Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF manual helps you and your staff 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.
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Chapter 1: Introduction

Florida Medicaid

The Medicaid program provides medical coverage to eligible individuals and families. The state and federal government share the cost of the Medicaid Program. The Agency for Health Care Administration (AHCA) 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:
- Children
- Children’s parents and caretakers/relatives
- 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 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). It 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 may enroll and receive services. UnitedHealthcare Community Plan serves members in the following regions:

Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk.
Region 11: Miami-Dade and Monroe.

How to Join Our Network

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

Our Approach to Health Care

WHOLE PERSON CARE MODEL

The Whole Person Care (WPC) program, or the care management model, helps empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and raise outcomes. Targeting 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 at the right time.

The program provides members with interventions for their complex medical, behavioral, social, pharmacy and specialty needs. The result is a 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 helps improve 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.
• Help with appointments with PCP and coordinating appointments. The clinical health advocate (CHA) refers members to an RN, behavioral health advocate (BHA) or other specialists as required.
• Education and support with complex conditions.
• Tools for helping members engage with care providers, such as appointment reminders and transportation help.
• Foundation to build trust and relationships with hard-to-engage members.

The WPC program goals are to:

• Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates.
• Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames.
• Identify and discuss behavioral health needs, measured by number of behavioral health care provider visits within identified time frames.
• Improve access to pharmacy.
• Identify and remove social and environmental barriers to care.
• Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS) 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 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 complete 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. Or call Provider Services at 888-716-8787 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. This includes viewing 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. 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 quality measure reports and obtain data on members with care opportunities.
• 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. 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 need 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, we have developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect how members take part in their health care. You must help UnitedHealthcare Community Plan meet this obligation for our members. Because cultural competency is such an important part of care delivery, we embed cultural competency training in all our care provider training strategies. Ongoing provider training is available through a web-based system that contains a wealth of health literacy trainings and web links to help you. This includes the National Center for Cultural Competence and The Institute of Medicine. For more information about our Cultural Competency Plan, go to UHCprovider.com. You may request a copy by calling Provider Services at 800-791-9233 for LTC or 877-842-3210 for MMA.

We also offer a Language Interpretation Line. We provide oral interpreter services 24 hours a day, seven days a week to our members free of charge. More than 240 non-English languages and hearing impaired services are available. If a UnitedHealthcare Community Plan member needs Interpreter Services, we prefer care providers use a professional interpreter. To access a professional interpreter during business hours, call Provider Services.

CARE PROVIDER PRIVILEGES

To help our members get the right care and keep out-of-pocket costs low, you must have privileges at applicable network facilities or arrangements with an network care 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 can replace 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.
• Lower 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.

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### How to Contact Us

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<th>MMA</th>
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<tr>
<td>Benefits</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td><a href="#">UHCprovider.com/benefits</a></td>
<td>Confirm a member’s benefits and/or prior authorization.</td>
</tr>
<tr>
<td>Cardiology Prior Authorization</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td><a href="#">UHCprovider.com/cardiology</a></td>
<td>Request prior authorization of the procedures and services outlined in this manual’s prior authorization requirements.</td>
</tr>
<tr>
<td>Chiropractic/Acupuncture and Massage Therapy</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td><a href="#">UHCprovider.com</a></td>
<td>Request prior authorization.</td>
</tr>
<tr>
<td>Claims</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td><a href="#">UHCprovider.com/claims</a></td>
<td>Ask about a claim status or about proper completion or submission of claims.</td>
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</table>

For a list of par providers, use [UHCprovider.com](#).
Optum provider credentialing/contracting questions: [myoptumhealthphysicalhealth.com](#).
800-873-4575

Mailing address:
UnitedHealthcare Community Plan
P.O. Box 31365
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
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<td>Electronic Data Intake Claim Issues</td>
<td></td>
<td></td>
<td><a href="mailto:ac_edi_ops@uhc.com">ac_edi_ops@uhc.com</a> 800-210-8315</td>
<td>Ask about claims issues or questions.</td>
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<tr>
<td>Electronic Data Intake Log-on Issues</td>
<td></td>
<td></td>
<td>800-842-1109</td>
<td>Learn more at UHCprovider.com/edi.</td>
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<tr>
<td>Eligibility</td>
<td>877-842-3210 800-791-9233</td>
<td></td>
<td>To access the app, sign in to UHCprovider.com/eligibility to access Link, then select the UnitedHealthcare Online app</td>
<td>Confirm member eligibility.</td>
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<td>Enterprise Voice Portal</td>
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<td></td>
<td>877-842-3210</td>
<td>Call for self-service functionality or call steering prior to speaking with a contact center agent.</td>
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<tr>
<td>Fraud, Waste and Abuse</td>
<td></td>
<td></td>
<td>800-455-4521 or 877-401-9430 Florida consumer hotline: 888-419-3456 Florida Attorney General's Office: 866-966-7226</td>
<td>Notify us of suspected fraud or abuse by a care provider or member.</td>
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<tr>
<td>Healthy Behaviors</td>
<td></td>
<td></td>
<td>800-825-8792</td>
<td>Have members call to ask for services about weight loss, quitting smoking and use of alcohol or other substances.</td>
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<tr>
<td>Healthy First Steps/Obstetrics (OB) Referral</td>
<td></td>
<td></td>
<td>800-599-5985</td>
<td>Refer high-risk OB members. Fax initial prenatal visit form.</td>
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<tr>
<td>LabCorp for Providers</td>
<td></td>
<td></td>
<td>800-833-3984</td>
<td>LabCorp is the preferred lab provider.</td>
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<td>Medicaid [Department of Children and Families]</td>
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<td>Medicaid.gov 866-762-2237</td>
<td>Contact Medicaid directly.</td>
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<td>Medical and Behavioral Claim Reconsiderations and Appeals</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td>Sign in to <a href="https://UHCprovider.com/claims">UHCprovider.com/claims</a> to access Link, then select the UnitedHealthcare Online app. Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 31365 Salt Lake City, UT 84131-0362</td>
<td>Ask about overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.</td>
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<tr>
<td>Member Services</td>
<td>888-716-8787</td>
<td>800-791-9233</td>
<td></td>
<td>Assist members with issues or concerns. Available 7 a.m. – 7 p.m. Central Time, Monday through Friday.</td>
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<tr>
<td>Mental Health &amp; Substance Abuse (Behavioral Health)</td>
<td>888-716-8787</td>
<td>800-791-9233</td>
<td></td>
<td>Refer members for behavioral health services. (A PCP referral is not required.)</td>
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<tr>
<td>Multilingual/Telecommunication Device for the Deaf (TDD) Services</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td>TDD 711</td>
<td>Available 8 a.m. – 5 p.m. Central Time, Monday through Friday, except state-designated holidays.</td>
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<td>National Credentialing Center (VETTS line)</td>
<td></td>
<td></td>
<td>877-842-3210</td>
<td>Self-service functionality to update or check credentialing information.</td>
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<td>National Plan and Provider Enumeration System (NPPES)</td>
<td></td>
<td></td>
<td><a href="https://nppes.cms.hhs.gov">nppes.cms.hhs.gov</a></td>
<td>Apply for a National Provider Identifier (NPI).</td>
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<td>Network Management Team</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
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<td>Ask about contracting and care provider services.</td>
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<tr>
<td>NurseLine</td>
<td></td>
<td>877-552-8105</td>
<td></td>
<td>Call 24 hours a day, seven days a week.</td>
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<td>Obstetrics and Baby Care</td>
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<td>Healthy First Steps</td>
<td>Links for pregnant moms and newborn babies.</td>
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<td>800-599-5985</td>
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<td>Fax: 877-353-6913</td>
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<td><a href="UHCBabyBlocks.com">Prenatal risk assessment form</a></td>
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<td>Optum Support Center</td>
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<td><a href="mailto:LinkSupport@optum.com">LinkSupport@optum.com</a></td>
<td>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.</td>
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<td>855-819-5909</td>
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<td>Pharmacy Services</td>
<td></td>
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<td>professionals.optumrx.com</td>
<td>OptumRx oversees and manages our network pharmacies.</td>
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<td>877-305-8952 (OptumRx)</td>
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<tr>
<td>Physical/Occupational/Speech Therapy</td>
<td>(managed by Optum)</td>
<td>800-791-9233</td>
<td>For a list of par providers, use UHCprovider.com.</td>
<td>Request prior authorization.</td>
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<td></td>
<td>800-873-4575</td>
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<td>UHCprovider.com</td>
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<td>Prior Authorization/Notification for Pharmacy</td>
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<td>myoptumhealthphysicalhealth.com</td>
<td>Request authorization for medications as required.</td>
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<tr>
<td>Prior Authorization/Notification of Health Services</td>
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<td></td>
<td>UHCCommunityPlan.com</td>
<td>For LTC HCBS Services: The care manager coordinates all services and authorizations based on the plan of care.</td>
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<td></td>
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<td>866-604-3267</td>
<td>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.</td>
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<td>Provider Services</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td>UHCprovider.com/FLcommunityplan</td>
<td>Available 7 a.m. – 5 p.m. Central Time, Monday through Friday.</td>
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<td>Radiology Prior Authorization</td>
<td></td>
<td></td>
<td>UHCprovider.com/priorauth 866-889-8054</td>
<td>Request prior authorization for the procedures and services outlined in this manual’s prior authorization requirements. Complete and current list of prior authorizations.</td>
</tr>
<tr>
<td>Referrals</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td>UHCprovider.com &gt; Click Menu on top right, then select Referrals or use LINK</td>
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<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td>National Med Trans 844-525-3092</td>
<td>Call to schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance.</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>888-716-8787 TTY 711</td>
<td>800-791-9233 TTY 711</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Vaccines for Children (VFC) program</td>
<td>888-716-8787 TTY 711</td>
<td></td>
<td>800-483-2543</td>
<td>You must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS). You must use the free vaccine when administering it to qualified eligible children. You must enroll as VFC providers with DHSS to bill for the vaccine administration.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>888-716-8787 TTY 711</td>
<td>800-791-9233 TTY 711</td>
<td></td>
<td>Request prior authorization for all routine eye exams and hardware. Authorizations must be obtained from 20/20.</td>
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<td>Whole Person Care Person-Centered Care Model (Care Management/Disease Management)</td>
<td>877-842-3210</td>
<td>800-791-9233</td>
<td><a href="mailto:Florida_CareManagement@uhc.com">Florida_CareManagement@uhc.com</a></td>
<td>Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.</td>
</tr>
<tr>
<td>Website for Florida Community Plan</td>
<td></td>
<td></td>
<td>UHCprovider.com/FLcommunityplan</td>
<td>Access your state-specific Community Plan information on this website.</td>
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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 representatives may take part in the planning and implementation of their care. To help ensure members and/or their representatives have this chance, UnitedHealthcare Community Plan requires you to:

1. Educate members, and/or their representatives 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 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 Provider > My Practice Profile Tool > 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 services for a reasonable time at our in-network rate. Provider Services can help you and our members with the transition.
Chapter 2: Care Provider Standards & Policies

ARRANGE SUBSTITUTE COVERAGE

If you cannot provide care and must find a substitute, arrange for care from other network 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.

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.

- Download the W-9 form at irs.gov > Forms & Instructions > Form W-9.
- Download the Care Provider Demographic Information Update Form at UHCprovider.com > Menu > Find a Care Provider > My Practice Profile Tool > Care Provider Paper Demographic Information Update Form.
- To update your care provider information online, go to UHCprovider.com > Menu > Find a Care Provider > My Practice Profile Tool > Go To My Practice Profile Tool.

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

Update your practice information through the Provider Data Management application on UHCprovider.com. Go to UHCprovider.com > Menu > Find a Provider > My Practice Profile Tool > 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 emergency department services. However, urgent care can provide quick after-hours treatment. It 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 provide in-home HCBS services within three hours of when the gap is reported.

HCBS REQUIREMENTS

Assisted living facilities and adult family care home providers support the member’s community inclusion and integration. They work with the case manager and member to help achieve the member’s personal goals and community activities.

Members living in assisted living facilities and adult family care home may use the following services unless medical, physical, or cognitive impairments prevent members from using them:

- Private or semi-private rooms, as available.
- Roommate for semi-private rooms.
- Locking door to living unit.
- Unlimited access and use of phone.
- Eating schedule.
- Activities schedule.
- Participation in facility and community activities.

Members may have unrestricted visitation and snacks as desired. In addition, they may prepare snacks as desired and maintain personal sleeping schedule.

Adult day care providers support the member’s community inclusion and integration. They work with the case manager and enrollee to facilitate the enrollee’s personal goals and community activities.

Members using adult day health services have the
following options unless medical, physical, or cognitive impairments limit these options:

- Daily activities.
- Physical environment.
- Interaction.
- Unlimited access and use of phone.
- Eating schedule.
- Activities schedule.
- Participation in facility and community activities.

They may have their:

- Right to privacy.
- Right to dignity and respect.
- Freedom from coercion and restraint.
- Self-expression opportunities to through individual initiative, autonomy, and independence.

PARTICIPATE IN QUALITY INITIATIVES
You must participate in and respond to our quality assessment and improvement activities. This includes requests for clinical documentation/medical records. These assessments and improvement may include HEDIS® and Well-Child Visits (EPSDT) performance measure improvement, Performance Improvement Projects (PIPs), Enrollee Satisfaction activities, Enrollee Medical Record Documentation Audits, and Critical and Adverse Incident reporting requirements. 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 preventive care and 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
Provide access to any member 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. Keep 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 commercial or 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 them 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
See Chapter 9 for Medical Record Standards.

INFORM MEMBERS OF ADVANCE DIRECTIVES
The federal Patient Self-determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you
must provide written information to members on state 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

Comply with the following appointment availability standards for regular and routine care appointments, urgent care appointments and after-hours care:

**PRIMARY CARE**

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week using the medical office’s daytime phone number. After-hours coverage consists of an answering service, call forwarding, care provider call coverage, or other customary and approved means
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 48 hours for medical and behavioral without prior authorization, 96 hours for medical and behavioral with prior authorization
- Non-urgent care appointment:
  - Post-discharge from an inpatient behavioral health admission for follow-up behavioral health treatment: within seven days
  - Initial outpatient behavioral health treatment: within 14 days
  - Ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 14 days
  - Primary care appointment: within 30 days
  - Specialist appointment after the appropriate referral is received by the specialist: within 60 days
- Physical exam: within 180 calendar days
- EPSDT appointments: within six weeks
- New member appointment: within 30 calendar days
- An after-hours phone call from an appropriate practitioner: within an hour of the member contacting the organization
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

Arrange for coverage of primary care services by a Medicaid-eligible provider during PCP absences due to vacation, illness or other situations that require the PCP to be unable to provide services.

**SPECIALTY CARE**

Specialists should arrange appointments for:

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

**BEHAVIORAL HEALTH CARE**

Arrange appointments for:

- Initial visit: within 10 business days
- Non-life-threatening emergency: within six hours

**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 conducts quarterly surveys to check appointment availability and access standards. You must participate in all activities related to these surveys.

Care Provider Directory

You are required to tell us, within five business days, if your ability to accept new patients changes. 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 help 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 not respond, we will remove you from our care provider directory after 10 business days.

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

In addition to reaching out for annual or bi-annual attestations, we are required to reach out 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

Confirm your provider data every quarter 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

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

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:
  - To access the Prior Authorization app, go to UHCprovider.com, then click Link.
  - Select the Prior Authorization and Notification app on Link.
  - View notification requirements.
- LTC Only:
  - Submit all HCBS authorizations through the care manager. They will send you an Administrative Service Order outlining the services to be provided.
  - Verify authorizations on UHCprovider.com using the Link application.

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

HCBS Critical Incident Reporting and Management

HCBS providers must report critical incidents based on the managed care plan’s requirements within 24 hours of the incident. The managed care plan does not require nursing facilities or assisted living facilities (ALF) to report critical incidents or provide incident reports. Critical incidents that happen in nursing facilities and ALFs are handled based on Florida law.

Reporting includes allegations of:
• Abuse (physical, sexual or mental).
• Exploitation, including financial.
• Neglect.
• Injury, serious illness or death of an individual.
• Involvement with law enforcement.
• Potential elopement/missing person.
• Major medication incidents.
• Any Code 15 reportable events.
• Report critical incidents to UnitedHealthcare Community Plan. Failure to do so may result in disciplinary action.

Adverse and Critical Incident Reporting and Management

Report to us any adverse or critical incidents immediately upon becoming aware of the incident. This includes after-hours, weekends and holidays. Email the report to our Quality Department at FLUHQCQM@uhc.com.

We do not require nursing facilities or assisted living facilities to report critical incidents or provide incident reports. Critical incidents that occur in these locations are handled by Florida law. If a critical incident occurs in a facility, the facility must notify AHCA.

An Adverse/Critical Incident is an event that negatively impacts members’ health, safety or welfare. Adverse incidents may include abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents.

While adverse incidents are completed for MMA members in any setting, critical incidents occur in a home and community-based long-term care service delivery setting. These include:

• Community-based residential alternatives (e.g., adult family care homes) other than assisted living facilities
• HCBS provider sites (e.g., adult day care)
• Member’s home (if the incident occurs during the provision of covered HCBS).

The following criteria are applicable for critical incident reporting:

• Unexpected enrollee death (e.g., homicide, suicide)
• Enrollee death by abuse, neglect, or exploitation
• Enrollee brain damage
• Enrollee spinal damage
• Permanent disfigurement
• Fracture or dislocation of bones or joints
• Any condition requiring specialized medical attention which is not consistent with the member’s routine care management
• Any condition requiring surgical intervention
• Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
• Any condition that extends the patient’s length of stay
• Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility
• Injury or major illness as a result of a care provider
• Sexual battery
• Medication errors
• Altercations requiring medical intervention

The following are criteria applicable for reporting a member’s adverse incident:

• Death
• Brain damage
• Spinal damage
• Permanent disfigurement
• Fracture or dislocation of bones or joints
• Any condition requiring definitive or specialized medical attention which is not consistent with the member’s routine care management
• Any condition requiring surgical intervention
• Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care
• Any condition that extends the patient’s length of stay
• Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility
Chapter 2: Care Provider Standards & Policies

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 our members may seek services from any participating care provider. The AHCA program requires members to be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a “medical home.”

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

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

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

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

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.

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

• Use patient care opportunity reports we supply identifying members who appear to be due for preventive health procedures or testing, medication review, or other care needs.
• Submit all accurately coded claims or encounters on time.
• 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
Responsibilities of PCPs and Specialists Serving in PCP Role

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

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

- Offer office visits on a timely basis, based on the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- 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 a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and based on 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.
- Comply with the 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**: RHCs help 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:
  - Preventive (wellness) health services from a care provider, PA, NP 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 PCC 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 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 at all times. 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 care 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](http://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](http://UHCprovider.com/priorauth).
- Identify and bill other insurance carriers, when appropriate.
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. 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 is the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change is effective on the request date.

Initial Assessment

All LTC Medicaid Managed Care members receive initial and ongoing care management assessments.

The care management (CM) creates and implements an individualized care plan for members who need services. The CM reviews the member’s progress and adjusts the care plan as necessary. They record all the orientation; health assessments, and care plan findings in UnitedHealthcare Community Plan’s care management system.

Member Responsibility (LTC Only)

AHCA bases the amount members pay toward the cost of their care on the member’s income and choice of residence.

We use the ACCESS Provider View system to find the member responsibility. This allows us to check a member’s Medicaid benefits and case information.

For services a nursing facility, hospice facility, ALF or adult family care home bills, we adjust reimbursement for member responsibility. Members may not be responsible for payment.
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

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 significant disability, or to alleviate severe pain
- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’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 and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, 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, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service. Medically necessary or medical necessity for inpatient hospital services require that those services furnished in a hospital on an inpatient basis 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.

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 may occur mid-month.

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

Obtain copies of the Member Handbook online by calling 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 members to notify AHCA when they know they are expecting. AHCA 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, AHCA 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 AHCA when the baby is born.

Members may call AHCA 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 can’t be enrolled with an MCO until birth, ask members to select and contact a PCP for their baby prior to delivery. This helps avoid 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 SMMC. AHCA 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 us 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. Document the call in the member’s chart.

**MEMBER IDENTIFICATION NUMBERS**

Each member receives a nine-digit UnitedHealthcare Community Plan member ID number. Use this number to communicate with us about a specific subscriber/member. The AHCA Medicaid number is also on the member’s ID card.

**PCP-Initiated Transfers**

A PCP may transfer a 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 us by mail with the specific event’s documentation. Documentation includes the dates of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address and phone number, and your name.

   Mailing address:
   
   UnitedHealthcare Community Plan
   Attn: Health Services
   3100 SW 145th Ave.
   Miramar, FL 33027

2. We prepare a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a positive PCP-member relationship.

3. If we 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 we can’t 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](http://UHCprovider.com/eligibility)
- **Provider Services** is available from 8 a.m. – 8 p.m. Central Time, Monday through Friday.

**Benefit Information**

Click [UHCCommunityPlan.com](http://UHCCommunityPlan.com) to view member benefit coverage information for both LTC and MMA.
Sample Health Member ID Cards

MMA ID CARD

In an emergency go to nearest emergency room or call 911.

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 2944, Hot Springs, AR 71903
For Pharmacists: 877-305-8952 Rx Prior Auth: 800-310-6826

MMA AND LTC ID CARD

In an emergency go to nearest emergency room or call 911.

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 2944, Hot Springs, AR 71903
For Pharmacists: 877-305-8952 Rx Prior Auth: 800-310-6826

LTC ID CARD

In an emergency go to nearest emergency room or call 911.

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: 800-791-9233
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 2944, Hot Springs, AR 71903
For Pharmacists: 877-305-8952 Rx Prior Auth: 800-310-6826

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 2944, Hot Springs, AR 71903
For Pharmacists: 877-305-8952 Rx Prior Auth: 800-310-6826
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
Florida Medicaid reimburses for services using an air ambulance when the recipient’s condition meets one of the following:
• A critical emergency situation in which life, limb, or essential body or organ function is jeopardized.
• A medical situation in which time constraints make the use of ground ambulance impractical.

EMERGENCY AMBULANCE TRANSPORTATION
An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:
• Injury to their overall health.
• Impairment to bodily functions.
• Dysfunction of a bodily organ or part.
Emergency transports (in- and out-of-network) are covered. They do not require an authorization.
Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. The ambulance provider must bill these services. 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 AMBULANCE 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, and parenting classes such as Lamaze. They also include pregnancy, health and wellness classes and meetings.

For non-urgent appointments, members must call for transportation at least 24 hours before their appointment. They can make an appointment by calling 866-372-9891.

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.

Domestic Violence
Screen members for signs of domestic violence. Offer referral services, as applicable, to domestic violence prevention community agencies.
Chapter 4: Medical Management

Emergency/Urgent Care Services

Emergency services do not require prior authorization. While we cover emergency services, we ask that you tell members about appropriate ER use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fever, cough and colds, and sore throats.

Covered emergency services include:

- Hospital ER, 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

The member should seek immediate care at the closest 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 ER 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:

- A plan care provider with privileges at the treating hospital takes over the member’s care.
- A plan care provider takes over the member’s care by sending them to another place of service.
- An MCO representative and the treating care provider reach an agreement about the member’s care.
- 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. Call Provider Services for a list of urgent care centers.

Emergency Care Resulting in Admissions

Emergency services do not require prior authorization. Nurses in the Prior Authorization and/or Clinical Services departments review emergency admissions within one business day of notification receipt. If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

Give emergency care without delay. Notify us about admission by calling the Prior Authorization Department.
UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage using evidence-based, nationally recognized or internally developed clinical criteria. We do not reward you or reviewers for issuing coverage denials and do not financially incentivize staff to support service underutilization.

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

**Care Coordination/Health Education**

Work with our qualified, full-time care coordinators to help ensure care coordination services are provided to members. This program helps members proactively 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 members’ quality of care, quality of life and health outcomes.
- Help members understand and help manage their condition and adhere to treatment plans. This includes medications and self-monitoring.
- Lower unnecessary hospital admissions and ER visits.
- Prevent disease progression and illnesses related to poorly managed disease processes.
- Empower members to make informed decisions.
- 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 on evidence-based guidelines or standards of care, to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager works with the member to identify educational opportunities, provides the appropriate health education and monitors the member’s progress toward managing their targeted condition.

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.

**Dental Services**

The state offers dental services through the following providers:

- **DentaQuest of Florida**
  11100 W Liberty Drive
  Milwaukee, WI. 53224
  [DentaQuest.com/Florida](http://DentaQuest.com/Florida)
  888-468-5509

- **Liberty Dental Plan of Florida**
  7870 Woodland Center Blvd.
  Tampa, FL. 33614
  [libertydentalplan.com/FLMedicaid](http://libertydentalplan.com/FLMedicaid)
  833-276-0850

- **Managed Care of North America (MCNA)**
  200 West Cypress Creek Road, Suite 500
  Fort Lauderdale, FL. 33309
  [mcnafl.net](http://mcnafl.net)
  800-494-6262

**Family Planning**

Voluntary services include referrals, education, counseling, diagnostic procedures, contraceptives and supplies. Members may choose the family planning method that is right for them.

You may not provide these services to members younger than age 18. We make exceptions for members who are any of the following:
- Married.
- A parent.
- Pregnant.

Exceptions also include if the member:
- Has a parent or guardian’s written consent.
- May suffer health problems without the services.

Members can go to any Medicaid care provider for these
services without a PCP referral. This includes any county health department. You must encourage all pregnant women and mothers to receive:

- Scheduled postpartum visit to talk about family planning.
- Counseling and family planning services.

The Family Planning Services Program does not include sterilization.

You may refuse to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons. You will not 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 AHCA Regulations for more information on sterilization.

**Hearing Services**

Monaural and binaural hearing aids are covered. This includes fitting, follow-up care, batteries and repair. Bilateral cochlear implants (e.g., 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 member, when the following criteria are met:

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

Provide or arrange for necessary care and services to manage a member’s terminal illness or related condition.

**CORE SERVICES**

Provide the following services, included in the per diem payment, based on 42 CFR 418.64:

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

**NON-CORE SERVICES**

Provide the following services, included in the per diem payment, when specified in the member’s plan of care and based on 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 based on 42 CFR 418.202.

Call 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 a PCP or other care provider orders 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. 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.

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first three obstetrical ultrasounds per pregnancy.

The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

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. We consider 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. Call 866-604-3267 to get prior approval for continuity of care.

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

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

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

Supply voluntary family planning, including a discussion of all methods of contraception, as appropriate. Give all women of childbearing age HIV counseling and offer them HIV testing.

Also complete a Practitioner Disease Report Form (DH Form 2136) and send to the Perinatal Hepatitis B Prevention Coordinator at the local CHD for all prenatal or postpartum enrollees and their infants who test HBsAg-positive.

Supply nutritional assessment and counseling to all pregnant and postpartum members and their children.

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 us of deliveries, call 866-604-3267. 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.

Male babies may be circumcised at no added cost to the member until they are 28 days old.

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 an NP, PA 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.

Bright Futures’ primary goal 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, and others.
centers, Indian Health Service clinics, and other primary care facilities. A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*. This objective will help ensure members 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: AHCA 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, 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. Contact AHCA for the form.

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

**NEONATAL RESOURCE SERVICES**

The NRS program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns admitted to the NICU are eligible upon birth (including babies who are transferred from PICU or newborn nursery) and/or any infants readmitted within their first 30 days of life and previously managed in the NICU. NRS follows all babies brought to the NICU.

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, 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 before and after discharge if the member is under NRS case management.

The NRS nurse case manager’s role includes:

- Planning and coordinating the discharge with the inpatient facility team.
- Coordinating care options and prior authorization. This includes home care, equipment and skilled nursing.
- Aligning discharge planning support and case management with acuity level of infant (low, moderate or high) for 30 days up to 15 months of life.
- Educating parents and families about available local resources and support services.
- Coordination with the WPC team for additional case management needs and services.

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

**INHALED NITRIC OXIDE**

Use the NRS guideline for Inhaled Nitric Oxide (iNO) therapy at UHCprovider.com/Policies and Protocols/ Clinical Guidelines.

**Outpatient Radiology Prior Authorization Program**

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

This applies to all network care providers who order or render any of the following advanced imaging procedures:
• Computerized tomography (CT)
• Magnetic resonance imaging (MRI)
• Magnetic resonance angiography (MRA)
• Positron-emission tomography (PET)
• Nuclear medicine
• Nuclear cardiology

Prior authorization is required for certain advanced imaging procedures listed for outpatient and office-based services only.

Advanced imaging procedures done and appropriately billed with any of the following places of service do not require prior authorization:
• ER visits.
• Observation unit.
• Urgent care.
• Inpatient stay.

If you don’t request prior authorization or check that one has been requested before performing an advanced imaging procedure, we may deny your claim. You may not balance bill claims denied for this reason.

To get or verify prior authorization:
• Online: UHCprovider.com/radiology; select the Go To Prior Authorization and Notification tool
• Phone: 866-889-8054 from 7 a.m. – 7 p.m. local 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, prior authorization crosswalk table, or evidence-based clinical guidelines, go to UHCprovider.com/radiology > Specific Radiology Programs.

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

SBIRT services are covered when they are:
• Provided by, or under the supervision of, a certified care provider or other certified licensed health care professional within the scope of their practice.
• Used to determine risk factors related to alcohol and other drug use disorders, provide interventions to enhance patient motivation to change, and make appropriate referrals as needed.
• Performed during an Evaluation and Management (E/M) exam. They are 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

Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy Prior Authorization

Members may receive covered physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech therapy (ST) under our plan.

MMA: We require prior authorization for PT/OT/RT/ST members. For therapy evaluations and re-evaluations, PCPs should submit authorizations through the Provider Authorization and Notification portal. For therapy visits, contact Provider Services 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/ST. This is handled by the LTC care manager.
them to change their behavior.

**Referral to treatment:** Refer members whose screening indicates a severe problem or dependence on 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.**

We cover SBIRT services when all 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 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
- ER – hospital
- Federally qualified health center (FQHC)
- Community mental health center
- Indian health service – freestanding facility
- Tribal 638 freestanding 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](http://cms.gov).

**MEDICATION-ASSISTED TREATMENT**

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat Opioid Use Disorders (OUD). The Food and Drug Administration (FDA)-approved medications for OUD include Buprenorphine, Methadone, and Naltrexone.

To prescribe Buprenorphine, you must complete the waiver through the Substance Abuse and Mental Health Services Administration (SAMHSA) and obtain a unique identification number from the United States Drug Enforcement Administration (DEA).

As a medical care provider, you may provide MAT services even if you don’t offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health provider, call the number on the back of the member’s health plan ID card or search for a behavioral health professional on [liveandworkwell.com](http://liveandworkwell.com).

To find a medical MAT provider in Florida:

1. Go to [UHCprovider.com](http://UHCprovider.com).
2. Select “Find a Provider” from the menu on the home page.
4. Click on “Medical Directory”.
5. Click on “Medicaid Plans”.
6. Click on applicable state.
7. Select applicable plan.
8. If needed, refine the search by selecting “Medication Assisted Treatment.”

**For more SAMHSA waiver information:**

Physicians — [samhsa.gov](http://samhsa.gov)

Nurse Practitioners (NPs) and Physician Assistants (PAs) — [samhsa.gov](http://samhsa.gov)

If you have questions about MAT, please call Provider Services at 877-842-3210, enter your Tax Identification Number (TIN) then say “Representative,” and “Representative” a second time. Then say “Something Else” to speak to a representative.

**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:

- 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. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within one day of identification.

**Waiver Programs**

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

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

**Identification** – Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or 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 dates of service.

- Type of service (primary and secondary) procedure codes 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.

If you have questions, call Prior Authorization Intake.

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision TAT</th>
<th>Practitioner notification of approval</th>
<th>Written practitioner/member notification of denial</th>
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<tr>
<td>Non-urgent Pre-service</td>
<td>Within seven calendar days from receipt of the request</td>
<td>Within 24 hours of the decision</td>
<td>Standard: Within seven calendar days after we receive request.</td>
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<tr>
<td>Urgent/Expedited Pre-service</td>
<td>Within two days or 48 hours of request receipt</td>
<td>Within two days or 48 hours of the request</td>
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<tr>
<td>Concurrent Review</td>
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<td>Notified within 24 hours of determination</td>
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<tr>
<td>Retrospective Review (Inpatient Only)</td>
<td>Within 30 calendar days of receiving all pertinent clinical information</td>
<td>Within 24 hours of determination</td>
<td>Within 24 hours of determination and member notification within two business days</td>
</tr>
</tbody>
</table>
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

Medically necessary services or supplies must:

• Prevent, diagnose, alleviate or cure a physical or mental illness or condition.
• Maintain health.
• Prevent the onset of an illness, condition or disability.
• Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity.
• Prevent the deterioration of a condition.
• Promote daily activities; remember the member’s functional capacity and capabilities appropriate for individuals of the same age.
• Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member.

Experimental treatments are not considered medically necessary.

Determination Process

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

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 care services.
- 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.

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

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

- Florida resident.
- 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”).

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


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 dates 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 AHCA’s access standards. 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:
  - Intermediate care facilities for members with mental handicap.
  - Prescription drugs.
  - 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. 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 American Academy of Pediatrics Bright Futures EPSDT schedule on [aap.org](http://aap.org) for all eligible UnitedHealthcare Community Plan members through age 21, including pregnant women. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments. It also includes 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 at [aap.org](http://aap.org).

### 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**

Based on the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care, children and adolescents should have a health checkup at:

- Infancy: 2-5 days, 1, 2, 4, 6, 9 months
- Early childhood: 12, 15, 18, 24 and 30 months
- Ages 3-20: yearly

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.)
- Physical developmental history
- Mental developmental history
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Referrals for diagnosis and treatment of conditions or problems identified during the health assessment.

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. 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**

Based on CMS standards, all children enrolled in Medicaid must receive blood lead screening tests at ages 12 months and 24 months. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one.

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. Report levels over 10ug/dL to the county health department where the member lives.

**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. Underinsured children are eligible to receive VFC vaccine only through a FQHC or RHC.)
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 acupuncture, chiropractic care and massage therapy 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

**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.”

**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.

**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 five 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.

Doula Services (MMA Only)

Members may receive unlimited non-clinical emotional, physical and informational support before, during and after their labor and birth. Doulas provide hands-on comfort measures, and they share resources about labor and birth. They facilitate positive communication between women and their maternity care providers.

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 Behaviors

Members may call Healthy Behaviors for assistance with weight loss, quitting smoking and the lowering their use of alcohol or other substances. They may call 800-825-8792.

Healthy First Steps (MMA Only)

Healthy First Steps™ (HFS) provides assistance to high-risk pregnant members as well as a specialized case management program for members with medical, behavioral, and social risks. The goal is improving birth outcomes and lowering NICU admissions by managing prenatal and postpartum care needs of pregnant members.

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 health care 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 Community Plan 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.

**Hearing Services**

Members may receive medically necessary hearing screenings and diagnostic testing.

For members age 21 and older, the plan covers:

- One hearing aid assessment, fitting, checking, and evaluation every 2 years.
- One in-ear monaural hearing aid per ear each year.
- One hearing aid, all other types, per ear every two years.

**Home-Delivered Meals**

After discharge from a hospital or nursing facility, members may receive up to three meals per year, once per day. In disaster scenarios, they may receive one meal annually. This service cannot be combined with Medical Nutrition Therapy.

**Makena**

Makena is a prescription hormone medicine used in women who are pregnant with only one baby and who have delivered a premature baby in the past. It cannot be given to women before they are 16 weeks pregnant.

- Must be ≥ 16 years of age.
- Must be currently pregnant with only one baby at 16 to 37 weeks gestation confirmed by supporting documentation or diagnosis codes.

Submit documentation of having a history of singleton spontaneous preterm birth.

Makena is not intended for use in women with multiple gestations or other risk factors for preterm birth.

**Meals (Non-Emergency Transportation Day-Trips)**

Meals are available for a member and their caregiver during medically necessary doctor visits more than 100 miles each way.

**Mobile Apps**

Medicaid beneficiaries may be eligible for a free phone through the federal Lifeline program. Members can enroll in the program by calling the Member Services line on the back of their ID card. Mobile 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.
- **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.

### 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 ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call 877-552-8105 to reach a nurse.

### Occupational Therapy

Occupational therapy includes treatments that help members maintain their daily activities. These include writing, feeding themselves, and using items around the house.

Members are covered for:

- One evaluation/re-evaluation per year
- Up to seven therapy units per week, for occupational, physical, and speech services.
- Up to four units per day.

### Programs Promoting Healthy Behaviors

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

- Smoking cessation
- Nutritional counseling
- Health Coaching for Weight Loss

Members may call Healthy Behaviors at 800-825-8792 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](http://uhclatino.com), our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

### Vaccines

Members may receive vaccines for TDap, influenza, singles and pneumonia at no added cost.
Vision

Members 21 years and older may receive:

- One eye exam a year.
- One set of glasses a year.
- One set of frames a year.
- A six-month supply of contact lenses with a doctor’s prescription.

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 5 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 5 years

Referral – Make referrals as a part of the initial health assessment of a pregnant, breastfeeding, or postpartum woman and children younger than 5.

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 9 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.
- Statewide inpatient psychiatric program.
- Outpatient assessment and treatment:
  - Day treatment
  - Psychiatric evaluation and 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)
  - Electroconvulsive therapy
  - Therapeutic behavioral on-site services
  - Telemental health
- Community support and rehabilitation services
- Targeted case management
- Day treatment/intensive outpatient
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 or calling 877-842-3210.

Collaboration with Other Health Care Professionals

When a member is receiving services from more than one professional, you must coordinate to deliver complete, safe and effective care. This is especially true when the member:

• Is prescribed medication.
• Has coexisting medical/psychiatric symptoms.
• Has been hospitalized for a medical or psychiatric condition.

Please talk to your patients about the benefits of sharing essential clinical information.

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.

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, hard reduction, treatment and recovery. Naloxone/Narcan is not considered treatment for opioid use disorders (OUDs).

BRIEF SUMMARY OF FRAMEWORK

• Prevention:
  - Prevent OUDs before they occur through pharmacy management, provider prescribing practices, and education.

• Harm Reduction:
  - Access to Naloxone and facilitating safe opioid use, storage, and disposal.

• Treatment:
  - Access and reduction of barriers to evidence-based and integrated treatment.

• Recovery:
  - Support case management, peer coaching and
referral to person-centered recovery resources.

- Strategic community relationships and approaches:
  - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and support 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 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](http://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](http://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). 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**

MAT is the gold standard for treating OUDs. MAT incorporates chronic disease management, medication use and other services, such as counseling and recovery support, to provide a comprehensive treatment approach. We have expanded MAT access to help ensure we have a robust member MAT network.

To find a behavioral health MAT provider in Florida:

1. Go to [UHCprovider.com](http://UHCprovider.com).
2. Select “Find a Provider” from the menu on the home page.
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 licensed opioid treatment programs in addition to private physicians licensed to prescribe MAT. This helps ensure access to MAT services in the member’s community.

To find medical MAT providers, see the MAT section in the medical management chapter of this manual.
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 it 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 ask that 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 have the right to:

- Request information on advance directives.
- Be treated with respect, dignity and privacy.
- Receive courtesy and prompt treatment.
- Receive cultural assistance, including having an interpreter during appointments and procedures.
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered.
- Know the qualifications of their health care provider.
- Give their consent for treatment unless unable to do so because life or health is in immediate danger.
- Discuss any and all treatment options with you.
- Refuse treatment directly or through an advance directive.
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do.
- Receive medically necessary services covered by their benefit plan.
- Receive information about in-network care providers and practitioners, and choose a care provider from our network.
- 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 agree to:

- 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 ER 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.
## 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:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality of Record</td>
<td>Office policies and procedures exist for:</td>
</tr>
<tr>
<td></td>
<td>• Privacy of the member medical record.</td>
</tr>
<tr>
<td></td>
<td>• Initial and periodic training of office staff about medical record privacy.</td>
</tr>
<tr>
<td></td>
<td>• Release of information.</td>
</tr>
<tr>
<td></td>
<td>• Record retention.</td>
</tr>
<tr>
<td></td>
<td>• Availability of medical record if housed in a different office location.</td>
</tr>
<tr>
<td>Record Organization</td>
<td>• Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours.</td>
</tr>
<tr>
<td></td>
<td>• Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be:</td>
</tr>
<tr>
<td></td>
<td>- In order.</td>
</tr>
<tr>
<td></td>
<td>- Fastened, if loose.</td>
</tr>
<tr>
<td></td>
<td>- Separate for each member.</td>
</tr>
<tr>
<td></td>
<td>- Filed in a manner for easy retrieval.</td>
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<tr>
<td></td>
<td>- Readily available to the treating care provider where the member generally receives care.</td>
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<tr>
<td></td>
<td>- Promptly sent to specialists upon request.</td>
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<tr>
<td></td>
<td>• Medical records are:</td>
</tr>
<tr>
<td></td>
<td>- Stored in a manner that helps ensure privacy.</td>
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<tr>
<td></td>
<td>- Released only to entities as designated consistent with federal requirements.</td>
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<tr>
<td></td>
<td>- Kept in a secure area accessible only to authorized personnel.</td>
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</tbody>
</table>
### 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
### 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*
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 description 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
- Working with a clinical quality expert, collaborating on ways to advance your practice’s overall clinical quality improvement efforts and integrate into your practice administration culture.
- Providing cutting-edge practice management expertise by professionals with extensive clinical quality experience with emphasis on nursing, public health, and clinical data analytics.

As a participating care provider, you may offer input through representation on our Quality Improvement and Provider Advisory Committees (QIC and PAC) and through your provider advocate.

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

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

- Providing requested timely medical records.
- Cooperating with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participating 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.
- Providing requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, secure email or secure fax.
- Participating in practitioner appointment access and availability surveys.
- Allowing the plan to use your performance data.
- Offering Medicaid members the same number of office hours as commercial members (or don’t restrict office hours you offer Medicaid members.)
- Collaborating on performance improvement
projects federal and state legislatures identify, such as Potentially Preventable Events (PPE), inappropriate ER use, and readmissions within 30 days and hospitalizations. We also expect you to help us improve birth outcomes across areas like C-sections, pre-term births and neonatal abstinence syndrome (NAS).

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 firms to analyze and report findings.

Survey results are reported to our Quality Improvement 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 recredentials 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 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 AHCA.

• 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 based on 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 RECREREDENTIALING**

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.

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

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

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

**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.

**ADVANCE DIRECTIVES**

As part of recredentialing, we may audit records of primary care providers, hospitals, home health agencies, personal care providers and hospices. This process
helps us determine whether you are following policies and procedures related to advance directives. These policies include:

- Respecting members’ advance directives, and placing them prominently in medical records.
- Adhering to charting standards that reflect the member’s advance directives.

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 from the Credentialing Committee’s decision.

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

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

APPLICANT RIGHTS AND NOTIFICATION
You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. You may call the NCC to correct your information at any time. If the NCC finds erroneous information, a representative will contact you by fax or in writing. You must submit corrections within 30 days of notification by phone, fax or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing or recredentialing application by calling the NCC (VETTS) number listed in How to Contact Us.

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

Resolving Disputes

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

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

HIPAA Compliance – Your Responsibilities

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

TRANSACTIONS AND CODE SETS

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

UNIQUE IDENTIFIER

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

NATIONAL PROVIDER IDENTIFIER (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 PCP office sites to help ensure facility quality.

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

- Clean and orderly overall appearance.
- Available handicapped parking.
- Handicapped accessible facility.
- Available adequate waiting room space.
- Adequate exam rooms for providing member care.
- Privacy in exam rooms.
- 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.
<table>
<thead>
<tr>
<th>QOS Issue</th>
<th>Criteria</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue may pose a substantive threat to patient’s safety</td>
<td>Access to facility in poor repair to pose a potential risk to patients</td>
<td>One complaint</td>
</tr>
<tr>
<td></td>
<td>Needles and other sharps exposed and accessible to patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug stocks accessible to patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other issues determined to pose a risk to patient safety</td>
<td></td>
</tr>
<tr>
<td>Issues with physical appearance, physical accessibility and adequacy of</td>
<td>Access to facility in poor repair to pose a potential risk to patients</td>
<td>Two complaints in six months</td>
</tr>
<tr>
<td>waiting and examination room space</td>
<td>Needles and other sharps exposed and accessible to patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug stocks accessible to patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other issues determined to pose a risk to patient safety</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>All other complaints concerning the office facilities</td>
<td>Three complaints in six months</td>
</tr>
</tbody>
</table>

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Chapter 11: Billing and Submission

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

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 NPI. The NPI identifies you in all standard transactions.

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

Your clean claims must include your NPI and Federal 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 dates 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 the law allows.

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.

**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 enshealth.com or call 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 ER services using revenue codes and the UB-04 claim form:
- Include ICD CM diagnosis codes.
- Identify other services by the CPT/HCPCS and modifiers.

**Capitated Services**

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 ER 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](http://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 SERVICES

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

• Member’s ID number
• Date of service
• Procedure code
• Amount billed
• Your ID number
• Claim number

Allow Provider Services 45 days to solve your concern. 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.
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 31365
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.

Third-Party Resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attached a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.
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. For claims, billing and payment questions, go to [UHCprovider.com](http://UHCprovider.com). The following grid lists the types of disputes and processes that apply:

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<th>SITUATION</th>
<th>DEFINITION</th>
<th>WHO MAY SUBMIT?</th>
<th>SUBMISSION ADDRESS</th>
<th>ONLINE FORM FOR FAX OR MAIL</th>
<th>CONTACT PHONE NUMBER/ FAX</th>
<th>WEBSITE (Care Providers Only) for Online Submissions</th>
<th>CARE PROVIDER FILING TIMEFRAME</th>
<th>UnitedHealthcare Community Plan RESPONSE TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Provider Claim Resubmission</td>
<td>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</td>
<td>• Member • Care provider on behalf of a member with member consent</td>
<td>UnitedHealthcare Community Plan P.O. Box 31365 Salt Lake City, UT 84131-0362</td>
<td><a href="http://UHCprovider.com/claims">UHCprovider.com/claims</a></td>
<td>MMA: 877-842-3210, LTC: 800-791-9233</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to <a href="http://UHCprovider.com/link">UHCprovider.com/link</a></td>
<td>must receive within 45 business days</td>
<td>30 business days</td>
</tr>
<tr>
<td>Care Provider Claim Reconsideration (step 1 of claim dispute)</td>
<td>Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.</td>
<td>• Member • Care provider on behalf of a member with member consent</td>
<td>UnitedHealthcare Community Plan P.O. Box 31365 Salt Lake City, UT 84131-0362</td>
<td><a href="http://UHCprovider.com/claims">UHCprovider.com/claims</a></td>
<td>MMA: 877-842-3210, LTC: 800-791-9233; Fax: 801-994-1224</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to <a href="http://UHCprovider.com/link">UHCprovider.com/link</a></td>
<td>must receive within 90 business days</td>
<td>45 business days</td>
</tr>
</tbody>
</table>
### APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

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<tr>
<th>SITUATION</th>
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<th>CARE PROVIDER FILING TIMEFRAME</th>
<th>CARE PROVIDER COMMUNITY PLAN RESPONSE TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Provider Claim Formal Appeal (step 2 of claim dispute)</td>
<td>A second review in which you did not agree with the outcome of the reconsideration.</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364, Salt Lake City, UT 84131-0364</td>
<td>UHC provider. com/ claims</td>
<td>MMA: 877-842-3210, LTC: 800-791-9233; Fax: 801-994-1224</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider. com/link</td>
<td>60 business days</td>
<td>30 business days</td>
</tr>
<tr>
<td>Care Provider Grievance</td>
<td>A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.</td>
<td>Care Provider</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364, Salt Lake City, UT 84131-0364</td>
<td>UHC provider. com/ claims</td>
<td>MMA: 877-842-3210, LTC: 800-791-9233</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider. com/link</td>
<td>45 days</td>
<td>90 calendar days</td>
</tr>
<tr>
<td>Member Appeal</td>
<td>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</td>
<td>UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364, Salt Lake City, UT 84131-0364</td>
<td>UHC provider. com/ claims</td>
<td>800-587-5187 (TTY); Fax: 801-994-1082 Expedited: 801-994-1349</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider. com/link</td>
<td>Standard and urgent appeals: 60 calendar days</td>
<td>Expedited appeals: We will respond within 48 hours Standard appeals: 30 days</td>
<td></td>
</tr>
</tbody>
</table>
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?**

You may need to update information on a claim you’ve already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

**When to use:**

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

**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 31365
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 31365
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 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 31365
  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.

### Overpayment

**What is it?**
An overpayment happens when we overpay a claim.

**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 based on 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 Overpayment Refund/Notification 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 Overpayment Refund/Notification form to:

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

Instructions and forms are on [UHCprovider.com](https://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.

### External Claim Dispute Resolution

Based on Florida statute 408.7057 and Florida Administrative Rule 59A-12.030, AHCA is contracted with MAXIMUS, an independent dispute resolution organization, to provide assistance to health care providers and health plans to resolve claim disputes. For details, visit the statewide provider and health plan claim dispute resolution program page on AHCA’s website at [ahca.myflorida.com](https://ahca.myflorida.com).
### Sample Overpayment Report

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

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Date of Service</th>
<th>Original Claim #</th>
<th>Date of Payment</th>
<th>Paid Amount</th>
<th>Amount of Overpayment</th>
<th>Reason for Overpayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11111</td>
<td>01/01/14</td>
<td>14A000000001</td>
<td>01/31/14</td>
<td>115.03</td>
<td>115.03</td>
<td>Double payment of claim</td>
</tr>
<tr>
<td>222222</td>
<td>02/02/14</td>
<td>14A000000002</td>
<td>03/15/14</td>
<td>279.34</td>
<td>27.19</td>
<td>Contract states $50, claim paid 77.29</td>
</tr>
<tr>
<td>3333333</td>
<td>03/03/14</td>
<td>14A000000003</td>
<td>04/01/14</td>
<td>131.41</td>
<td>99.81</td>
<td>You paid 4 units, we billed only 1</td>
</tr>
<tr>
<td>44444444</td>
<td>04/04/14</td>
<td>14A000000004</td>
<td>05/02/14</td>
<td>412.26</td>
<td>412.26</td>
<td>Member has other insurance</td>
</tr>
<tr>
<td>55555555</td>
<td>05/05/14</td>
<td>14A000000005</td>
<td>06/15/14</td>
<td>332.63</td>
<td>332.63</td>
<td>Member terminated</td>
</tr>
</tbody>
</table>

### 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  
  Attn: Appeals and Grievances Unit  
  P.O. Box 31364  
  Salt Lake City, UT 84131-0364

- **Fax:** Send the appeal to 801-994-1082.

### External Claim Dispute Resolution

Based on Florida statute 408.7057 and Florida Administrative Rule 59A-12.030, AHCA is contracted with MAXIMUS, an independent dispute resolution organization, to provide assistance to health care providers and health plans to resolve claim disputes. For more information, go to the statewide care provider and health plan claim dispute resolution program page on ahca.myflorida.com.
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.

Provider Grievance

What is it?

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

When to file:

You may file a grievance about:

- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.
- Member issues or UnitedHealthcare Community Plan issues.

- Availability of health services from UnitedHealthcare Community Plan to a member.
- The delivery of health services.
- The quality of service.

How to file:

File verbally or in writing.

- Phone: Call Provider Services toll free at MMA: 877-842-3210 
  LTC: 800-791-9233
- Mail: Send care provider name, contact information and your grievance to:
  UnitedHealthcare Community Plan
  Attn: Appeals and Grievances Unit
  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

You may only file a grievance on a member’s behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures.

Member Appeals and Grievances Definitions and Procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances.
MEMBER BENEFIT APPEALS

What is it?
An appeal is a formal way to share dissatisfaction with a claim determination.

You or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn’t act within the time frame 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:
You or the member may 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 84131-0364

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

If you appeal by phone, you must follow up in writing, ask the member to sign the written appeal, and mail it to UnitedHealthcare Community Plan.

Fax: 800-757-2617

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

- Receive a copy of the rule used to make the decision.
- 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 within 10 days 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. As the care provider, you cannot ask for a continuation. Only the member may do so.
- We resolve a standard appeal 30 calendar days from the day 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.
- We resolve an expedited appeal within 48 hours from when we receive it.

If submitting the appeal by mail or fax, you must complete the Authorization of Review (AOR) form-Claim Appeal. A copy of the form is online at UHCprovider.com.

MEMBER GRIEVANCE

What is it?
Grievances are complaints related to UnitedHealthcare Community Plan policies and/or procedures.

When to use:
You may act on the member’s behalf with their written consent.

Where to send:
You or the member may call or mail the information anytime to:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364
We will send an answer no longer than 30 calendar days from when you filed the complaint/grievance or as quickly as the member’s health condition requires. We offer a 14 calendar day extension if the member or UnitedHealthcare Community Plan requests additional time.

The member may also file a grievance in writing to the state of Florida within 30 calendar days of receipt of the first determination letter.

**State Fair Hearings**

**What is it?**

A fair hearing lets members share why they think Florida Medicaid services should not have been denied, reduced or terminated.

**When to use:**

Members have 90 days from the letter date to ask for a hearing. At that point, they will be mailed a hearing form. Once they complete the form and send it back, we set a hearing date.

**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 Member Services for help writing the letter.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer. Written consent is required.

**Processes Related to Reversal of Our Initial Decision**

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

1. As quickly as the member’s health condition requires, or
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the state fair hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the 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.

**Federal False Claims Act**

The False Claims Act (31 USC § 3279-33) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false claim to the U.S. government for payment.

"Knowingly" means a person, with respect to information, has actual knowledge of the falsity of information in the claim; acts in deliberate ignorance of the truth or falsity of the information in a claim; or acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud. Instead, people can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing a false claim to be submitted.

Penalties can be up to three times the value of the false claim, plus from $5,500 to $11,000 in fines, per claim.

**Whistleblower Provisions**

To encourage people to report misconduct involving false claims, the act includes a whistleblower provision. This provision allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government. Those seeking whistleblower status must meet several criteria to prevail as outlined.

**ORIGINAL SOURCE**

The whistleblower must be the original source of the information reported to the U.S. government. They must have direct and independent knowledge of the false claims activities and voluntarily provide this information to the government. The matter disclosed cannot already be the subject of a federal investigation.

**RIGHTS OF PARTIES TO WHISTLEBLOWER ACTIONS**

If the government decides the lawsuit has merit and decides to join, the lawsuit is directed by the U.S. Department of Justice. At this point, the government is the “plaintiff,” or party suing. If the government decides not to intervene, the whistleblower may continue with the lawsuit on their own.

**AWARD TO WHISTLEBLOWERS**

If the lawsuit is successful (after being prosecuted by the government), the whistleblower may receive an award ranging from 15 to 30% of the amount the government recovers.
The whistleblower may also be entitled to reasonable expenses, including attorneys’ fees and costs for bringing the lawsuit.

**NO RETALIATION PROTECTION FOR WHISTLEBLOWERS**

In addition to a financial award, the act grants whistleblowers additional relief, including employment reinstatement, back pay, and other compensation arising from retaliatory conduct against them for filing an action under the act or committing other acts. This includes providing testimony of assisting in a False Claims Act action. Our employees are protected from retaliation (e.g., discharge, demotion, suspension, threat, harassment, discrimination) in the event any employee files a claim pursuant to the act or otherwise makes a good faith report alleging fraud, waste or abuse in a federal health care program, including the Medicare and Medicaid programs, to UnitedHealthcare Community Plan or the proper authorities, subject to the terms and conditions of UnitedHealthcare Community Plan’s Compliance Plan.

**STATE LAWS**

States where UnitedHealthcare Community Plan does business have laws with civil or criminal penalties for false claims and statements in addition to the penalties provided in the act.

**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. To access to the publicly accessible, excluded party online databases, please see the following links:

- [General Services Administration (GSA) System for Award Management](https://www.usa.gov/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.

**Human Trafficking**

Human trafficking is the transporting, soliciting, recruiting, harboring, providing, or obtaining of another person for transport for forced labor, domestic servitude or sexual exploitation using force, fraud and/or coercion.

Look for these warning signs when treating members:

- A scripted or inconsistent health history
- An unwillingness or hesitance to answer questions about an injury or illness
- Accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner or employer)
- Fearful or nervous behavior or avoids eye contact
- Resistance to help or shows hostile behavior
- Cannot provide their address
- Lack of awareness for their location, the date or time
- Does not have their identification documents
- Not in control of their own money
- Not being paid or wages are withheld

**HOW TO HELP:**

If you have information regarding suspected Human Trafficking of a child in Florida contact the Florida Abuse Hotline at 800-962-2873.

If you have information regarding suspected Human Trafficking of an adult anywhere in the United States or of a child outside of Florida please contact the National Human Trafficking Resource Center at 888-373-7888.
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
- 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. You may also find training on various topics at UHCprovider.com > Menu > Resource Library > More Resource Topics > Training.

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

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.


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 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.

Activities of Daily Living (ADLs)
ADLs include:
- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (e.g., taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

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

Adverse Benefit Determination
(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the state.
(5) The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.
(6) For a resident of a rural area, the denial of a member’s request to exercise their right, to obtain services outside the network.
(7) The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Advance directive
Legal papers that list a member’s wishes about their end-of-life health care.

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

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

Ancillary Provider Services
Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.
**Appeal**
A member request that their health insurer or plan review an adverse benefit determination.

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

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

**Capitation**
A prepaid, periodic payment to care providers, based on the number of assigned members made to a care provider for providing covered services for a specific period.

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

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

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

**CMS**
Centers for Medicare and Medicaid Services, the federal regulatory agency for these programs.

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

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

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

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

**Current Procedural Terminology (CPT) Codes**
A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

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

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

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

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

**Disenrollment**
The discontinuance of a member’s eligibility to receive covered services from a contractor.
Dispute
Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.
Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
As defined by 42 U.S.C. § 1396d(r)(5) and 42 CFR 440.40(b) or its successive regulation. A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

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

Electronic Funds Transfer (EFT)
The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)
An electronic version of a member’s health record and the care they have received.

Electronic Visit Verification (EVV)
An EVV helps electronically verify the delivery of services. It also helps you view and schedule visits and submit claims in a timely manner. An EVV system may also help:
• Ensure members get their approved services as scheduled.
• Prepare you for audits.
• Ensure compliance with the Agency for Health Care Administration (AHCA) contract requirements.

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 a 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 a 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 expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Fee For Service (FFS)
A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

FHC
Family Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.
**Grievance**
Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination. (See appeals/dispute.)

Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. Grievance includes an member’s right to dispute an extension of time proposed to make an authorization decision.

**Healthcare Effectiveness Data and Information Set (HEDIS)**
A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plans and how it compares to other plans.

**HIPAA**
Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

**Home and Community-Based Services (HCBS)**
Services that help Medicaid beneficiaries live in the community and avoid institutionalization.

**Home Health Care (Home Health Services)**
As defined in Rule 59G-4.130, F.A.C. Health care services and supplies provided in the home, under physician’s orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

**In-Network Provider**
A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

**Medicaid**
A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

**Medical Emergency**
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention, you could reasonably expect one of the following to result:

- Their health would be put in serious danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

**Medically Necessary**
As defined in Rule 59G-1.010, F.A.C. Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

**Member**
An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.

**NPI**
National Provider Identifier. Required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

**Out-Of-Area Care**
Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

**Participant Direction Option (PDO)**
A service delivery option that lets LTC members have decision-making authority over allowable services and how those services are delivered. This includes hiring and firing service providers. A member choosing participant direction accepts responsibility for taking a direct role in managing their care.

**Patient Responsibility (PR)**
The cost of Medicaid long-term care services not paid for by the Medicaid program for which the member is responsible. PR is the amount members must contribute toward the cost of their care. The PR amount is DCF and is based on income and choice of residence.
Plan of Care (POC)
A description of the member’s needs and goals for long-term care as well as the services and supports needed to meet those goals. The POC shows the projected duration, desired frequency, and type of provider furnishing each service. It also shows the scope of the services to be provided.

Preventive Health Care
Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary Care Provider (PCP)
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior Authorization (Notification)
The process where health care providers seek approval prior to rendering health care services, DME or drugs as required by UnitedHealthcare Community Plan policy.

Provider Group
A partnership, association, corporation, or other group of care providers.

Quality Management (QM)
a methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Rural Health Clinic
A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Service Area
The geographic area served by UnitedHealthcare Community Plan, designated and approved by AHCA.

Specialist
As described in Rule 59G-1.010, F.A.C. A care provider licensed in the state of Florida and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing
An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

TANF
Temporary Assistance to Needy Families. As described in 45 CFR 260.20. A state program that gives cash assistance to low-income families with children.

Third-Party Liability (TPL)
A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely Filing
When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.

UnitedHealthcare Community Plan
An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

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).

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.

Value-Added
As described in 42 CFR 438.3(e)(i).