2018
Care Provider Manual

2018 Physician, Health Care Professional, Facility and Ancillary Care Provider Manual for Long-Term Care and Medical Assistance

Florida

UnitedHealthcare®
Community Plan

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Welcome

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

If you have questions about the information or material in this manual, or about any of our policies or procedures, call Medical Assistance (MMA) Provider Services at **877-842-3210** or Long-Term Care (LTC) Provider Services at **800-791-9233**.

CLICK THE FOLLOWING LINKS TO ACCESS DIFFERENT MANUALS:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to **UHCprovider.com**. Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

EASILY FIND INFORMATION IN THIS MANUAL USING THE FOLLOWING STEPS:

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

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

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

Important Information about the Use of This Manual

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

This manual will be amended as policies change.

PARTICIPATION AGREEMENT

In this manual, we refer to your Participation Agreement as “Agreement”.

LONG-TERM CARE AND MEDICAL ASSISTANCE

All content within this manual applies to both Long-Term Care (LTC) and Medical Assistance (MMA) unless otherwise noted.

Table of Contents

Chapter 1: Introduction

Florida Medicaid

The Medicaid program provides medical coverage to low-income individuals and families. The state and federal government share the cost of the Medicaid Program.

The Agency for Health Care Administration administers Medicaid services in Florida. Either the Department of Children and Families (DCF) or the Social Security Administration (for SSI recipients) determines member eligibility.

DCF determines Medicaid eligibility for:

- Parents and caretakers relatives of children
- Children
- Pregnant women
- Former foster care individuals
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving Supplemental Security Income (SSI)

Medicaid Managed Care Program

Florida has offered Medicaid services since 1970. Medicaid provides health care coverage for eligible children, seniors, disabled adults and pregnant women. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid Managed Care (SMMC) and includes two programs: one for medical assistance (MMA) and one for long-term care (LTC). Only members who meet eligibility requirements and are living in a region with authorized managed care plans are eligible to enroll and receive services. UnitedHealthcare Community Plan serves members in the following regions:

Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union.

Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia.

Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk.

Region 11: Miami-Dade and Monroe.

Our Approach to Health Care

WHOLE PERSON CARE MODEL

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

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

- Market-specific care management encompassing medical, behavioral and social care.
- Extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.

- Field-based interventions engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plan.
- Assistance with appointments with PCP and coordinating appointments. The CHA refers members to an RN, BHA or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The goals of the WPC program are to:

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

Care Provider Resources

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

Referring Your Patient

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Member Services at **800-587-5187**, TTY 711. You may also call Provider Services at **877-842-3210** for MMA or **800-791-9233** for LTC.

SECURE CARE PROVIDER WEBSITE

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

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

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limit.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box on **UHCprovider.com**, and the search results will display all documents and/or web pages containing that code.
- Find certain web pages more quickly using direct URLs. You'll see changes in the way we direct you to specific web pages on our **UHCprovider.com** provider portal. You can now use certain direct URLs, which helps you find and remember specific web pages easily and quickly. You can access our most used and popular web pages on

UHCprovider.com by typing in that page's direct URL identified by a forward slash in the web address, e.g. **UHCprovider.com/claims**. When you see that forward slash in our web links, you can copy the direct URL into your web page address bar to quickly access that page.

PROVIDER SERVICES

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

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

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

NETWORK MANAGEMENT DEPARTMENT

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

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

CULTURAL COMPETENCY RESOURCES

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. You must help UnitedHealthcare Community Plan meet this obligation for our members.

For more information about the Cultural Competency Plan, go to UHCCommunityPlan.com. You may request a copy by calling 800-791-9233 for LTC or 877-842-3210 for MMA.

CARE PROVIDER PRIVILEGES

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

DIRECT CONNECT

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

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.
- Avoid duplicate recoupment and returned checks.
- Decrease resolution timeframes.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

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

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

COMPLIANCE

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

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care Guidelines) for care determinations.

How to Contact Us

Topic	MMA	LTC	Contact	Information
Benefits	877-842-3210	800-791-9233	**UHCprovider.com/benefits**	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization	877-842-3210	800-791-9233	For prior authorization or a current list of CPT codes that require prior authorization, visit **UHCprovider.com/cardiology**. Click Menu on top left, select Prior Authorization and Notification, then Cardiology	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements.
Chiropractic/ Acupunture and Massage Therapy	877-842-3210	800-791-9233	For a list of par providers, use **UHCprovider.com**. Optum provider credentialing/ contracting questions: **myoptumhealthphysicalhealth.com**. 800-873-4575	This benefit requires prior authorization.
Claims	877-842-3210	800-791-9233	Use the Link Provider Portal at **UHCprovider.com/claims** Mailing address: **UnitedHealthcare Community Plan** P.O. Box 31362 Salt Lake City, UT 84131-0362 For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	Ask about a claim status or about proper completion or submission of claims.
Behavioral Claim Disputes			**providerexpress.com** 866-673-6315	Ask about behavioral claim disputes.

Topic	MMA	LTC	Contact	Information
Claim Overpayments	877-842-3210	800-791-9233	See the Overpayment section for requirements before sending your request. Sign in to **UHCprovider.com/claims** to access Link, then select the UnitedHealthcare Online app Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments.
Electronic Data Intake Claim Issues			**ac_edi_ops@uhc.com** 800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues			800-842-1109	Information is also available at **UHCprovider.com/edi**.
Eligibility	877-842-3210	800-791-9233	To access the app, sign in to **UHCprovider.com/eligibility** to access Link, then select the UnitedHealthcare Online app	Confirm member eligibility.
Enterprise Voice Portal			877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud and Abuse			800-455-4521 or 877-401-9430	Notify us of suspected fraud or abuse by a care provider or member.
Healthy First Steps/Obstetrics (OB) Referral			800-599-5985	Refer high-risk OB members. Fax initial prenatal visit form.
LabCorp for Providers			800-833-3984	LabCorp is the preferred lab provider.
Medicaid [Department of Social Services]			**Medicaid.gov** 866-762-2237	Contact Medicaid directly.

Topic	MMA	LTC	Contact	Information
Medical Claim Disputes	877-842-3210	800-791-9233	Sign in to **UHCprovider.com/claims** to access Link, then select the UnitedHealthcare Online app Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 31362 Salt Lake City, UT 84131-0362 Appeals mailing address: **Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	888-716-8787	800-791-9233		Assist members with issues or concerns. Available 7 a.m. – 7 p.m. Central Time, Monday through Friday.
Mental Health & Substance Abuse (Behavioral Health)	888-716-8787	800-791-9233		Refer members for behavioral health services. (A PCP referral is not required.)
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	877-842-3210	800-791-9233	TDD 711	Available 8 a.m. – 5 p.m. Central Time, Monday through Friday, except state-designated holidays.
National Credentialing Center (VETTS line)			877-842-3210	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)			**nppes.cms.hhs.gov** 800-465-3203	Apply for a National Provider Identifier (NPI).
Network Management Team	877-842-3210	800-791-9233		Ask about contracting and care provider services.

Topic	MMA	LTC	Contact	Information
NurseLine			866-351-6827	Available 24 hours a day, seven days a week.
Obstetrics and Baby Care			Healthy First Steps 800-599-5985 Fax: 877-353-6913 Pregnancy Notification Form **Prenatal risk assessment form** **UHCBabyBlocks.com**	Links for pregnant moms and newborn babies.
Optum Support Center			**LinkSupport@optum.com** 855-819-5909	Available 7 a.m. – 9 p.m. Central Time, Monday through Friday; 6 a.m. – 6 p.m. Central Time, Saturday; and 9 a.m. – 6 p.m. Central Time, Sunday.
Pharmacy Services			**professionals.optumrx.com** 877-305-8952 (OptumRx)	OptumRx oversees and manages our network pharmacies.
Physical/ Occupational/ Speech Therapy	(managed by Optum) 800-873-4575	800-791-9233	For a list of par providers, use **UHCprovider.com**. Optum provider credentialing/ contracting questions: **myoptumhealthphysicalhealth.com**.	This benefit requires prior authorization.
Prior Authorization/ Notification for Pharmacy			**UHCprovider.com/priorauth** 800-310-6826 Fax: 866-940-7328	Request authorization for medications as required. For LTC HCBS Services: The care manager coordinates all services and authorizations based on the plan of care.
Prior Authorization/ Notification of Health Services			**UHCCommunityPlan.com** 866-604-3267 Fax: 866-622-1428	Request authorization/notify of the procedures and services outline in the prior authorization/notification requirements section of this manual. Complete and current list of prior authorizations.
Provider Services	877-842-3210	800-791-9233	**UHCprovider.com/FLcommunityplan**	Available 7 a.m. – 5 p.m. Central Time, Monday through Friday.

Topic	MMA	LTC	Contact	Information
Radiology Prior Authorization			UHCprovider.com/priorauth 866-889-8054 Fax: 866-607-5975	Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements. Complete and current list of prior authorizations.
Referrals	877-842-3210	800-791-9233	UHCprovider.com > Click Menu on top right, then select Referrals or use LINK	
Tobacco Free Quit Line			800-784-8669	Ask about services for quitting tobacco/ smoking.
Transportation			National Med Trans 844-525-3092	Call to schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance.
Utilization Management	888-716-8787 TTY 711	800-791-9233 TTY 711		UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program.
Vaccines for Children (VFC) program			800-483-2543	Care providers must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.
Vision Services	888-716-8787 TTY 711	800-791-9233 TTY 711		Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from 20/20.

Topic	MMA	LTC	Contact	Information
Whole Person Care Person-Centered Care Model (Care Management/ Disease Management)	877-842-3210	800-791-9233	Florida_CareManagement@uhc.com	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Website for Florida Community Plan			UHCprovider.com/FLcommunityplan	Access your state specific community plan information on this website.

Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

NON-DISCRIMINATION

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

COMMUNICATION BETWEEN CARE PROVIDERS AND MEMBERS

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

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

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

PROVIDE OFFICIAL NOTICE

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

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

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

TRANSITION MEMBER CARE FOLLOWING TERMINATION OF YOUR PARTICIPATION

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

ARRANGE SUBSTITUTE COVERAGE

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

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

ADMINISTRATIVE TERMINATIONS FOR INACTIVITY

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

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

CHANGING AN EXISTING TIN OR ADDING A HEALTH CARE PROVIDER

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

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

UPDATING YOUR PRACTICE OR FACILITY INFORMATION

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

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

AFTER-HOURS CARE (MMA ONLY)

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

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

AFTER-HOURS CARE (LTC ONLY)

The managed care plan provides members with HCBS based on their needs. HCBS is available on a daily basis or for extended hours. When an unexpected gap in in-home HCBS occurs, the plan helps ensure in-home HCBS services are provided within three hours of when the gap is reported.

PARTICIPATE IN QUALITY INITIATIVES

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

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by United States government agencies and professional specialty societies. See Chapter 10 for more details on the initiatives.

PROVIDE ACCESS TO YOUR RECORDS

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 15 years or longer if required by applicable statutes or regulations.

PERFORMANCE DATA

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

COMPLY WITH PROTOCOLS

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

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

OFFICE HOURS

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

PROTECT CONFIDENTIALITY OF MEMBER DATA

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

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

FOLLOW MEDICAL RECORD STANDARDS

Please reference Chapter 9 for Medical Record Standards.

INFORM MEMBERS

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

Appointment Standards (Florida DCF Access and Availability Standards)

Comply with the following appointment availability standards:

PRIMARY CARE

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 30 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

SPECIALTY CARE

Specialists should arrange appointments for:

- Routine appointment type: within 30 working days of request/referral

PRENATAL CARE

Prenatal care providers should arrange OB/GYN appointments for:

- First and second trimester: within seven calendar days of request
- Third trimester: within three days of request
- High-risk: within three calendar days of identification of high risk

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

Care Provider Directory

You are required to tell us, within five business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

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

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

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

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

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

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

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

PROVIDER ATTESTATION

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

Prior Authorization Request

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

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

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

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

Identify and bill other insurance carriers when appropriate.

If you have questions, please call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 3, 7 a.m. – 9 p.m. Central Time, Monday through Friday.

Timeliness Standards for Notifying Members of Test Results

After receiving results, notify members within:

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

Requirements for PCP and Specialists Serving in PCP Role

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.

- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by telephone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.

HCBS Critical Incident Reporting and Management

HCBS providers must report critical incidents according to the managed care plan's requirements within 24 hours of the incident. The managed care plan does not require nursing facilities or ALFs to report critical incidents or provide incident reports. Critical incidents that happen in nursing facilities and ALFs are handled based on Florida law. This includes but is not limited to ss. 400.147 and 429.23, F.S., and Chapters 39 and 415, F.S.

Reporting includes allegations of:

- Abuse (physical, sexual or mental);
- Exploitation, including financial exploitation;
- Neglect;
- Injury, serious illness or death of an individual that occurs within the agency's programs when abuse or neglect is suspected;
- Involvement with law enforcement;
- Potential elopement/missing person;
- Major medication incidents; and
- Any of the Code 15 Reportable events.

Failure to report adverse/critical incidents is subject to disciplinary action in accordance to established UnitedHealthcare Community Plan policy.

Members' quality of care issues (QOC), including those related to adverse events/critical incidents must be reported to and a resolution coordinated with UnitedHealthcare Community Plan's Quality Management Department, according to the established policy (QM-006).

Responsibilities of PCPs and Specialists Serving in PCP Role

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

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
  - Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
  - Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
  - Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.

- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the Florida DCF Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Rural Health Clinic, Federally Qualified Health Center or Primary Care Clinic as PCP

Members may choose a Rural Health Clinic (RHC), a Federally Qualified Health Center (FQHC) or a Primary Care Clinic (PCC) as their PCP.

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

Primary Care Provider Checklist

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

- Verify eligibility using Link at **UHCprovider.com/eligibility** or by calling Provider Services.
- Verify member identity with photo identification, if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth** to locate and view the current prior authorization information and notification requirements.
- Refer to UnitedHealthcare Community Plan participating specialists unless we authorize otherwise.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form. See Chapter 11 for more information on submitting forms.

Specialist Care Providers Responsibilities

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

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care.
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.

- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the Florida DCF Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

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

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

Prenatal Care Responsibilities

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

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

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

An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory.

Ancillary Care Provider Responsibilities

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

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

Ancillary Care Provider Checklist

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

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

Chapter 3: Care Provider Office Procedures and Member Benefits

Assignment to PCP Panel Roster

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

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

Sign in to **UHCprovider.com** > select Link > select 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.

Choosing a Primary Care Provider

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

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

Initial Assessment

All UnitedHealthcare LTC Medicaid Managed Care enrollees receive initial and ongoing face-to-face care management assessments.

The care management (CM) will develop and implement an individualized care plan for enrollees requiring services, review the enrollee's progress and adjust the care plan as necessary to help ensure that the enrollee continues to receive an appropriate level of care. The CM documents all the orientation; health assessments, reassessment, and care plan findings in UnitedHealthcare Community Plan's care management system software program.

Patient Responsibility (LTC Only)

The amount members must contribute toward the cost of their care is determined by the Department of Children and Families (DCF) based on the member's income and choice of residence.

We use the ACCESS Florida DCF Provider View system to find the member responsibility. This allows us to check a member's Medicaid benefits and view their case information.

For services billed by a nursing facility, hospice facility, assisted living facility or adult family care home, reimbursement will be adjusted for patient responsibility. Patient responsibility may be zero.

Deductibles/Copayments (MMA Only)

Members have no deductibles or copayments for covered services.

Medically Necessary Service

UnitedHealthcare Community Plan only pays for medically necessary services.

MEDICALLY NECESSARY DEFINITION

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

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

Member Assignment

ASSIGNMENT TO UNITEDHEALTHCARE COMMUNITY PLAN

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

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

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

IMMEDIATE ENROLLMENT CHANGES:

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

Get eligibility information by calling the **Medicaid Inquiry line** at 877-842-3210 for MMA or 800-791-9233 for LTC.

UNBORN ENROLLMENT CHANGES:

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

Members may call the DCF at **888-367-6554**.

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

PCP SELECTION:

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

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

Member Eligibility

UnitedHealthcare Community Plan serves members enrolled in Florida's Statewide Medicaid Managed Care Program (SMMC). DCF determines program eligibility. A person who becomes eligible for the Florida SMMC program either chooses or is assigned to one of the Florida SMMC contracted health plans.

Member ID Card

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

If a fraud, waste and abuse event arises from a care provider or a member, notify UnitedHealthcare Community Plan in writing, as discussed in Chapter 12 of this manual. Or you may call the **Fraud, Waste, and Abuse Hotline**.

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

MEMBER IDENTIFICATION NUMBERS

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Florida DCF Medicaid Number is also on the member ID card.

PCP-Initiated Transfers

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

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

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   3100 SW 145th Ave.
   Miramar, FL 33027
2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Verifying Member Enrollment

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

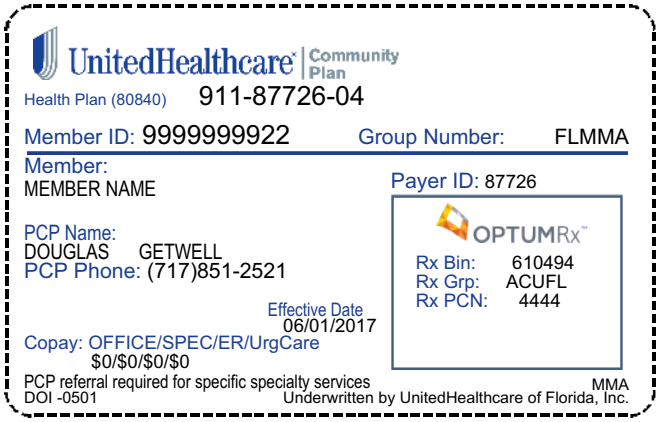
- Provider Portal: access the Link portal through **UHCprovider.com/eligibility**
- **UnitedHealthcare Provider Service** is available from 8 a.m. – 8 p.m. Central Time, Monday through Friday.

Benefit Information

Click **UHCCommunityPlan.com** to view member benefit coverage information for both LTC and MMA.

Sample Health Member ID Card

MMA ID CARD


UnitedHealthcare Community Plan

Health Plan (80840) 911-87726-04

Member ID: 9999999922 Group Number: FLMMA

Member:
MEMBER NAME

PCP Name:
DOUGLAS GETWELL
PCP Phone: (717)851-2521

Payer ID: 87726

OPTUMRx
Rx Bin: 610494
Rx Grp: ACUFL
Rx PCN: 4444

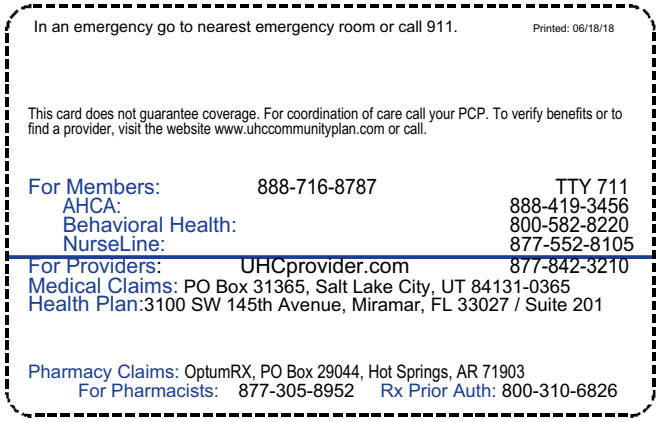
Effective Date
06/01/2017

Copay: OFFICE/SPEC/ER/UrgCare
$0/$0/$0/$0

PCP referral required for specific specialty services

DOI -0501

MMA
Underwritten by UnitedHealthcare of Florida, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 06/18/18

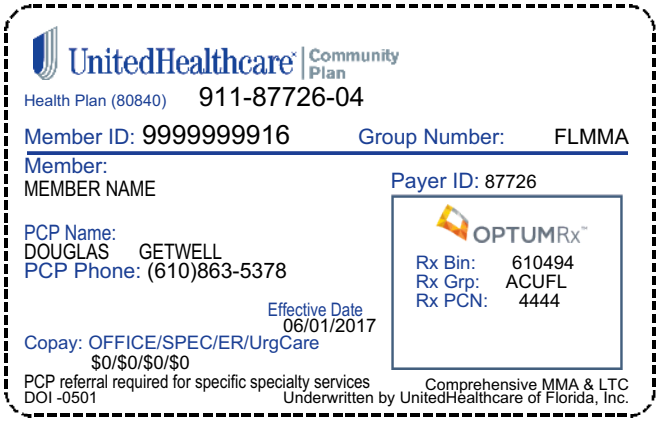
This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhccommunityplan.com or call.

For Members: 888-716-8787 TTY 711
AHCA: 888-419-3456
Behavioral Health: 800-582-8220
NurseLine: 877-552-8105

For Providers: UHCprovider.com 877-842-3210
Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan:3100 SW 145th Avenue, Miramar, FL 33027 / Suite 201

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952 Rx Prior Auth: 800-310-6826

MMA AND LTC ID CARD


UnitedHealthcare Community Plan

Health Plan (80840) 911-87726-04

Member ID: 9999999916 Group Number: FLMMA

Member:
MEMBER NAME

PCP Name:
DOUGLAS GETWELL
PCP Phone: (610)863-5378

Payer ID: 87726

OPTUMRx
Rx Bin: 610494
Rx Grp: ACUFL
Rx PCN: 4444

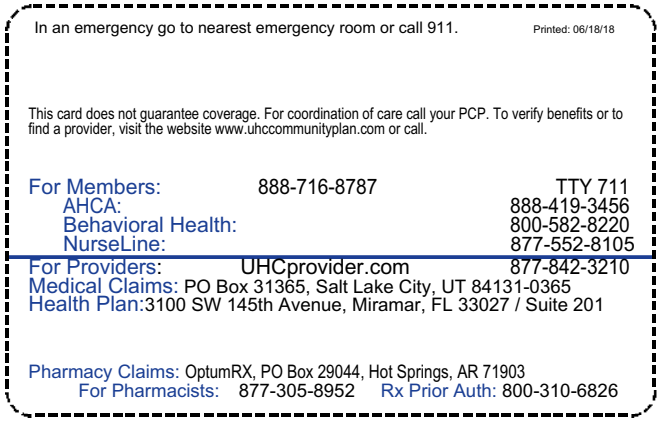
Effective Date
06/01/2017

Copay: OFFICE/SPEC/ER/UrgCare
$0/$0/$0/$0

PCP referral required for specific specialty services

DOI -0501

Comprehensive MMA & LTC
Underwritten by UnitedHealthcare of Florida, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 06/18/18

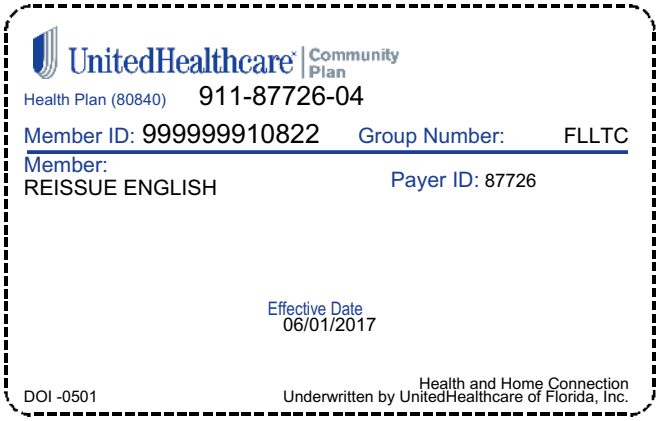
This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website www.uhccommunityplan.com or call.

For Members: 888-716-8787 TTY 711
AHCA: 888-419-3456
Behavioral Health: 800-582-8220
NurseLine: 877-552-8105

For Providers: UHCprovider.com 877-842-3210
Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan:3100 SW 145th Avenue, Miramar, FL 33027 / Suite 201

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952 Rx Prior Auth: 800-310-6826

LTC ID CARD


UnitedHealthcare Community Plan

Health Plan (80840) 911-87726-04

Member ID: 999999910822 Group Number: FLLTC

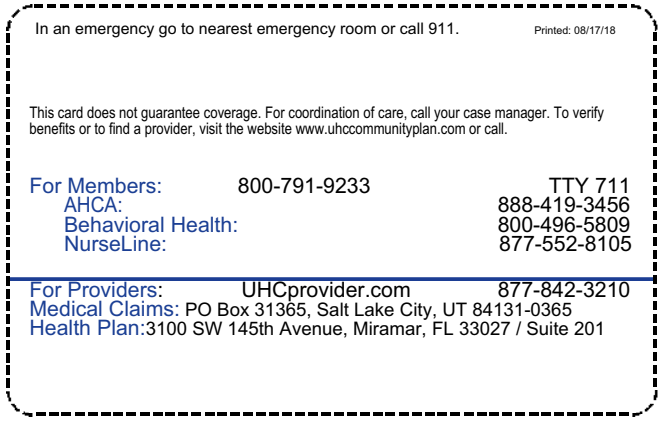
Member:
REISSUE ENGLISH

Payer ID: 87726

Effective Date
06/01/2017

DOI -0501

Health and Home Connection
Underwritten by UnitedHealthcare of Florida, Inc.


In an emergency go to nearest emergency room or call 911. Printed: 08/17/18

This card does not guarantee coverage. For coordination of care, call your case manager. To verify benefits or to find a provider, visit the website www.uhccommunityplan.com or call.

For Members: 800-791-9233 TTY 711
AHCA: 888-419-3456
Behavioral Health: 800-496-5809
NurseLine: 877-552-8105

For Providers: UHCprovider.com 877-842-3210
Medical Claims: PO Box 31365, Salt Lake City, UT 84131-0365
Health Plan:3100 SW 145th Avenue, Miramar, FL 33027 / Suite 201

Chapter 4: Medical Management

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

Ambulance Services

AIR AMBULANCE

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

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

EMERGENCY AMBULANCE TRANSPORTATION

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

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

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

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

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

NON-EMERGENT TRANSPORTATION

UnitedHealthcare Community Plan members may get non-emergent transportation services through National Med Trans for covered services. Covered transportation includes sedan, taxi, wheelchair-equipped vehicle, public transit, mileage repayment and shared rides. Members may get transportation when:

- They are bed-confined before, during and after transport; and
- The services cannot be provided at their home (including a nursing facility or ICF/MR).

Value-added non-emergent transportation services include substance abuse support groups, WIC appointments, parenting classes such as Lamaze, and pregnancy, health and wellness classes and meetings.

For non-urgent appointments, members must call for transportation at least three days before their appointment.They can make an appointment by calling **866-372-9891**.

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

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

Bus transportation will also be available if the member:

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

Emergency/Urgent Care Services

Emergency Services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fever, cough and colds, and sore throats.

Covered services include:

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

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

EMERGENCY ROOM CARE

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

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

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

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

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

URGENT CARE (NON-EMERGENT)

Urgent care services are covered.

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

Emergency Care Resulting in Admissions

Emergency services do not require prior authorization.

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

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

UnitedHealthcare Community Plan uses evidence-based, nationally accredited, clinical criteria for determinations of appropriateness of care. UnitedHealthcare Community Plan does not reward for denials.

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

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

Family Planning

Family planning services help members plan a family size or space the time between having children. These voluntary services include referrals, educational information, counseling, diagnostic procedures and contraceptive drugs and supplies. Members have full freedom of choice of family planning methods.

These services may not be provided to members younger than age 18 unless they meet one of the following conditions:

- Married.
- A parent.
- Pregnant.
- Have written consent by a parent or legal guardian.
- In the opinion of a care provider, the member may suffer health hazards if services are not provided.

Family planning does not include sterilization.

Members can go to any care provider who participates with Medicaid for these services without a referral from a PCP. This includes any county health department.

Encourage all pregnant women and mothers to receive care, and make yourself available to them. Also document in the medical records that the following has been completed:

- Scheduled postpartum visit for voluntary family planning, discussing all methods of contraception as appropriate.
- Counseling and services for family planning to all women and their partners.

These terms do not prevent care providers or other person from refusing to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons. Care providers nor any other person shall be held liable for such refusal.

PARENTING/CHILD BIRTH EDUCATION PROGRAMS

- Child birth education is covered.
- Parenting education is not covered.

VOLUNTARY STERILIZATION

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

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DCF Regulations for more information on sterilization.

Care Coordination/ Health Education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to ensure care coordination 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

- 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 care coordination 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.

Hearing Services

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

Hospice

Florida Medicaid reimburses for services that meet all the following standards:

- Determined medically necessary;
- Do not duplicate another service;
- Meet the criteria as specified in this policy.

Florida Medicaid reimburses for 365/6 days of hospice services per year, per recipient, when the following criteria are met:

- You conduct an initial assessment in accordance with 42 CFR 418.54.
- You develop and maintain a plan of care in accordance with section 400.6095, F.S.
- Services are rendered in accordance with 42 CFR 418.202 and 42 CFR 418.302

You must provide or arrange for necessary care and services to manage a recipient's terminal illness or related condition. This includes the following.

CORE SERVICES

The following services, included in the per diem payment, must be provided in accordance with 42 CFR 418.64:

- Counseling services
- Dietitian services
- Medical social services
- Nursing services
- Care provider services

NON-CORE SERVICES

The following services, included in the per diem payment, must be provided when specified in the recipient's plan of care and in accordance with 42 CFR 418.70-78 and 42 CFR 418.106-108:

- Hospice aide services
- Medical supplies and durable medical equipment
- Pharmacy services
- Therapy services
- Volunteer services
- Any other item or service specified in the plan of care as reasonable and necessary to manage the member's terminal illness or related condition in accordance with 42 CFR 418.202

Please contact Provider Services if you have questions about these services.

Laboratory, X-rays, Imaging Procedures

ADVANCED OUTPATIENT IMAGING PROCEDURES

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

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

Reference the Medical Management chapter for more information on the Radiology Prior Authorization Program.

LAB SERVICES

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

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

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

See the Billing and Encounters chapter for more information.

Maternity/Pregnancy/ Well-Child Care (MMA Only)

PREGNANCY/MATERNITY

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the mother has been a UnitedHealthcare Community Plan member for three or more consecutive months or had seven or more prenatal visits.

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

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

1. the woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. if she has an established relationship with a non-participating obstetrician.

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

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

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

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

MATERNITY ADMISSIONS

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

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

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

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

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

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

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

A CNM must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise.

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a nurse practitioner, physician's assistant or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

You do not have to be present when services are provided. However, you must assume professional responsibility for the medical services provided and help ensure approval of the care plan.

POST MATERNITY CARE

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

NEWBORN ENROLLMENT

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members (provided the mother was admitted using her ForwardHealth ID card).

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

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

BRIGHT FUTURES ASSESSMENT

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

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

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

HOME CARE AND ALL PRIOR AUTHORIZATION SERVICES

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

HYSTERECTOMIES

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

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

Exception: Florida DCF does not require informed consent if:

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

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

PREGNANCY TERMINATION SERVICES

Pregnancy termination services are not covered, except in cases to preserve the woman's life. In this case, follow the Florida consent procedures for abortion.

Allowable pregnancy termination services do not require a referral from the member's primary care provider. Members must use the UnitedHealthcare Community Plan care provider network.

STERILIZATION AND HYSTERECTOMY PROCEDURES

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

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

STERILIZATION INFORMED CONSENT

A member has only given informed consent if the Florida Department of Social Services Medical Assistance Consent Form for sterilization is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

STERILIZATION CONSENT FORM

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. The Florida Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.

- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

Have three copies of the consent form:

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

Neonatal Resource Services (NICU Case Management) (MMA Only)

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

NEONATAL RESOURCE SERVICES

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

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

The NRS nurse case manager will:

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

The NRS nurse case manager's role includes:

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

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

Radiology Prior Authorization Program

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

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

The following images do not require prior authorization:

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

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

To get or verify prior authorization:

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

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

PT/OT/ST Prior Authorization Program

MMA: We require prior authorization for PT/OT/ST members. Please contact Optum for approval using the **Prior Authorization Request Form**. This applies to freestanding and facility providers but not home health or SNFs.

LTC: We require prior authorization for PT/OT/SLP. This is handled by the LTC care manager.

Screening, brief interventions, and referral to treatment (SBIRT) services

SBIRT Services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.
- Determining risk factors 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 Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention 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, you can identify members 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: Refer members whose screening indicates a severe problem or dependence s 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

For more information about E/M services and outreach, see the Department of Health and Human Services Evaluation and Services online guide at **cms.gov**.

Specialty Pharmacy Medications

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

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

Specialty pharmacy medications are available through our specialty pharmacy network.

Find out what drugs, including specialty, are covered by looking at the Prescription Drug List (PDL). Some specialty medications require prior authorization. These are found on the Drug Criteria listing on the state website.

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).

RESPONSIBILITIES:

Identification – The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with 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 Health Department (LHD). The PCP must report known or suspected cases of TB to the LHD TB Control Program within one day of identification.

Waiver Programs

HUMAN IMMUNODEFICIENCY VIRUS (HIV)/ ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) HCBS WAIVER PROGRAM

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

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

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

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

OTHER FEDERAL WAIVER PROGRAMS

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may 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 Medicaid Program.

Medical Management Guidelines

ADMISSION AUTHORIZATION AND PRIOR AUTHORIZATION GUIDELINES

All prior authorizations must have the following:

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

For behavioral health and substance use disorder authorizations, please call **800-582-8220**.

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

You may submit prior authorization requests and clinical information online using the PAAN prior authorization and notification system.

Type of Request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent Pre-service	Within seven calendar days from receipt of the request.	Within 24 hours of the decision	**Standard:** Within seven calendar days after we receive request.
Urgent/Expedited Pre-service	Within three calendar days of request receipt	Within three days of the request	Within three days of the request
Concurrent Review	Within 24 hours or next business day following	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review (Inpatient Only)	Within 30 calendar days of receiving all pertinent clinical information	Within 24 hours of determination	Within 24 hours of determination and member notification within two business days

Concurrent Review Guidelines

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

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

CONCURRENT REVIEW DETAILS

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

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

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

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.

Determination of Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain
- Be individualized and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the member's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational
- Be reflective of the level of service that can be safely furnished and for which no equally effective, more conservative or less costly treatment is available statewide
- Be given in a way not primarily intended for the member's convenience nor that of the recipient's caretaker or the care provider

The fact that a care provider has prescribed, recommended, or approved medical or allied care, goods, or services does not make them medically necessary, a medical necessity or a covered service. Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis. They could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

Determination Process

The Agency is the final arbiter of medical necessity. In making determinations, the agency must use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based on the information available at the time the goods or services were provided.

Long-Term Support Services (LTC Only)

Long-Term Support Services (LTSS) is an alternative to out-of-home care (such as nursing homes). It helps pay for services provided to members so they can remain safely in their own home. The types of services authorized through LTSS are:

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

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

More information about LTC benefits is available on **UHCCommunityPlan.com/FI**.

Eligibility – Members must be 18 years or older, or disabled, or blind. In some cases, disabled children are also eligible for LTSS. Additional eligibility requirements:

- Florida resident physically residing in the United States
- Meet Medicaid recipient eligibility criteria
- Reside in own home (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 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 LTSS.

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

Medical Necessity for Members Younger Than 21 Years

UnitedHealthcare Community Plan provides all medically necessary services for members younger than age 21, even if the service is not a covered benefit or has a limit. As long as a service is medically necessary, services are not bound by coverage, monetary, or time limits. Request prior authorization for non-Medicaid covered services medically necessary using the stated guidelines.

Evidence-Based Clinical Guidelines

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

Medical and Drug Policies and Coverage Determination Guidelines

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

Referral Guidelines

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

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

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

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

Reimbursement

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

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

UnitedHealthcare Community Plan will not reimburse:

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

Second Opinion Benefit

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

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at **877-842-3210** for MMA or **800-791-9233** for LTC.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services Not Covered by UnitedHealthcare Community Plan

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

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

  - Intermediate care facilities for members with mental handicap.
  - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
- Phones and TVs used when in the hospital.
- Personal comfort items used in the hospital such as a barber.
- Contact lenses, unless used to treat eye disease.
- Sunglasses and photo-gray lenses.
- Ambulances, unless medically necessary.
- Infertility services.

Services Requiring Prior Authorization

For a list of services that require prior authorization, go to **UHCprovider.com/priorauth**.

DIRECT ACCESS SERVICES — NATIVE AMERICANS

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

SEEK PRIOR AUTHORIZATION WITHIN THE FOLLOWING TIME FRAMES

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

Utilization Management Guidelines

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

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

UTILIZATION MANAGEMENT (UM) APPEALS

These appeals contest UnitedHealthcare Community Plan's UM decisions. They are appeals of UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. Adverse determination decisions may include UnitedHealthcare Community Plan's decision to deny a service authorization request or to authorize a service in an amount, duration, or scope less than requested. See Appeals in **Chapter 12** for more details.

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

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

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; and growth and development tracking.

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

Development Disability Services and Coordination with Regional Centers

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

Referral – If you determine supportive services would benefit the member, refer the member 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 coordinator. The Care Coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary, and therapeutic covered services.

Early Start Program

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

Referral — refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified

the need for services. 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, contact the Local Education Agency (LEA) 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.

Continuity of Care — support the development of the Individualized Family Service Plan (IFSP) developed by the Early Start Program through either the RC or LEA. The assigned coordinator will help the local Regional Center or local Early Start Program and you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP. UnitedHealthcare Community Plan provides member case management and care coordination to help ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP developed by the Early Start Program, with your participation.

Full Screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead assessment (Use the Lead Risk Assessment form.)
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision

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

Interperiodic Screens

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

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

Lead Screening/Treatment

Call Provider Services if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Vaccines for Children program (VFC)

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

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

Contact **VFC** with questions.
Phone: 800-219-3224
Fax: 573-526-5220

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

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

Children in this category may not only receive vaccinations from a federally qualified health center or rural health clinic; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine).

Chapter 6: Value-Added Services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **877-842-3210** for MMA or **800-791-9233** for LTC unless otherwise noted.

Adult Pain Management

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication.

This benefit requires prior authorization. Please use the following coverage codes:

Acupuncture: 97810, 97811, 97813, 97814

Chiro: 98940, 98941, 98942, 98943

Massage: 97010, 97112, 97124 and 97140

Alere 17P Program

An injection for up to delivery or 36 weeks, six days' gestation. It lowers the risk of pre-term labor.

Baby Blocks™ Program (MMA Only)

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

BABY BLOCKS™ BENEFIT

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

How it Works

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

How You Can Help

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

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

Bed Hold (LTC Only)

Expanded benefits include assisted living facility and adult family care home bed hold days. Services are paid to the facility for up to 15 days if the member is admitted to an inpatient facility.

Notify the member's case manager within one business day.

Chronic Condition Management

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

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

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

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

Early Intervention Program (MMA Only)

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

Healthy First Steps (MMA Only)

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

HFS-MATERNAL CARE MODEL

The HFS-Maternal care model strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it.
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care.
- Increase the member's understanding of pregnancy and newborn care.
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits.
- Foster a care provider-member partnership before and after delivery as well as for non-emergent settings.

- Encourage members to stop smoking with our Quit for Life tobacco program.
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs
- Program staff act as a liaison between members, care providers, and United Healthcare for care coordination

Tell UnitedHealthcare Community Plan when a member becomes pregnant. Faxing a Prenatal Risk Assessment form to the **Healthy First Steps program** at **800-599-5985** will initiate case management program outreach.

KidsHealth (MMA Only)

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

Mobile Apps

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

- **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.
- **SMART** Patient allows users to track important numbers such as blood pressure, record appointments, and record doctors' orders. It also helps them view educational videos.
- **OptumizeME** allows users to set health and fitness goals, challenge other users to set their own goals, and post the results on Facebook.
- **DocGPS** provides mobile users the ability to search UnitedHealthcare Community Plan's provider network and obtain travel directions to a care provider's location. The app provides users with the ability to call a care provider by tapping on the search result.
- **Text4baby** is a free mobile information service that helps members through their pregnancy and baby's first year of life. The weekly text4baby messages give tips about:
  - Keeping healthy.
  - Labor and delivery.
  - Breastfeeding.
  - The importance of immunizations (shots).
  - Exercise and healthy eating.

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

My HealthLine (cellphone program)

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

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

-

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call **800-582-8220** to reach a nurse.

Programs Promothing Healthy Behaviors

We offer programs to help members stop smoking, lose weight, or get help with drug abuse. The programs are:

- Substance Abuse Incentive
- Smoking Cessation
- Health Coaching for Weight Loss

Members may call Member Services for more information.

Quit for Life®

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

SUD Recovery Coaching

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

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

UHC Latino

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

Women, Infants and Children Supplemental Nutrition Program (WIC) (MMA Only)

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

Eligibility –

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

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

A current hemoglobin or hematocrit is required:

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

Chapter 7: Mental Health and Substance Use

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with mental health and substance use disorder (SUD) benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law.

The National Optum Behavioral Health manual is located on **providerexpress.com**.

This chapter does not replace the national Optum network manual. Rather, it supplements the national manual by focusing on Medicaid's specific services and procedures.

You must have a National Provider Identification (NPI) number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, go to the Department of Social Services website at **nppes.cms.hhs.gov** > go to the section titled "Apply to be a Medicaid Provider."

Credentialing

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

Covered Services

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

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

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

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital.
- Outpatient assessment and treatment:
  - Day treatment
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telemental health
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)

Eligibility

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

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to **UHCprovider.com/priorauth**, calling **866-604-3267**, or faxing **866-607-5975**.

Portal Access

Website: **UHCprovider.com**

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

View the Prior Authorization list, find forms and access the care provider manual. Or call Provider Services at **888-716-8787** for MMA or **800-791-9233** for LTC to verify eligibility and benefit information (available 8 a.m. - 8 p.m. Central Time, Monday through Friday).

Website: **providerexpress.com**

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

Appeals and Grievances

Call **888-716-8787** for MMA or **800-791-9233** for LTC, and a Provider Services representative will assist you with the Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the notice of action.

Send written requests to:

UnitedHealthcare Community Plan Attention: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

Phone: 888-716-8787

TTY 711

Fax: 800-757-2617

Claims

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

Monitoring Audits

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

Addressing the Opioid Epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction.

BRIEF SUMMARY OF FRAMEWORK

- Prevention:
  - Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
  - Support case management and referral to person-centered recovery resources.

- Harm Reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community partnerships and approaches:
  - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.

INCREASING EDUCATION & AWARENESS OF OPIOIDS

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

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

PRESCRIBING OPIOIDS

Go to our **Drug Lists and Pharmacy page** to learn more about which opioids require prior authorization and if there are prescription limits.

PHARMACY LOCK-IN

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances, etc). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least one year.

Expanding Medication Assisted Treatment (MAT) Access & Capacity

Evidence-based MAT treatment is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have an adequate member MAT network.

To find a MAT provider in Florida:

1. Go to **UHCprovider.com**,
2. Select "Find a Care Provider" from the menu on the home page
3. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services
4. Click on "Search for a Behavioral Health Provider"
5. Enter "(city)" and "(state)" for options
6. Refine the search by selecting "Medication Assisted Treatment"

We contract with OUD Centers of Excellence (where available), which are designated as premier facilities to help ensure people with OUD stay in treatment and receive appropriate follow-up care and supports within their communities.

Chapter 8: Member Rights and Responsibilities

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

Privacy Regulations

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

ACCESS TO PROTECTED HEALTH INFORMATION

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

AMENDMENT OF PHI

Our members have the right to ask that information be changed if they believe it is inaccurate or incomplete. Any request must be in writing and explain why they want the change. This request must be acted on within 60 days. The timing may be extended 30 days with written notice to the member. If the request is denied, members may have a disagreement statement added to their health information.

ACCOUNTING OF DISCLOSURES

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

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

RIGHT TO REQUEST RESTRICTIONS

Members have the right to ask you or us to restrict the use and disclosures of their PHI for treatment, payment and health care operations. This request may be denied. If it is granted, the covered entity is bound by any restriction to which is agreed. Document these restrictions. We must agree to restrict disclosure. Members may request to restrict disclosures to family members or to others who are involved in their care or its payment.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

Members have the right to request communications from you or us be sent to a separate location or other means. Accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member Rights and Responsibilities

The following information is in the Member Handbook.

NATIVE AMERICAN ACCESS TO CARE

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

MEMBER RIGHTS

Members may:

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

MEMBER RESPONSIBILITIES

Members should:

- Understand their benefits so they can get the most value from them.
- Show you their Medicaid member ID card.
- Prevent others from using their ID card.
- Understand their health problems and give you true and complete information.
- Ask questions about treatment.
- Work with you to set treatment goals.
- Follow the agreed-upon treatment plan.
- Get to know you before they are sick.
- Keep appointments or tell you when they cannot keep them.
- Treat your staff and our staff with respect and courtesy.
- Get any approvals needed before receiving treatment.
- Use the emergency room only during a serious threat to life or health.
- Notify us of any change in address or family status.
- Make sure you are in-network.
- Follow your advice and understand what may happen if they do not follow it.
- Give you and us information that could help improve their health.

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

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

Chapter 9: Medical Records

Medical Record Charting Standards

You are required to keep complete and orderly medical records, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review determines compliance to the following requirements:

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location.
Record Organization	• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be: - In order. - Fastened, if loose. - Separate for each member. - Filed in a manner for easy retrieval. - Readily available to the treating care provider where the member generally receives care. - Promptly sent to specialists upon request. • Medical records are: - Stored in a manner that helps ensure privacy. - Released only to entities as designated consistent with federal requirements. - Kept in a secure area accessible only to authorized personnel.

Topic	Contact
Procedural Elements	**Medical records are readable*** • Sign and date all entries. • Member name/identification number is on each page of the record. • Document language or cultural needs. • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member's first language is something other than English. • Procedure for monitoring and handling missed appointments is in place. • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.*
History	An initial history (for members seen three or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Topic	Contact
Problem Evaluation and Management	Documentation for each visit includes: • Appropriate vital signs (Measurement of height, weight, and BMI annually) - **Chief complaint*** - **Physical assessment*** - **Diagnosis*** - **Treatment plan*** • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

***Critical element**

SCREENING AND DOCUMENTATION TOOLS

These tools were developed to help you follow regulatory requirements and practice.

Medical Record Review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 85% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than two visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions (or note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initialed by primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

Chapter 10: Quality Management (QM) Program and Compliance Information

What is the Quality Improvement Program?

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

The program consists of:

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

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

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

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

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

Quality Improvement Program

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

As a participating care provider, you may offer input through representation on our Quality Improvement Committees and your provider services representative/ provider advocate. We require your cooperation and compliance to:

- Allow the plan to use your performance data.
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members.)

Care Provider Satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

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

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

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

Credentialing Standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Florida statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

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

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

AHCA AND UNITEDHEALTHCARE COMMUNITY PLAN STANDARDS

You must successfully meet Agency for Health Care Administration (AHCA) and UnitedHealthcare Community Plan standards for network participation.

Requirements include all of the below: (Compliance with all credentialing rules is required every three years unless indicated with **. The ** documents are required annually.)

Completed care provider application;

- W9;
- **A copy of your current medical license for medical care providers, or occupational or facility license as applicable to care provider type, or authority to do business;
- No revocation, moratorium or suspension of your state license by AHCA or the Department of Health, if applicable;
- **No sanctions imposed on the care provider by Medicare or Medicaid (validated by OIG and/or EPLS report);
- No record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;
- A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating care providers not currently enrolled in Medicaid's fee-for-service program;
- AHCA-approved attestation to compliance;
- As defined by UnitedHealthcare Community Plan, you will need to submit a roster listing of all staff who qualify as direct care providers (face-to-face contact and have access to enrollee information) as it relates to UnitedHealthcare LTC Medicaid Managed Care Plan enrollees. The roster will be used to confirm staff compliance by accessing the AHCA background screening portal.
- Professional liability claims history (requires loss/run report);
- Liability insurance;
- **Occupational License or Tax Receipt; Medicaid ID number; (You do not have to participate in the Florida Medicaid program; however, you must be eligible for participation. If AHCA determines you are not eligible to participate in the Medicaid program,

you are considered ineligible to participate in the LTC Medicaid Managed Care Plan. The Medicaid number is assigned for encounter data reporting purposes only. If you do not have a Medicaid number, the plan can apply for one on your behalf).

- Tax ID number;
- NPI number (transportation, emergency response system, home-delivered meals, environmental adaptation and pest control providers are excluded);
- Disclosure of ownership;
- Debarment letter;
- Work history; and
- Attestation to abuse/neglect/exploitation training.

Credentialing and Contracting Policies and Procedures

Credentialing and recredentialing policies and procedures include the following:

- All direct service care providers must complete abuse, neglect and exploitation training.
- Approval of new care providers and imposition of sanctions, termination, suspension and restrictions on existing care providers.
- Identification of quality deficiencies that result in UnitedHealthcare Community Plan's restriction, suspension, termination or sanctioning of a care provider.

Care providers not currently enrolled in Medicaid's fee-for-service program must submit fingerprints electronically following the process described on the AHCA's Background Screening website. Medicaid eligibility is verified through this background screening system. We will not contract with any care provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.

Individuals already screened as Medicaid care providers or screened within the past 12 months by another Florida agency or department using the same criteria as the agency are not required to submit fingerprints electronically but shall document the results of the previous screening.

Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on AHCA's background screening website.

Provider Credentialing Rights

Health care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct information; and
- To be told the status of your credentialing or recredentialing application, upon request.

Subcontractor Responsibilities

We enter into subcontractor arrangements, as appropriate. We agree to make payment to all subcontractors pursuant to all state and federal laws, rules and regulations.

All model and executed subcontracts and amendments used by the managed care plan under this contract shall meet the following requirements:

- Provide for inspections of any records pertinent to the Contract by the Agency and DCF.
- Care providers and subcontractors agree to comply with record retention requirements for practitioner or care provider licensure, require records be maintained for a period no less than 10 years from the close of the contract and retained further if the records are under review or audit until the review or audit is complete (prior approval for the disposition of records must be requested and approved by UnitedHealthcare Community Plan if the subcontract is continuous).

- Subcontractor agrees to provide assurance all licensed medical professionals are credentialed in accordance with state credentialing requirements, credentialing activities have been delegated. Additionally, subcontractors are required to secure and maintain, during the life of the subcontract, workers' compensation insurance for all of its employees connected with the work under this contract unless such employees are covered by the protection afforded by the managed care plan. Such insurance shall comply with Florida's Workers' Compensation Law.

This subcontractor must help ensure ability for enrollee's to obtain services, and provide monitoring of services provided to the managed care plan enrollee's by the subcontractor.

Subcontractors are also subject to background checks.

Credentialing and Recredentialing Process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. (Optum Network uses NCC to credential nursing facilities.) You must go through the credentialing and recredentialing process before you may treat our members.

CARE PROVIDERS SUBJECT TO CREDENTIALING AND RECREDENTIALING

UnitedHealthcare Community Plan evaluates the following practitioners:

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

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or
- Nurse practitioners and physician assistants who practice under a credentialed UnitedHealthcare Community Plan care provider.

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

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

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

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

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

ADVERSE CREDENTIALING DETERMINATION APPEALS

If UnitedHealthcare Community Plan makes an adverse determination regarding your participation, you are notified in writing and given an opportunity to initiate a formal appeal.

TERMINATION

You must give us notice to terminate as outlined in your contract with us, and your active enrollees are notified of that termination. We also notify AHCA. In addition to termination procedures listed in your contract, AHCA or UnitedHealthcare Community Plan may request immediate termination of your contract if, after notice of non-compliance, you do not comply with the contract. You will have no additional right to appeal this termination outside the standard rights on termination.

Peer Review

CREDENTIALING PROCESS

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

RECREDENTIALING PROCESS

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

PERFORMANCE REVIEW

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

APPLICANT RIGHTS AND NOTIFICATION

You may review the information in support of credentialing/ recredentialing applications as well as your application status. This review is at your request and is facilitated by the credentialing staff. The staff notifies you of any information found during the credentialing or recredentialing process that varies from what you gave UnitedHealthcare Community Plan. You may correct errors if the credentialing staff asks for clarification.

CONFIDENTIALITY

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

FAILURE TO MEET RECREDENTIALING REQUIREMENTS

If you don't meet our recredentialing requirements, we will end your participation with our network. We will give you a written termination notice. The termination notice will include the reasoning, the effective date and an explanation of your appeal rights, if applicable.

Resolving Disputes

CONTRACT CONCERNS

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

South Florida
UnitedHealthcare – Miramar Office 3100 SW 145th Avenue
Miramar, FL 33027

Central Florida
Network Management
495 North Keller Road, Suite 200
Maitland, FL 32751

North Florida
10151 Deerwood Park Blvd
Bldg 100, Suite 420
Jacksonville, FL 32256

West Florida
Network Management
9009 Corporate Lakes Drive, Suite 200
Tampa, FL 33634

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

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

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

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

HIPAA Compliance – Your Responsibilities

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

TRANSACTIONS AND CODE SETS

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

UNIQUE IDENTIFIER

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

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

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

SECURITY

Covered entities must meet basic security measures:

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

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

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

Ethics & Integrity

INTRODUCTION

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

COMPLIANCE PROGRAM

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

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

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

REPORTING AND AUDITING

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

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

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud and Abuse line**.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

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

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

EXTRAPOLATION AUDITS OF CORPORATE-WIDE BILLING

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

RECORD RETENTION, REVIEWS AND AUDITS

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

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

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

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

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

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

DELEGATING AND SUBCONTRACTING

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

Office Site Quality

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

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

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

CRITERIA FOR SITE VISITS

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

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

Chapter 11: Billing and Submission

Our Claims Process

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.

For a complete description of the process, go to **UHCprovider.com/guides** > View online version > Chapter 9 Our Claims Process.

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions.

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

Your clean claims must include your NPI and Federal Tax Identification Number. Also include the Unique Care Provider Identification Number (UPIN) laboratory claims.

General Billing Guidelines

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

Fee Schedule

Reimbursements also depend on the fee schedule and the procedure performed. Refer to your bulletins for correct coding.

Bill for HCBS services using the existing Healthcare Common Procedure Coding System (HCPCS) codes, modifiers and units listed in the Payment Appendix of your Agreement.

Modifier Codes

Use the appropriate **modifier codes** on your claim form. The modifier must be used based on the date of service.

Member ID Card for Billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with the member ID.

Acceptable Claim Forms

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

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

Clean Claims and Submission Requirements

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

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

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

Submit any services completed by nurse practitioners or physician assistants who are part of a collaborative agreement.

Care Provider Coding

UnitedHealthcare Community Plan complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-9 or ICD-10 code.

Electronic Claims Submission and Billing

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

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.
- All claims are set up as “commercial” through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don’t successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

If you treat another diagnosis, use that ICD CM code as well.

For more information, contact **EDI Claims**. You can also see **www.enshealth.com** or contact Provider Services.

EDI Companion Documents

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

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

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

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

Importance and Usage of EDI Acknowledgment/Status Reports

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

To get your reports, make sure your software vendor has connected to our clearinghouse OptumInsight at **enshealth.com**.

If you are not yet an OptumInsight client, we will tell you how to receive Clearinghouse Acknowledgment Reports.

e-Business Support

UnitedHealthcare Community Plan offices are open Monday through Friday. They can help you with Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse or entity that uses OptumInsight.

Support is also available for **EDI Claims** and **EDI Log-on Issues**.

Find more information at **UHCprovider.com**, Click Menu, then Resource Library to find Electronic Data Interchange menu.

IMPORTANT EDI PAYER INFORMATION

- Claim Payer ID: 87726
- ERA Payer ID: UFNEP
- ERA ID 04567 for dates of services before June 1, 2017 use previous ERA # 87726

Completing the CMS 1500 Claim Form

Companion documents for 837 transactions are on **UHCprovider.com**, Click Menu, then Resource Library to find the EDI section.

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

Completing the UB-04 Form

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

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

Capitated Services

CAPITATED CARE PROVIDERS

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period of time. We pay you whether or not that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

We use the term 'medical group/IPA' interchangeably with the term 'capitated care providers'. Capitation payment arrangements apply to participating physicians, health care providers, facilities and ancillary care providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, and
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital they received emergency room treatment, observation or other outpatient hospital services.

We deny claims submitted with service dates that don't match the itemization and medical records. This is a billing error denial.

Form Reminders

- Note the Attending Provider Name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims.
- Send the Referring Provider NPI and name on outpatient claims when this care provider is not the Attending Provider.
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims.
- Behavioral health care providers can bill using multiple site-specific NPIs.

Subrogation and Coordination of Benefit

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

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

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

Hospital and Clinic Method of Billing Professional Services

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

Correct Coding Initiative

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

COMPREHENSIVE AND COMPONENT CODES

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

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

Clinical Laboratory Improvements Amendments

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

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

Billing Multiple Units

When billing multiple units:

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

Billing Guidelines for Obstetrical Services

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

- If billing for both delivery and prenatal care, use the date of delivery.
- Use one unit with the appropriate charge in the charge column.
- Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Billing Guidelines for Transplants

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

Ambulance Claims (Emergency)

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

National Drug Code

Claims must include:

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

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

Medical Necessity

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

Place of Service Codes

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

Asking About a Claim

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

PROVIDER SERVICE

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

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

Allow Provider Services 45 days to solve your concern. Limit phone calls to five issues per call.

UNITEDHEALTHCARE COMMUNITY PLAN PROVIDER PORTAL

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

LINK: YOUR GATEWAY TO UNITEDHEALTHCARE COMMUNITY PLAN ONLINE PROVIDER TOOLS AND RESOURCES

Link lets you move quickly between applications. This helps you:

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

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

Find Link training on **UHCprovider.com**.

Resolving Claim Issues

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

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 31362
Salt Lake City, UT 84131-03620

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

FOR PAPER CLAIMS

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

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

TIMELY FILING

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

- A denial/rejection letter from another carrier.
- Another carrier's explanation of benefits.
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service.

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement.

Balance Billing

Do not balance bill members if:

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

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

If you don't know who your provider advocate is, email **Florida_PR_Team@uhc.com**. A provider advocate will get back to you.

Chapter 12: Claim Reconsiderations, Appeals and Grievances

There are a number of ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your provider contract.

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Care Provider Claim Resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission	• Member • Care provider on behalf of a member with member consent	UnitedHealthcare Community Plan P.O. Box 31362 Salt Lake City, UT 84131-0362	UHC provider.com/claims	MMA: 877-842-3210, LTC: 800-791-9233	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link.	**must receive within** 45 business days	30 business days
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	• Member • Care provider on behalf of a member with member consent	UnitedHealthcare Community Plan P.O. Box 31362 Salt Lake City, UT 84131-0362	UHC provider.com/claims	MMA: 877-842-3210, LTC: 800-791-9233; Fax: 801-994-1224	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link.	must receive within 90 business days	45 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	**DEFINITION**	**WHO MAY SUBMIT?**	**SUBMISSION ADDRESS**	**ONLINE FORM FOR FAX OR MAIL**	**CONTACT PHONE NUMBER/ FAX**	**WEBSITE (Care Providers Only) for Online Submissions**	**CARE PROVIDER FILING TIMEFRAME**	**UnitedHealthcare Community Plan RESPONSE TIMEFRAME**
Care Provider Claim Formal Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364, Salt Lake City, UT 84131-0364	**UHCprovider.com/claims**	MMA: 877-842-3210, LTC: 800-791-9233; Fax: 801-994-1224	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	60 business days	30 business days
Care Provider Grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364, Salt Lake City, UT 84131-0364	**UHCprovider.com/claims**	MMA: 877-842-3210, LTC: 800-791-9233	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	45 days	90 calendar days
Member Appeal	A request to change an adverse benefit determination that we made.	*Member *Member's authorized representative (such as friend or family member) with written member consent *Care provider on behalf of a member with member's written consent	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364, Salt Lake City, UT 84131-0364	**UHCprovider.com/claims**	800-587-5187 (TTY); Fax: 800-757-2617	Use the Claims Management or ClaimsLink application on Link. To access Link, go to **UHCprovider.com/link**.	Standard and urgent appeals-60 calendar days	Urgent appeals We will respond within 48 hours Standard appeals-30 days

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

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

Denial

Your claim may be denied for administrative or medical necessity reasons.

An **Administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim Correction

What is it?

A corrected claim replaces a previously denied submitted claim due to an error. A denied claim has been through claim processing and determined it can't be paid.

When to use:

Submit a corrected claim to fix one that has already processed.

How to use:

Use the claims reconsideration application on Link. To access Link, sign in to **UHCprovider.com** using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 31362
Salt Lake City, UT 84131-0362

Additional Information:

When correcting or submitting late charges on 837 institution claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim.

Resubmitting a Claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address.

- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 31362
Salt Lake City, UT 84131-0362

Warning! If your claim was denied and you resubmit it, you will receive a **duplicate claim rejection**. A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim Reconsideration (step one of dispute)

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly.

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim.
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation.

How to use:

If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone, mail or fax:

- **Electronically:** Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone:** Call Provider Services at MMA: **877-842-3210**; LTC: **800-791-9233** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- Mail: Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 31362
  Salt Lake City, UT 84131-0362

  This form is available at **UHCprovider.com**.
- Fax: Send the Claim Reconsideration Request Form to **801-994-1224**.

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- A denial or rejection letter from another insurance carrier.
- Another insurance carrier's explanation of benefits.
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically, phone, mail or fax with the following information:

- **Electronic claims:** Include the EDI acceptance report stating we received your claim.
- **Mail or fax reconsiderations:** Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name.
  - Correct date of service.
  - Claim submission date.

Additional Information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Appeals (step two of dispute)

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step one, use the claim appeal process.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically, by mail or fax. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments.
- **Mail:** Send the appeal to:

  UnitedHealthcare Community Plan
  Grievances and Appeals
  P.O. Box 31364
  Salt Lake City, UT 84131-0364
- **Fax:** Send the appeal to **801-994-1082**.

We have a one-year timely filing limitation to complete all steps in the reconsideration and appeal process. It starts on the date of the first EOB.

TIPS FOR SUCCESSFUL CLAIMS RESOLUTION

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call **Provider Services** if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call **Provider Services**.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Overpayment

What is it?

An overpayment happens when we overpay a claim you don't dispute.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check or the Return Overpayment through the Adjustment Request form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Return Overpayment through Adjustment Request form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com**.

If you do not agree with the overpayment findings, submit a dispute within the required timeframe as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

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

***The information provided is sample data only for illustrative purposes. Please populate and return with the data relevant to your claims that have been overpaid.**

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states $50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

Provider Grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.
- Member issues or UnitedHealthcare Community Plan issues.
- Availability of health services from UnitedHealthcare Community Plan to a member.
- The delivery of health services.
- The quality of service.

How to file:

File verbally or in writing. You have 45 calendar days to file a written complaint for non-claims issues. You have 90 days to file claims issues.

- **Phone:** Call Provider Services toll free at
  MMA: **877-842-3210**
  LTC: **800-791-9233**
- **Mail:** Send care provider name, contact information and your grievance to:

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

You may also send a letter to:

South Florida
UnitedHealthcare – Miramar Office 3100 SW 145th Avenue
Miramar, FL 33027

Central Florida
Network Management
495 North Keller Road, Suite 200
Maitland, FL 32751

North Florida
10151 Deerwood Park Blvd Bldg 100, Suite 420
Jacksonville, FL 32256

West Florida
Network Management
9009 Corporate Lakes Drive, Suite 200
Tampa, FL 33634

A representative will try to resolve your complaint through informal discussions. If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described and in our agreement.

If you disagree with the outcome, an arbitration proceeding may be filed as described below and in your contract 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 management process, we will follow the procedures set forth in those departments to resolve the concern or complaint. After following those procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in your 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, an arbitration proceeding may be filed as described below and in our agreement.

Member Appeals and Grievances Definitions and Procedures

UnitedHealthcare Community Plan uses the Centers for Medicare and Medicaid Services (CMS) definitions for appeals and grievances.

APPEALS

What is it?

An appeal is a formal request from a member to seek a review of an adverse benefit determination made by the Managed Care Plan pursuant to 42 CFR 438.400(b).

You or a member may appeal when the plan:

- Makes a harmful determination or limits a requested service(s). This includes the type or level of service.
- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.

- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame CMS or the state requires.

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

Call, mail or fax the information within 60 days from the date the service was denied to:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364

Toll-free: **800-587-5187** (TTY **711**)

Fax: **800-757-2617**

How to use:

Whenever you deny a service, you must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- The member or representative may review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member's health. You have two business days to provide certification of the appeal and evidence and allegations in person or in writing. Provider certification is a written confirmation from you that the expedited request is urgent.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service.
- We must resolve a standard appeal 48 hours from the day we receive it.
- We must resolve an expedited appeal 48 hours from when we receive it. We may extend the response up to 14 calendar days if the following conditions apply:
  1. Member requests we take longer.
  2. We request additional information and explain how the delay is in the member's interest.

MEMBER GRIEVANCE

What is it?

Grievances are complaints related to UnitedHealthcare Community Plan policy, procedures or payments.

When to use:

You may file a grievance as the member's representative.

Where to send:

You or the member may file a grievance by calling Member Services or writing UnitedHealthcare Community Plan:

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

We will send an answer no longer than 90 working days from when you filed the complaint/grievance.

State Fair Hearings

What is it?

A fair hearing is the next level of appeal after the member has exhausted their appeal rights with the health plan. The AHCA conducts these proceedings.

When to use:

Members have 120 days after receipt of the Notice of Plan Appeal Resolution letter following a denial in whole or part of a requested service/supplies or the reduction, suspension or termination of a previously authorized service. At that point, the member will be mailed an acknowledgment hearing form. Once completed, the form is sent back to the hearing office for review and

confirmation of jurisdiction. A hearing date is then scheduled.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

Phone: **877-254-1055** (toll-free)

Fax: **239-338-2642**

MedicaidHearingUnit@ahca.myflorida.com

- The member may ask UnitedHealthcare Community Plan Customer Service for help writing the letter.
- If the member has not been given their rights to a hearing contact the Participant Services Unit at **800-392-2161**.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer.
- Hearings are held on the phone. Members may go to the local Family Support Division office for the hearing or can take part from home.

Processes Related to Reversal of Our Initial Decision

If the State Fair Hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the member's health condition requires. If the decision reverses denied authorization of services and the disputed services were received pending appeal, we pay for those services as specified in policy and/or regulation.

Fraud, Waste and Abuse

Call the toll-free **Fraud, Waste and Abuse Hotline** to report questionable incidents involving plan members or care providers. You can also make a report by calling the State Consumer Hotline at 888-419-3456 or the Florida Attorney General's office at 866-966-7226.

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find the UnitedHealth Group policy on Fraud, Waste and Abuse at **UHCprovider.com** or call **877-401-9430**.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

EXCLUSION CHECKS

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- **Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)**
- **General Services Administration (GSA) System for Award Management**

WHAT YOU NEED TO DO FOR EXCLUSION CHECKS

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Chapter 13: Care Provider Communications & Outreach

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and Florida's managed care program. It includes the following care provider components:

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

Care Provider Websites

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. The **UHCprovider.com** portal facilitates care provider communications related to administrative functions. Our interactive website empowers you to electronically determine member eligibility, submit claims, and view claim status.

We have also implemented an internet-based prior authorization system on **UHCprovider.com**. This site lets you request medical and advanced outpatient imaging procedures online rather than by phone. The website also has:

- An online version of this manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements
- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (UHC on Air, PreCheck MyScript, etc.)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is **UHCCommunityPlan.com** > select Member.

Care Provider Office Visits

Care Provider Advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a care provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Florida network at least three times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

The newsletters also include notifications about changes in laws and regulations. UnitedHealthcare Community Plan posts electronic bulletins on **UHCprovider.com**, Click Menu, then Resource Library, News to quickly share urgent information that affects the entire network.

Find more information about the Network Bulletin, Medical Policy Update Bulletin and other communications on **UHCprovider.com/guides** > Provider Communication Chapter 17.

Care Provider Manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, a removable quick reference guide and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

Find the following forms on the state's website at **flrules.org**:

- **Consent for Sterilization Form**
- **State of Florida Hysterectomy Acknowledgment Form, HAF-5000**

Outreach and Marketing Guidelines for Member Materials

You may make available and/or distribute managed care plan marketing materials as long as you and/or the facility distributes or makes available marketing materials for all managed care plans with which you participate.

If you agree to make available and/or distribute managed care plan marketing materials, do so knowing you must accept future requests from other managed care plans with which you participate. You are also permitted to display posters or other materials in common areas such as the waiting room.

Additionally, LTC facilities may provide materials in admission packets announcing all managed care plan contractual relationships.

Through education, outreach and monitoring, we work with you to help ensure you are aware of and comply with these guidelines. For example, you may engage in discussions with recipients should a recipient seek advice. However, you must remain neutral when assisting with enrollment decisions.

You may not:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in a managed care plan based on financial or any other interests that you may have.
- Mail marketing materials on behalf of a managed care plan.
- Offer anything of value to induce recipients/members to select them as their care provider.
- Offer inducements to persuade recipients to enroll in a managed care plan.
- Conduct health screenings as a marketing activity.
- Accept compensation directly or indirectly from a managed care plan for marketing activities.
- Distribute marketing materials within an exam room setting.
- Furnish to managed care plans, lists of their Medicaid patients or the membership of any managed care plan.

You may:

- Provide the names of the managed care plans with which you participate.
- Make available and/or distribute managed care plan marketing materials.
- Refer your patients to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid Area Office.
- Share information with patients from the AHCA website or CMS website.
- Announce new or continuing affiliations with a Managed Care Plan through general advertising (e.g., radio, television, websites).
- Make new affiliation announcements within the first 30 calendar days of the new care provider agreement.
- Make one announcement to patients of a new affiliation that names only that managed care plan when such announcement is conveyed through direct mail, email, or phone.

Additional direct mail and/or email communications from you to patients regarding affiliations must include a list of all managed care plans with which you contract.

Any affiliation communication materials that include managed care plan-specific information (e.g., benefits, formularies) must be prior approved by the agency.

You may distribute printed information provided by a managed care plan to their patients comparing the benefits of all of the different managed care plans with which you contract. The managed care plans will help ensure that:

- Materials do not "rank order" or highlight specific Managed Care Plans and include only objective information.
- Such materials have the concurrence of all managed care plans involved in the comparison and are approved by the agency prior to distribution.

The managed care plans identify a lead plan to coordinate submission of the materials.

Chapter 14: Glossary

AABD
Assistance to the aged, blind and disabled

Abuse (by care provider)
Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)
Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Action
The denial or limited authorization of a requested service, including the type, level or care provider of service; reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:

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

Advance directive
A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the state courts), relating to the provision of health care when the member is incapacitated.

Ambulatory Care
Health care services that do not involve spending the night in the hospital. Also called “outpatient care”. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility
A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary Provider Services
Diagnostic tests, laboratory tests, therapy services, radiology services, and pharmaceuticals ordered by primary care physicians or specialists.

Appeal
A member request that their health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

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

Billed Charges
Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation
The per-member, per-month amount, including any adjustments, paid by the Agency to a managed care plan for each Medicaid recipient enrolled under a contract for the provision of Medicaid services during the payment period.

Case Manager
The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member’s representative and the member’s Primary Care Provider (PCP).

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

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

CMS
A Medicaid specialty plan for children with chronic conditions operated by the Florida Department of Health's Children's Medical Services Network as specified in s. 409.974(4), F.S., through a single, statewide contract with the Agency that is not subject to the SMMC procurement requirements, or regional plan limits but must meet all other plan requirements for the MMA program.

Contracted Health Professionals
Primary care providers, care provider specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of Benefits (COB)
A process of figuring out which of two or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered Services
The portion of a medical or vision expense that a health insurance or plan has agreed to pay for or reimburse.

Credentialing
The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current Procedural Terminology (CPT) Codes
A systematic listing and coding of procedures and services published annually by the American Medical Association.

Delivery System
The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

Disallow Amount (Amt)
Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates.
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning
Screening eligible candidates for continuing care following treatment in an acute care facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment
The discontinuance of a member's eligibility to receive covered services from a contractor.

Dispute
A disagreement involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
As defined by 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b) or its successive regulation.

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

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member's health record and the care they have received.

Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

Encounter
A record of health care-related services by care providers registered with Medicaid to an patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process by which an eligible Medicaid recipient signs up to participate in a managed care plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal
An oral or written request by a member or member's representative received by UnitedHealthcare Community Plan requesting a faster reconsideration of an action. This speed is necessary when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance
A grievance where delay in resolution could harm the member's health or life.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
As defined by 42 CFR 438.400(b).

Healthcare Effectiveness Data and Information Set (HEDIS)
The data and information set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

HIPAA
Health Insurance Portability and Accountability Act of 1996. A federal law that includes requirements to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

Home Health Care (Home Health Services)
As defined in Rule 59G-4.130, F.A.C.

In-Network Provider
A health care practitioner or entity authorized to do business in Florida and contracted with the managed care plan to provide services to the managed care plan's enrollees.

Medicaid
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in serious danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary
As defined in Rule 59G-1.010, F.A.C.

Member
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

NPI
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-Of-Area Care
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventative Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A managed care plan staff or participating care provider practicing as a general or family practitioner, internist, pediatrician, obstetrician, gynecologist, advanced registered nurse practitioner, physician assistant or other specialty approved by the Agency who furnishes primary care and patient management services to a member.

Prior Authorization (Notification)
The act of authorizing specific services before they are rendered.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by Florida DCF.

Specialist
As described in Rule 59G-1.010, F.A.C.

State Fair Hearing
An administrative hearing requested if the member or care provider does not agree with a Notice of Decision or Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. As described in 45 CFR 260.20.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When an enrollee files for continuation of benefits on or before the later of the following:

a. Within 10 days of the managed care plan sending the notice of adverse benefit determination; or
b. The intended effective date of the managed care plan's proposed adverse benefit determination.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

Unborn Activation
The process by which an unborn child, who has been assigned a Medicaid ID number, is made Medicaid-eligible upon birth.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Unscheduled Trip
As defined in Rule 59G-4.330, F.A.C.

Urban
An area with a population density of greater than 100 individuals per square mile or an area defined by the most recent United States Census as urban, i.e., as having a metropolitan statistical area (MSA).

Urgent care
Services for conditions, which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or substantially restrict a member's activity (e.g., infectious illnesses, influenza, respiratory ailments).

Urgent medical
Any sudden or unforeseen situation that requires immediate action to prevent hospitalization or nursing facility placement.

Username
An identifying pseudonym associated with the author to messages or content generated.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Validation
The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Value-Added
As described in 42 CFR 438.3(e)(i).