor to act within the time frames for disposition, resolution, and notification of appeals and grievances, or for a rural area resident with only one managed care plan available, the denial of a member's request to receive services from outside the plan's contracted network:

1. From any other provider (in terms of training, experience, and specialization) not available within the network;
2. From an out of network provider that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating providers within 60 calendar days;
3. Because the only provider available does not provide the service because of moral or religious objections;
4. Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available with the contracted network;

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the provider

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term "ambulatory care" usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal – An oral or written request by a member or member's personal representative received by UnitedHealthcare Community Plan for review of an action.

- A health insurance program for eligible Medicaid recipients under Title XIX of the SSA. Healthy Options is now managed care coverage in California " to the end of the definition

Authorization – Approval obtained by providers from UnitedHealthcare Community Plan for a designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

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Behavioral Health Treatment - Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

- The treatment is prescribed by a licensed participating care provider of the California Business and Professions Code or developed by a licensed participating psychologist
- The treatment is provided under a treatment plan prescribed by a participating Qualified Autism Service Provider and is administered by one of the following:
  - A participating Qualified Autism Service Provider
  - A participating Qualified Autism Service Professional supervised and employed by the participating Qualified Autism Service Provider
  - A participating Qualified Autism Service Paraprofessional supervised and employed by a participating Qualified Autism Service Provider
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the participating Qualified Autism Service Provider does all of the following:
  - Describes the Member's behavioral health impairments to be treated
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to Optum upon request.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

Clean Claim - A claim that has no defect, impropriety (including lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction by a provider.

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Core Provider Agreement – A basic contract that HCA holds with medical providers serving HCA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare Community Plan.

Current Procedural Terminology (CPT) Codes – American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers' offices, and home health care.

Denied Claims Review – The process for providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a provider.

Dual Coverage – When a member is enrolled with two UnitedHealthcare Community Plan plans at the same time.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

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). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Emergency Care – The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

Expedited Appeal – An oral or written request by a member or member's personal representative received by UnitedHealthcare Community Plan requesting an expedited reconsideration of an action 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 would jeopardize the member's life or materially jeopardize the member's health.

Fee-For-Service (FFS) – FFS is a term UnitedHealthcare Community Plan uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member. FFS is also the term HCA uses when a client, not (managed care) eligible, is able to go to any medical provider who will accept the MAID card.

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Grievance – An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan.

Health Plan Employer Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

Hearing – An outside hearing conducted by the Office of Administrative Hearings available to all HO members. The member presents their appeal to an Administrative Law Judge. This is available only to HO members after accessing UnitedHealthcare Community Plan's appeal process.

HIPAA – Health Insurance Portability and Accountability Act

Independent Practice Association (IPA) – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.

Medically Necessary Services – Services reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more
conservative or substantially less costly course of treatment available or suitable for the member requesting the service. Course of treatment may include mere observation or, where appropriate, no treatment at all. Medically necessary services include, but not be limited to, diagnostic, therapeutic, and preventive services generally and customarily provided in the service area.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

A. Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
B. Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous member of UnitedHealthcare Community Plan.

NCQA – National Committee for Quality Assurance

Participating Provider – A provider that has a written agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their agreement.

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Provider Group – A partnership, association, corporation, or other group of providers.
Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating provider responsible for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to; pediatricians, family providers, general providers, internists, naturopaths,
provider assistants (under the supervision of a provider), or advanced registered nurse practitioners (ARNP), as designated by UnitedHealthcare Community Plan.

Qualified Autism Service Provider - is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervised or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervised, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee

Qualified Autism Service Professional - An individual who meets all of the following criteria:

- Provides Behavioral Health Treatment
- Is employed and supervised by a Qualified Autism Service Provider
- Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code

Qualified Autism Service Paraprofessional - An unlicensed and uncertified individual who meets all of the following criteria:

- Is employed and supervised by a Qualified Autism Service Provider
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
- Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non- clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.

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Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled members.

Service Area – A geographic area serviced by UnitedHealthcare Community Plan, designated and approved by HCA.

Specialist – Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

Sub-Contract – A written agreement between a health plan and a participating provider, or between a participating provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

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 will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for SCHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning and case management.

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