

2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary
Florida Healthy Kids

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Chapter 1: Introduction

Welcome

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

Click the following links to access different manuals:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual — go to UHCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired 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.

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

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

Important Information about the use of this manual

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

We amend the manual as policies change.

Contact Information

Provider Services	877-842-3210 UHCprovider.com	<ul style="list-style-type: none"> To inquire about a patient's eligibility or benefits, check claim status, or for translations or TDD services. To ask about your participation. Notify us of demographic and practice changes. Address claims issues. File a physician complaint. Request a copy of the plan's Cultural Competency Plan at no charge. Request a copy of the care provider manual.
Prior-Authorization Notification	866-894-5796 UHCprovider.com	To notify us of the procedures and services outlined in the prior authorization requirements section of this guide.
Pharmacy Services	UHCprovider.com Tel: 877-842-1508 <ul style="list-style-type: none"> Tel: 800-310-6826 Tel: 888-900-3232 Tel: 866-528-1758 Fax: 877-265-4976 Fax: 800-757-2617 	To view or request a copy of the Preferred Drug List (PDL) <ul style="list-style-type: none"> Medications requiring notification Self-injectable medications IV infusions/IV medications For easy Rx fax service Pharmacy appeals (must be in writing)
Mental Health Substance Abuse, Vision, Transplant or Dental Services	See member's ID card for carrier information or call customer service.	To ask about a patient's behavioral health, vision, transplant or dental benefits.
Claims Address	Florida Healthy Kids (FHK) UnitedHealthcare Community Plan P.O. Box 31348 Salt Lake City, UT 84131	For claims with dates of service before June 1, 2017, please use the previous mailing address: UnitedHealthcare of Florida P.O. Box 31362 Salt Lake City, UT 84131

Online Resources

Link and UHCprovider.com

Use Link – your gateway to UnitedHealthcare’s online tools – to perform secure transactions for UnitedHealthcare Community Plan members:

- View patient eligibility and benefits
- Check the status of a claim
- Submit a claim reconsideration
- Submit referrals

To submit a single CMS-1500 claim form, go to UHCprovider.com/claims.

The following reports are also available at the website:

- PCP Panel Report
- Capitation (CAP) Reports
- Claim Trends

- Provider Profile
- Early and Periodic Screening, Diagnosis, and Treatment
- Preventive Health Measures

To access Link and reports that require secure access, sign in to UHCprovider.com using your Optum ID. If you don't have an Optum ID or need help remembering your ID or password, the sign-in screens will help guide you through the process.

To learn more about Link, please visit UHCprovider.com > Quick Links > Link: Learn More. Or call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 3, 7 a.m. – 9 p.m., Central Time, Monday through Friday.

Provider Attestation

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

Description of Florida Healthy Kids

The Florida Healthy Kids (FHK) Corporation was established in 1990 by the Florida Legislature as a public-private initiative to improve access to comprehensive health insurance for the state's uninsured children. FHK is a Children's Health Insurance Program (CHIP), or "Title XXI": "the program created by the federal Balanced Budget Act of 1997 as Title XXI of the Social Security Act."

Chapter 2: Our Claims & Encounter Process

You will want to be paid promptly for the services you provide. Here's what you can do to help ensure prompt payment:

1. Use [UHCprovider.com](https://www.uhcprovider.com), our free website for network physicians and health care professionals. At UnitedHealthcare Online you can check eligibility and claims status and submit claims electronically for faster claims payment. To register, call 866-UHC-FAST (842-3278).
2. Once you've registered, review the member's eligibility on the website at [UHCprovider.com](https://www.uhcprovider.com).

To check eligibility by phone, call 877-842-3210.

3. Notify us of planned procedures and services on our prior authorization list.
4. Prepare a complete and accurate claim form (see "Complete Claims" section.)
5. Submit the claim online at [UHCprovider.com](https://www.uhcprovider.com) or one of these other options.
 - WebMD or another clearinghouse vendor - If you currently use WebMD or another vendor to submit claims electronically, be sure to use our electronic payer ID 87726 to submit claims to us. For more information, contact your vendor or our EDI unit at 800-842-1109. To become a registered user of WebMD, call 877-469-3263, select option I.
 - **Florida Healthy Kids (FHK)**
UnitedHealthcare of Florida
P.O. Box 31348
Salt Lake City, UT 84131

Claims Processing Rules and Resources

Automated Claims Adjudication and PRAs

The process to correct claims that require additional information or had missing information will be automated to reduce the need to retroactively correct claims. When a claim needs correction, you'll no longer receive letters when claims can't be paid due to missing or inaccurate information. The PRA will include a description of the information needed to pay the claim, eliminating the need for a separate letter.

Facility and Professional Claim Types

For UnitedHealthcare Community Plan, we will process claims according to coverage and billing rules for facility and professional claim types.

To access our policies for these claim processing rules, please visit [UHCprovider.com](https://www.uhcprovider.com) > Menu > Resource Library. There, you can view bulletins, the care provider manual, and reimbursement policies.

Encounter Data

- Encounter data should be submitted using the same claims submission process listed above.
- As a capitated care provider, you must submit encounter claims when services are rendered to our members. This information is vital to our ability to report the Healthcare Effectiveness Data and Information Set (HEDIS), Child Health Check Up and other quality incentives required by the state of Florida.
- UnitedHealthcare Community Plan is contractually obligated to submit accurate, detailed, and complete encounter information to our state regulators. Consequently, our capitated participating care providers are required to submit accurate, detailed, and complete encounter information to us. Encounter submission constitutes the care provider's certification of the services rendered.

Complete Claims

Whether you use an electronic or paper form, complete a CMS 1500 or UB-04 form, a complete claim includes the following information:

- Member's name, sex, date of birth and relationship to subscriber
- Subscriber's employer group name and group number
- Name, signature, "remit to" address and phone number of physician or care provider performing the service, as in your contract document
- Physician's or care provider's federal tax ID number
- Date of service(s), place of service(s) and number of services (units) rendered
- Current CPT-4 and HCPCS procedure codes with modifiers where appropriate

- Current ICD-10 diagnostic codes by specific service code to the highest level of specificity
- Referring physician's name (if applicable)
- Charges per service and total charges
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers as well as CPT 99360 (physician standby)
- An anesthesia report for claims submitted with a 23 QS, G8 or G9 modifier
- A detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or "other" revenue codes as well as experimental or reconstructive services
- Nursing notes and treatment plan for claims submitted for home health care, nursing or skilled nursing services*
- Purchase price for DME rental claims exceeding \$1,000*

If you need to correct and re-submit a claim, submit a new CMS 1500 or UB-04 indicating the correction being made. Hand-corrected claim re-submissions will not be accepted.

Additional information may be required by us for particular types of services or based on particular circumstances or state requirements.

* Home Health, Infusion Therapy and Durable Medical Equipment (DME) services are rendered by a capitated network. These services need to be coordinated and paid by the contracted network.

Additional information needed for a complete UB-04 form:

- Date and hour of admission and discharge, as well as member's status-at-discharge code
- Type of bill code
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current revenue code and description
- Current principal diagnosis code (highest level of specificity)
- Current other diagnosis codes, if applicable (highest level of specificity)
- Attending physician ID
- Bill all outpatient surgeries with the appropriate revenue and CPT code if reimbursed according to ambulatory surgery groupings.

- Provide specific CPT and appropriate revenue code (e.g., laboratory, radiology, diagnostic or therapeutic) for services reimbursed based on a contractual fee maximum.
- Attach an itemized list of services or complete box 45 for physical, occupational or speech therapy services (revenue code 420-449) submitted on a UB-04.
- Attached an itemized statement if submitting a claim that will reach the contracted stop/loss.
- Submit claims according to any special billing instructions that may be indicated in your agreement (or letter of agreement).

If you have questions about submitting claims to us, please contact our Provider Services helpline.

Claim Adjustments

If you believe you were underpaid, please call Provider Services and request an adjustment as soon as possible. If a claim issue is not resolved through the standard process, then you should submit a reconsideration request through the normal processes:

- Website: UHCprovider.com
- Provider Services toll-free number: 877-842-3210.
- Allow 30 days and check status through the appropriate website or by calling Provider Services.
- Call Center can assist care providers with (and up to 20) claims on one phone call.

If you or our staff identifies a claim where you were overpaid, we ask that you send us the overpayment within 30 calendar days from the date of your identification of the overpayment or our request. If your payment is not received by that time, we may apply the overpayment against future claim payments.

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

If you disagree with a claim adjustment, you can appeal the determination (see Claims Disputes).

If you are submitting corrected claims by mail, complete the Adjustment Request Form. Submit it with the required documentation to:

UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, UT 84131

If you are submitting corrected claims online, complete the required UnitedHealthcare Claim Reconsideration Request Form. Check the appropriate reason for submission, and attach required documents.



Go to UHCprovider.com. Click on Claims and Payments > Claim Reconsideration. Log in to complete the process.

Claims Disputes

If you disagree with a claim payment determination, send a letter of appeal to the claim office at:

UnitedHealthcare Community Plan
P.O.Box 31364
Salt Lake City, UT 84131

Your appeal must be submitted to us within 12 months from the date of payment shown on the EOB or PRA.

If you are disputing a claim that was denied because filing was not timely, for:

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

Care providers are reimbursed on the Medicaid fee schedule amount. If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed as described in your agreement.

ERAs and PRAs

The Electronic Remittance Advice (ERA) Payer ID number is 04567. For dates of service before June 1, 2017, please use the previous ERA Payer ID number 87726.

If you are signed up to receive ERAs, you'll receive both paper and electronic remittance advices for 31 days after your first payment. For example: If your first payment is June 15, you'll receive ERAs and paper remittance advices until July 16, and only ERAs thereafter.

You can still view, save and print the paper version at UHCprovider.com/claims.

Electronic Payments & Statements

Electronic Payments & Statements (EPS) is UnitedHealthcare's solution for electronic funds transfers (EFT) and electronic remittance advice (ERA). It's one of the most efficient ways to get paid. There's no change to your posting method and no special software is required. By enrolling in EPS, you can:

- Receive claims payments by direct deposit.
- Access your explanations of benefits (EOBs) online or through 835 ERA files.

Care providers who are enrolled in EPS are automatically enrolled with the new ERA Payer ID 04567.

Mid-Level Claims Reimbursement

UnitedHealthcare Community Plan reimburses mid-level claims for the following care providers:

- Nurse practitioners
- Physician assistants
- Registered nurse first assistants

In accordance with your provider agreement, you will be reimbursed using the Florida Medicaid fee schedule. The affected services and codes may be found at ahca.myflorida.com.

Anesthesia Unit Billing Guidelines

UnitedHealthcare Community Plan asks that you:

- Submit claims with the number of units based on the total anesthesia service time. Any portion of a 15-minute increment equals one unit.
- Include the appropriate HCPCS modifiers. These modifiers identify monitored anesthesia and whether a procedure was:
 - Personally performed,
 - Medically directed, or
 - Medically supervised.

We validate this information for reimbursement. In addition, bill according to Florida Medicaid guidelines to avoid a payment reduction.

To review the reimbursement guidelines and anesthesia policies, go to UHCprovider.com/policies.

Subrogation and Coordination of Benefits

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

1. Subrogation - We reserve the legal right to recover benefits paid for a patient's health care services when a third party causes the patient's injury or illness.
2. COB - Coordination of benefits is administered according to the patient's benefit contract and in accordance with applicable statutes and regulations.

Retroactive Eligibility Changes

Eligibility under a benefit contract may change retroactively if:

1. We receive information that an individual is no longer a patient.
2. The individual's policy/benefit contract has been terminated.
3. The eligibility information we receive is later determined to be false.

If you have submitted a claim(s) that is impacted by a retroactive eligibility change, a claim adjustment may be necessary. The reason for the claim adjustment will be reflected on the PRA.


Chapter 3: Member Identification Card

UnitedHealthcare Community Plan members receive an ID card containing information that helps you process claims accurately.

Be sure to check the member's ID card at each visit.

Sample Medicaid ID card. This is a sample card, members may receive a card that looks different than the card below.

Front (No RX Copay Plan)

 **UnitedHealthcare** | Community Plan
Health Plan (80840) 911-87726-04

Member ID: 000000001 Group Number: FLFHK


Member:
NEW M ENGLISH Payer ID: 87726

PCP Name:
DOUGLAS GETWELL
PCP Phone: (717)851-6816


Effective Date
06/01/2017

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

PCP referral required for specific specialty services
DOI -0501 Florida Healthy Kids
Underwritten by UnitedHealthcare of Florida, Inc.

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

Front (\$5 RX Copay Plan)

 **UnitedHealthcare** | Community Plan
Health Plan (80840) 911-87726-04

Member ID: 000000005 Group Number: FLFHK


Member:
NEW E ENGLISH Payer ID: 87726

PCP Name:
DOUGLAS GETWELL
PCP Phone: (724)836-6900

Effective Date
06/01/2017

Copay: OFFICE/SPEC/ER/UrgCare
\$5/\$5/\$10/\$5

PCP referral required for specific specialty services
DOI -0501 Florida Healthy Kids
Underwritten by UnitedHealthcare of Florida, Inc.

 **OPTUMRx**
 Rx Bin: 610494
 Rx Grp: ACUFL
 Rx PCN: 4444
 COPAY:TIER 1
 \$5

Back (Same for both FHK plans)

In an emergency go to nearest emergency room or call 911. Printed 03/08/17

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: 888-216-0015 TTY 711
 NurseLine: 877-552-8105
 Behavioral Health: 800-582-8220
 KidCare (Premium/Renewal): 800-821-5437

For Providers: www.unitedhealthcareonline.com 877-842-3210
 Medical Claims: PO Box 31348, Salt Lake City, UT 84131-0348
 Health Plan: 3100 SW 145th Avenue, Miramar, FL 33027 / Suite 201

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

Chapter 4: Our Products

This table provides information about some of the most common UnitedHealthcare Community Plan products. Visit UHCprovider.com for more information about our products in your area. The Florida Healthy Kids plan offers coverage to children in the following counties: Alachua, Baker, Bay, Bradford, Broward, Charlotte, Citrus, Clay, Desoto, Duval, Escambia, Flagler, Glades, Gulf, Hamilton, Hardee, Hendry, Hernando, Highlands, Holmes, Indian River, Jackson, Lafayette, Lee,

Manatee, Miami-Dade, Monroe, Nassau, Okaloosa, Orange, Osceola, Palm Beach, Putnam, Santa Rosa, St. Johns, Suwanee, Taylor, Union, Volusia, Walton, and Washington counties. If a patient presents an identification card with a product name with which you are not familiar, please contact Provider Services. This product list is provided for your convenience and is subject to change.

Attributes	Healthy Kids
How do customers access physicians and health care professionals?	Customers may access services through a Healthy Kids physician and health care professional network.
Does a primary physician have to make a referral to a specialist? (Some states have enacted direct access requirements. If those requirements exist, they will be noted in the contracts state amendment appendix.)	Primary physicians should coordinate care with appropriate in-network specialists. An Online Referral Form must be entered on UHCprovider.com prior to the specialist service being received.
Is the treating physician required to notify Health Services?	Yes, refer to “prior notification requirements.”
Does the physician or care provider collect a co-payment from customers?	Yes, at time of visit.
* Some medical services under Florida Healthy Kids require co-payments. Check your benefit grid.	

Chapter 5: Notification Requirements

Prior Notification List

Prior Notification Requirements	Explanation
Abortion	State Reporting Requirement
Admissions	All inpatient admissions, including maternity, acute hospital, rehabilitation facilities, hospice and skilled nursing facilities. Elective Admissions: Notification required at least 14 days prior to scheduled procedure Emergency Admissions: Within one business day of an emergency or urgent admission After Ambulatory Surgery: Within one business day of an inpatient admission after ambulatory surgery
Circumcision – All Medicaid members after 12 weeks of age	Medical Necessity Determination
Cosmetic or Reconstructive Surgery, including but not limited to: <ul style="list-style-type: none"> Blepharoplasty Breast reconstruction & reduction Vein stripping & ligation Sclerotherapy 	Medical Necessity Determination
Durable Medical Equipment (DME) >\$1,000	DME with retail cost of > \$1,000 whether for purchase or rental must use network care providers
General Anesthesia related to Dental Procedures	Medical Necessity Determination
Home Health Care Services (HHC) <ul style="list-style-type: none"> Infusion All other 	All home-based services, including nursing, respiratory therapy, IV infusion and hospice
Medical Injectables including but not limited to: <ul style="list-style-type: none"> Acthar HP Botulinum Toxins Immune Globulins Makena 	Medical Necessity Determination
Out of Network Services (All Non-Participating)	Non-network participating professionals in any category of service
Pain Management Programs	All outpatient and inpatient services, referrals to pain management centers and anesthesia injections
PET Scans	Medical Necessity Determination
Prosthetics/Orthotics > \$1,000	Medical Necessity Determination
Therapies, including: <ul style="list-style-type: none"> Physical therapy Occupational therapy Speech therapy 	All locations must call for prior notification. Medical Necessity Determination
Transplant Evaluations	Notification at the time of, or prior to, the request for evaluation; all services pre and post; all transplant types

* Please provide the following information to allow us to better serve you:

Member name; ID number; date of birth; CPT /ICD 10/HCPCS codes and any other information necessary to complete the authorization process.

The presence or absence of a procedure or service on the above list does not mean that it is a covered benefit for your Medicaid member. The notification requirements on this list do not change or otherwise affect current requirements for outpatient prescription drug benefits or behavioral health benefit.

For questions about benefit coverage, call the Customer Service number on the member's ID card.

Prior Authorization Fax Request Form (Fax # : 866-607-5975)

This FAX form has been developed to streamline the Prior Auth request process, and to give you a response as quickly as possible. Please complete all fields on the form, and refer to the listing of services that require authorization; you only need to request authorization for services on that list. The list can be found at www.americhoice.com. Please select the appropriate health plan and refer to provider materials.

Date: _____ Contact Person _____

Telephone #: _____ Fax #: _____

Requesting Provider: _____ Telephone #: _____

- Initial request Urgent Routine
 Request for an extension Urgent Routine

Urgent is defined as "significant impact to health of the member if not completed within 72 hours"

Member Information:

Member Name: _____ Member ID/JD# _____ Date of Birth: _____

Patient Name: _____ Member ID/JD# _____ Date of Birth: _____

- Is request related to MVA or work-related injury? Does member have other insurance?
 Yes No Yes No Medicare Part A Part B
 Other insurance name and policy # _____

Servicing Provider Information:

Date of Service: _____ Provider ID: _____

Physician or Servicing Provider: _____ Phone #: _____

Address: _____ Fax #: _____

Facility: _____ PAR or Non-PAR (please circle one)

If Non-par will provider accept Medicaid/Medicare default rate - Yes No

Type of Service:

- | | | |
|---|--|--|
| <input type="checkbox"/> DME – Purchase | <input type="checkbox"/> Cosmetic or Reconstructive | <input type="checkbox"/> Home Health/Hospice Services |
| <input type="checkbox"/> DME – Rental | <input type="checkbox"/> Surgery | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Prosthetic / Orthotics | <input type="checkbox"/> PT / OT / ST | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Inpatient Elective Surgery | <input type="checkbox"/> MRI, MRA or PET Scan | <input type="checkbox"/> Out Of Network (please explain) |
| <input type="checkbox"/> Transplantation Evaluation | <input type="checkbox"/> Gastric Bypass Eval/Surgery | <input type="checkbox"/> Other _____ |

Clinical Information:

Diagnoses: _____ ICD-9 Codes: _____

CPT/HCPCS Codes: _____

Procedures: _____

Number of visits: _____ Duration: _____ Frequency: _____

Number of previous visits: _____ Service name/code for previous visits: _____

NOTE: In order to process your request completed and timely, Please submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, labs results, radiology reports) to support request for services. Any request for OON services must include documentation on the reason for the request along with the name of the OON provider. **FAILURE TO PROVIDE SUFFICIENT CLINICAL INFORMATION WILL RESULT IN A DELAY IN YOUR REQUEST.**

UnitedHealthcare of FL, Inc (AmeriChoice).

AHCA-B-H-086 12/09-08/12

To request prior authorization, submit your request online, by phone or fax:

- Online: UHCprovider.com/priorauth
- Phone: 866-604-3267
- Fax: 866-607-5975

Determination of Medical Necessity

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. 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; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the care provider.

Notify Health Services Within the Following Time Frames

- **Emergency Admission**
 - Within one business day of an emergency or urgent admission.
- **After Ambulatory Surgery**
 - Within one business day of an inpatient admission after ambulatory surgery.
- **Non-Emergency Care (except maternity)**
 - At least 14 business days prior to non-emergent, non-urgent hospital admissions and/or outpatient services.

Return calls to Case Managers and Medical Directors and provide complete health information within one business day.

Failure to notify Health Services may result in denial of payment for non-notified admission dates.

Hospital Notification Requirements

UnitedHealthcare Community Plan contracts with hospitalist groups within our contracted hospitals to handle all admissions and emergency room presentations by our Florida Healthy Kids members. Working with these groups facilitates the management and coordination of care for your patients and our members.

The Hospitalist program is a dynamic one. We regularly review Hospitalist performance to help ensure that the hospitalists continue their dedication to quality of care and resource efficiency. All hospitals must contact our contracted Hospitalist groups for all potential (emergency room presentations) and necessary admissions; unless the patient’s primary care provider (PCP) or treating specialist indicates otherwise.

Clinical Peer Review

Health care professionals who conduct peer clinical reviews are available by telephone to discuss review determinations with the attending physician, or other ordering care providers. If the original clinical peer reviewer making the initial determination is not available within one business day, we will provide an alternate clinical peer for discussion.

Chapter 6: Network Participation

PCP Responsibilities/Procedures/New Member Processing

To encourage members to visit their PCP, the UnitedHealthcare Community Plan Enrollee Services department will mail each new member an introductory letter that includes the name, address, and phone number of the member's PCP. The mailing includes information about our benefits. It requests members make an appointment with their PCP for an initial health assessment.

In addition to the contact by UnitedHealthcare Community Plan, PCPs should welcome their new members and request they seek an initial health screening. At the first visit, ask members to authorize the release of their medical records to you if they are seeking services from you for the first time or after a break in service. Once received, you can identify if they have received past screenings according to our approved periodicity schedules and national/UnitedHealthcare Community Plan clinical guidelines and recommended preventive health service schedules. This will also allow PCPs to identify which services need completing.

PCPs are responsible for coordinating care for members and for generating referrals to network specialists using the referral Link tool on UHCprovider.com prior to the member seeking care with any specialty network physician. To generate a referral, the PCP should follow these steps on the UHCprovider.com home page:

1. Log on using your practice's assigned login information.
2. Select the "referralLink Florida Community Plan" tile.
3. Click option for Create New Referral.
4. Search and select member needing referral.
5. Select referring care provider contact details.
6. Search and select participating specialist.
7. Enter the referral details (dates, number of visits, diagnosis code, notes, etc.), and then submit.

Once submitted, you will receive a status and certification ID. Existing referrals can be viewed by selecting the search option on the main member referral page.

Referrals **must** be entered through the referral Link tool on UHCprovider.com prior to the specialist service being received. Retroactive referrals are not accepted. Each referral may include up to six months of visits to a given network specialist. After the six months of visits have been used, an additional referral to that network specialist may be entered for up to another six months of visits.

More information on the referral submission process can be found at UHCprovider.com > Quick Links > Link: Learn More > referralLink (For Community Plan of Florida Providers Only).

Services not requiring a referral

- Any services from a participating network obstetrician/gynecologist.
- Routine refractive eye exam from a participating care provider.
- Mental health/substance abuse services with participating network behavioral health clinicians.
- Services rendered in any emergency room, network urgent care center or convenience clinic.
- Physician services for emergency/unscheduled admissions.
- Services from inpatient consulting physicians.
- Consultation and treatment with participating network dermatologists.
- Consultation and treatment with participating network podiatrists.
- Any other services for which applicable law does not allow us to impose a referral requirement.

PCPs are REQUIRED to participate in the Florida SHOTS program, a free, statewide, online immunization registry sponsored by the Florida Department of Health. This program provides an easy tracking tool for care providers; it prospectively forecasts upcoming immunizations needs; and is able to produce the 680 form required by law for schools and child care centers, eliminating additional work by care providers.

PCP Responsibilities With Non-Compliant Members

PCPs have a responsibility to respond to members who either fail to keep appointments or fail to follow a care provider's plan of care as either can interrupt continuity of care and lead to a delay or failure on the part of the member to get medical diagnosis or treatment. UnitedHealthcare Community Plan expects care providers sites to have a procedure for dealing with non-compliant members and member notification. While it is the member's responsibility to keep appointments and to comply with the plan of care prescribed by the PCP, you in turn have responsibilities when this does not occur. The member must be notified of their non-compliance, and you need to document this activity whether done orally or in writing. This is further required should you need to involuntarily

disenroll a member from a panel for non-compliance. Both UnitedHealthcare Community Plan and the Florida Healthy Kids Corporation will be monitoring this activity.

Failure to show

Failure to show is defined as a member who has missed three consecutive appointments within a six-month time period with the same health care provider or facility and does not notify the health care provider that they are unable to keep the scheduled appointment.

Failure to follow plan of care

This is when a member chooses not to comply with the care provider-prescribed plan of care. Seek assistance from our Member Services department at the phone number on the back of their Member ID card.

Removing a Member from PCP Panel

Care providers must make a reasonable effort to establish and maintain an appropriate relationship with their patients who are our members. When such a relationship cannot be established or a breakdown occurs, the PCP has the right to request termination of the relationship by withdrawing as the member's PCP.



To request a member removal from your panel, please call your Provider Relations Representative at 877-842-3210.

To request involuntary disenrollment from a PCP panel, the PCP must keep appropriate records documenting the reasons for failure to establish and maintain a relationship. Prior to requesting a disenrollment, the PCP must make every effort to assist the member in correcting the situation. If the situation is not resolved, the PCP must notify the member and Member Services by certified mail of their intention to terminate the relationship. This letter must include an intended effective date of the change, which must be at least 30 days following the date of the letter, and an explanation that care will continue at the current PCP office until the date of change. The letter must also refer the member to seek additional assistance including a change of PCP by calling Member Services at the phone number on the back of the Member ID card.

Provide Official Written Notice

You must notify Network Management of the following events, in writing, within 10 calendar days of your knowledge of their occurrence:

1. Material changes in, cancellation or termination of liability insurance;
2. Change in practice ownership, name, address, phone or federal tax ID number;

3. Bankruptcy or insolvency;
4. Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
5. Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program; and
6. Loss or suspension of your license to practice.
7. Provide an annual attestation of active patient load. "Active" is defined by a patient who has been seen at least three times in a year. Active patient load includes all patients, not just ours, and should not exceed 3,000. If your total active patient load exceeds 3,000, your panel will be closed to new membership until a new attestation form is received.

To do so, send notice to one of the following addresses:

South Florida:

3100 SW 145th Avenue,
Miramar, FL 33027

Central Florida:

495 North Keller Road,
Suite 200, Maitland, FL 32751

West Florida:

9009 Corporate Lake Drive,
Suite 200, Tampa, FL 33634

North Florida:

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

Federal Regulations require use of your NPI on all electronic claims and paper claims for many Medicaid agencies, including AHCA. Claims may be rejected or denied when submitted without an NPI or with an invalid NPI. Care providers are also required to have a valid Medicaid Provider Number. The health plan may take whatever steps are necessary to help ensure that the care provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s), as a participating care provider of the health plan and that the provider's submission of encounter data is accepted by the Florida MMIS and/or the State's encounter data warehouse.



NPI information can be faxed to 866-943-0517, emailed to americhoice_dbm_npi@uhc.com or mailed to UnitedHealthcare DBM Claims, P.O. Box 16900, Phoenix, AZ 85011.

Transition Patient Care Following Termination of Your Participation

If your network participation terminates for any reason, you are required to participate in the transition of your patient toward timely and effective care. This may include providing service(s) for a reasonable time at our contracted rate. Customer Service is available to help you and your patient with the transition.

Arrange Substitute Coverage

If you are unable to provide care and want to arrange for a substitute, we ask that you try to arrange for care from other physicians and health care professionals who are contracted to participate with the Florida Healthy Kids product. For the most current listing of network physicians and health care professionals, visit UHCprovider.com > Find Dr. A non-network physician or health care professional will need to apply for participation and, if accepted, sign a participation agreement.

Participate in Quality Initiatives

You are expected to cooperate with our quality assessment and improvement activities and to comply with our clinical guidelines, patient safety (risk reduction) efforts and data confidentiality procedures.

Protect Confidentiality of Patient Data

Our members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill our obligations and to facilitate improvements to our members' health care experience. We require our affiliates and business partners to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records.

Provide Access to Your Records

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

Follow Medical Record Standards

Care providers must minimally adhere to medical record standards as below. Medical record documentation tools can be found in Medicaid Handbooks and upon request to the UnitedHealthcare of Florida, Quality Management Department.

- Each record must contain identifying information, including member name, member identification number (Medicaid #), date of birth, gender, and legal guardianship (if any).
- Each record must have the member's name and identification number on each page.
- Each record must include past medical history, including significant illnesses and medical conditions on a problem list. Include dates of onset and resolution.
- Each record must be organized, legible and maintained in detail.
- Each record must contain a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications. For children and adolescents, history includes prenatal care, birth, operations and childhood illnesses.
- All entries in each record must be dated and signed by the appropriate party.
- All entries in each record must indicate the chief complaint or purpose of the visit: the objective, diagnosis, medical findings or impressions of the care provider.
- Each record must include diagnoses consistent with findings and treatment plans consistent with diagnoses.
- All entries in each record must indicate studies ordered, for example: lab, X-ray, EKG, and referral reports.
- All entries in each record must indicate therapies administered and prescribed. For medication records, include the name of medication, dosage, amount dispensed and dispensing instructions.
- All entries in each record must include the name and profession of the practitioner rendering services, for example: M.D., D.O., O.D., including signature or initials of practitioner.
- All entries in each record must include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up, and outcome of services.
- Each record must contain an immunization history.
- Each record must contain information on smoking/ETOH (ethyl alcohol)/substance abuse.

- Each record must contain summaries of all emergency services and care and hospital discharges with appropriate medically-indicated follow-up.
- All records must have documented all referral services.
- Records must include documentation of all services provided; such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- All records must reflect the primary language spoken by the member and translation needs of the member.
- All records must identify members needing communication assistance in the delivery of health care services.
- Give prominence to notes on medication allergies and adverse reactions. Also note if the patient has no known allergies or adverse reactions.
- Breast Cancer Screening.
- BMI Assessment.*
- Lipid Profile Annually.
- Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor (ARB) Therapy.
- Lead Screening in Children (Lead Blood Test).*
- Persistence of Beta-Blocker Treatment after a Heart Attack.
- Frequency of HIV Disease Monitoring Lab Tests.
- Highly Active Anti-Retroviral Treatment.
- HIV-Related Medical Visits.
- Child Health Check-Up.*
- Cervical Cancer Screening.*
- Childhood Immunization Status.*
- Immunizations for Adolescents.*
- Well Child 1st 15 Months.*
- Well Child Years 3-6.*
- Adolescent Well Care.*
- Mental Health Readmission Rate.
- F/U After Hospitalization for Mental Illness.
- Antidepressant Medication Management.
- Follow-up Care for Children Prescribed ADHD Medication.*
- Use of Appropriate Rx in Asthma.
- Controlling HBP.*
- Comprehensive Diabetes Care.*
- Adult Access to Preventive/Ambulatory Health Services.
- Annual Dental Visits.
- Prenatal & Postpartum Care.
- Prenatal Care Frequency.
- Ambulatory Care (Includes ER measure).
- Mental Health Utilization-Inpt D/C & Avg LOS.
- Mental Health Utilization-Inpt, Intermediate & Ambulatory Services.
- Access/Availability.
- Member Satisfaction.
- Care Provider Satisfaction.
- Pediatric Preventive Care.*
- Adult Preventive Care.*

Inform Patients of Advance Directives

The federal Patient Self-determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through advance directive.

Under the federal act, physicians and care providers, including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about a patient's right to accept or refuse treatment, and about your own policies regarding advance directives.

To comply with this requirement, we also inform our members of state laws on advance directives through our member handbooks and other communications.

UnitedHealthcare of Florida Quality Improvement Program

UnitedHealthcare of Florida has as its mission to improve the quality of care to Medicaid recipients, to provide a high standard of health care and education, to improve the health status of the community, and to have satisfied members and care providers.

There are many areas that can be assessed to determine how successfully we provide care. The quality indicators assessed will depend on your practice type and the plan that the member is in. Care provider performance on indicators will be assessed at least annually. These indicators are largely determined by the state of Florida and/or our accrediting body, and include:

* Refer to the UnitedHealthcare Preventive Health Guidelines.

Member Availability/Accessibility to Services

You are required to meet the following access to care standards:

- Emergency medical care - available 24 hours a day/7 days a week.
- Urgent care - within one day.
- Routine sick care - within one week.
- Well care - within 4 weeks.

You must offer the same number of office hours to Florida Healthy Kids (FHK) members as you do for commercial members or comparable Medicaid fee-for-service, if you serve only Medicaid enrollees.

After-Hours Availability/Call Coverage

- Access to the PCP or licensed clinician must be 24 hours a day/seven days a week.
- After-hours access must be with someone who is licensed to render a clinical decision.
- After-hours access does not include an answering machine unless it results in a prompt callback by a licensed clinician.

The UnitedHealthcare Community Plan Quality Monitoring Program Minimally Incorporates:

- The generation of utilization reports for services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, durable medical equipment companies, and pharmacies.
- Facility audits and medical record reviews to monitor services provided by PCPs and high volume specialists (OB-GYNs).
- Monitoring practice guidelines through medical record reviews and utilization reports.
- The monitoring of high volume/high risk services based on review of demographic and epidemiological distribution of members.
- Review of acute and chronic care services.
- Continuity and coordination of care.
- Over- and under-utilization of medical resources.
- Care provider and member satisfaction surveys.
- Complaint and grievance monitoring and analysis.
- Compliance with practice guidelines, including preventive health guidelines.

Follow Practice Protocols

We have adopted preventive, chronic, and complex practice protocols for children, adolescents, and adults. The guidelines are updated minimally once per year. They include preventive health, immunization, mental health, and other clinical guidelines and preventive health schedules. To view our guidelines, visit UHCprovider.com for other authoritative medical sources. A printable version is available online for downloading. To request a copy of our practice protocols by phone, please call Provider Services.

Cultural Competency

We have a comprehensive written Cultural Competency Plan describing how the health plan will help ensure that services are provided in a culturally competent manner to our members, including those with limited English proficiency. You may request, at no charge, a copy of our Cultural Competency Plan by calling Provider Services at 877-842-3210 or visit UHCprovider.com.

Resolving Disputes

Contract concern or complaint regarding policies, procedures or administrative functions. If you have a concern or complaint about your agreement with us, send a letter containing the details to:

For 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

West Florida

Network Management
9009 Corporate Lake Drive, Suite 200
Tampa, FL 33634

North Florida

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

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

If your concern or complaint relates to a matter that is generally administered by certain UnitedHealthcare Community Plan procedures, such as the Credentialing or Health Services process, we will follow the procedures set forth in those plans to resolve the concern or complaint.

Participation Appeal – Is a written request by the care provider to the Provider Affairs Subcommittee to reconsider a care provider’s participation decision.

The Provider Affairs Subcommittee must provide a fair hearing appeal opportunity for care providers in a timely manner according to set policies and procedures, and to render judgment.

- To request an appeal hearing, the care provider must make the request in writing to the Chair of the Provider Affairs Subcommittee within 30 days from the date of notification of the termination.
- The plan provides you with a summary of the rights in the hearing in accordance with the Health Care Quality Improvement Act of 1986.
- The plan furnishes written notice of the time, place, and date of any hearing on the proposed action.
- The plan provides you with a list of witnesses to be called against you at the hearing.
- All hearings occur before at least three board-certified practitioners, one of whom is not otherwise involved in network management and who is a clinical peer of the participating care provider who filed the appeal.
- The plan informs you that your right to a hearing will be forfeited if you do not appear at the hearing.
- The plan grants you the following rights:
 - The right to have a record of the hearing made.
 - The right to call and cross-examine witnesses.
 - The right to present evidence.
 - The right to submit a written statement.
 - The right to be represented by an attorney.
- After the hearing, the plan provides you a copy of the written recommendation of the hearing committee within 10 days.
- After the hearing, the plan provides you with a written decision, including the basis for the decision within 30 days. The decision contains the right to a second-level hearing.
- All peer review activities and data collected for such purposes are confidential pursuant to Florida State Law.
- The plan offers a second level hearing, if necessary. The hearing committee will be composed of three entirely

different board-certified care providers, one of whom is not otherwise involved in network management and who is a clinical peer of the participating provider who filed the appeal.

- Standards for written recommendations, written decisions and basis for the decision, and notifications are the same as the first-level appeal.
- There is no further appeal for the decision of the second-level appeal.

If we have a concern or complaint about our agreement with you, we’ll send you a letter containing the details. If we can’t resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described below and in our agreement.

Arbitration

Any arbitration proceeding under your agreement will be conducted in Broward County, Florida under the auspices of the American Arbitration Association, as further described in our agreement.

For more information on the American Arbitration Association guidelines, visit their website at www.adr.org.

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

Uphold Member “Bill of Rights”

The State must help ensure that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the health plan and its care providers or the State agency treat the member.

We tell our members they have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you: (These rights and responsibilities are reprinted from our member handbook.)

Customers have the right to:

- Receive information about us, our services and network physicians and health care professionals in accordance with federal and state regulations.
- Be treated with respect and with due consideration for their dignity and privacy by UnitedHealthcare Community Plan personnel, network physicians, and health care professionals, as well as privacy and confidentiality for treatments, tests or procedures received.

- Voice concerns about the service and care they receive, as well as register complaints and appeals concerning their health plan or the care provided to them and receive timely responses to their concerns.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand, regardless of cost or benefit coverage.
- Participate with their PCP and other caregivers in decisions about their health care, including the right to refuse treatment.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards.
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of his or her medical records, and request that they be amended or corrected.

Customers have the responsibility to:

- Know and confirm their benefits before receiving treatment.
- Contact an appropriate health care professional when they have a medical need or concern.
- Show their identification card before receiving health care services.
- Verify that the physician or health care professional they received services from is in the UnitedHealthcare Community Plan network.
- Use emergency room services only for injury or illness that, if not treated immediately, could pose serious threat to their life or health.
- Keep scheduled appointments.
- Provide information needed for their care.
- Follow the agreed-upon instructions and guidelines of physicians and health care professionals.
- Notify UnitedHealthcare Community Plan Customer Service of a change in address, family status or other coverage information.

Care Provider Compliance/Fraud & Abuse

UnitedHealthcare Community Plan actively attempts to prevent and identify suspected incidents of fraud and abuse. All activities seen as fraud and or abuse will be reported to Florida Healthy Kids (FHK) as appropriate and as needed. We actively, prospectively, and retrospectively analyze the potential for, and occurrence of, fraud and abuse. We monitor for fraud and abuse using resources such as (but not limited to) claims/encounter data, credentialing/re-credentialing, utilization management, quality management, and grievance/appeals. We also routinely access and use the HHS Office of Inspector General List of Excluded Individuals/Entities to identify individuals excluded from participation in Medicaid. Confidentiality will be maintained for the suspect person or entity. All rights afforded to both care providers and members will be reserved and enforced during the process. Care providers must comply with all aspects of the UnitedHealthcare Community Plan fraud and abuse plan/requirements.

Chapter 7: Healthy Kids Plan Summary

UnitedHealthcare Community Plan and the Florida Healthy Kids Corporation are partners in providing low-cost health insurance coverage for children ages 5 through 18. Parents enroll their children by meeting certain eligibility criteria and pay a monthly premium. The Healthy Kids plan is available to participants residing within the approved service area. All participants must not be enrolled in or eligible for Medicaid, Medicare or other comparable governmental health programs as well as private health insurance coverage. The Healthy Kids plan is a PCP-based product, in which the plan participant must select a PCP who participates in the plan. The designated PCP coordinates all of the plan participant's care and services.

Helpful Administrative Information

Every plan participant is sent a UnitedHealthcare Healthy Kids Identification Card at the beginning of the first month they are effective with the program along with a plan participant handbook and instructions regarding obtaining services.

Member eligibility can be verified by:

- Checking eligibility online through UnitedHealthcare Online or VETSS (Voice Enabled Telephone Self-Service System) Call 877-842-3210, or
- Calling AMI (Automated Member Information) at 877-842-3210 or
- Calling the toll-free Customer Service number listed on the back of the member's ID card.

UnitedHealthcare Healthy Kids ID card

The card includes the member's name and UnitedHealthcare Community Plan ID number. The number consists of a group number (FLFHK) and a member number (9 digits), effective date, the PCP's name and phone number.

Please verify that the name of the PCP providing services and the name of the PCP on the card are the same.

This card does not verify eligibility. Care providers will need to confirm eligibility before rendering services. Eligibility can be verified as explained above.

Opioid Limits

UnitedHealthcare Community Plan implemented a 90 morphine equivalent doses (MED) supply limit for the long-acting opioid class.

We updated prior authorization criteria to match the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization will apply to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at [cdc.gov](https://www.cdc.gov) > More CDC Topics > Injury, Violence & Safety > Prescription Drug Overdose > CDC Guideline for Prescribing Opioids for Chronic Pain. For more information, access our website at www.liveandworkwell.com.

Access Requirements

Healthy Kids participants should be provided timely treatment in accordance with the following:

- Emergency care shall be provided immediately.
- Urgently needed care shall be provided within 24 hours.
- Routine care of patients who do not require emergency or urgently needed care shall be provided within seven calendar days.
- Physical examinations shall be provided within four weeks of request for appointment.
- Follow-up care shall be provided as medically appropriate.

Children's Medical Services (CMS)

Children with special health care needs expected to last 12 months or longer (i.e., spina bifida, leukemia, diabetes, severe behavioral health conditions) may be eligible for a Florida Kidcare program that provides a network of specialty care providers and intensive case management. This program is available for children up to 19 years. Medical eligibility is determined by a CMS nurse or case manager. Should you identify a patient with chronic issues that may benefit from a plan referral to CMS, please contact our Health Services at 800-825-8792 ext. 4562 and ext. 4436 or contact CMS directly at the numbers provided in this manual.

Member Complaints and Grievances

If a member has a concern or question regarding care or coverage under the plan, they should contact Member Services at the toll-free number on the back of their identification card, Monday through Friday. A customer service representative will answer any questions or concerns. The representative will try to resolve the problem. If the representative does not resolve the problem, the member has the right to file a formal grievance.

Grievance Resolution

A grievance may be submitted to the plan or the independent review organization at any time from the occurrence of the events upon which the complaint is based.

The member or care provider, acting on behalf of the member and with the member's written consent, may file a grievance either orally or in writing. An oral request should be followed up with a written request, but the time frame for resolution begins the date the plan receives the oral filing. Assistance can be requested to help prepare a written grievance.

A written acknowledgement of the grievance will be sent to member. The grievance will be resolved within the State-established time frames not to exceed 90 days from the day the plan receives the grievance. The plan's written notice of the disposition will include results and date of grievance resolution.

If the member is not satisfied with the plan's final decision, they have the right to appeal to the independent review organization. The member must make the request for an independent review organization review within one year of receipt of the final decision letter from the plan.

Appeals Process

An appeal is a review by the insurer of an adverse benefit determination. The member may file an appeal, and a care provider, acting on behalf of the member's written consent may file an appeal. The appeal can be filed orally or in writing and the member or care provider must follow an oral filing with a written, signed appeal.

The plan will follow the state of Florida's timelines for resolving each appeal. The plan will provide written notice of the disposition that includes the results and date of appeal resolution, and will inform the member of rights of benefits, and the independent review organization.

Expedited Review

There may be times when UnitedHealthcare Community Plan does not cover health care services based on the information received. These decisions can be appealed. When the member's health care condition is such that the life, health or ability to get better will be seriously affected if immediate health care is not received, an urgent grievance may be filed. You or the member may call us or put the request in writing.

- If we make a decision on behalf of a member that you are not happy with and you want to file an appeal but feel the time for this appeal could be a danger to their life or health or cause them to be injured, you may ask for a fast review on behalf of the member. Fast reviews are also called expedited appeals. You and the member will get the answer to the fast review within 72 hours. For fast reviews, please call UnitedHealthcare Community Plan at 866-799-1328.
- When we get your request for an expedited appeal we will make the decision if your appeal requires a fast review. If we decide that your appeal does not need a fast review, we will let you and the member know and then process your appeal as a regular appeal according to the procedures and timeframes mentioned in the section "How to file an Appeal". You can always call the Customer Service department or speak to your field representative if you need more information on expedited appeals.

The case will be reviewed by different care providers from those who did not approve the health care services the first time.

Helpful Benefit Information

Delivery of Medical Services

Healthy Kids members must obtain referrals for specialty care services and ancillary services. For hospital-related services please consult page 18 of the Physician and Health Care Professional Administrative Guide. Payment may be withheld if proper referrals or prior notification is not obtained. In the case of an emergency, immediate treatment should be provided and contact made with the PCP as soon as possible, preferably within 24 hours.

Copayments

UnitedHealthcare Florida Healthy Kids plan participants are subject to copayments and should be collected at the time of obtaining services.

Participating Florida Healthy Kids Counties:

Alachua	Duval	Highlands	Nassau	Taylor
Baker	Escambia	Holmes	Okaloosa	Union
Bay	Flagler	Indian River	Orange	Volusia
Bradford	Glades	Jackson	Osceola	Walton
Broward	Gulf	Lafayette	Palm Beach	Washington
Charlotte	Hamilton	Lee	Putnam	
Citrus	Hardee	Manatee	St. Johns	
Clay	Hendry	Miami-Dade	Santa Rosa	
De Soto	Hernando	Monroe	Suwannee	

Chapter 8: Florida Healthy Kids Benefits

For details about Florida Healthy Kids member benefits, go to UHCCommunityPlan.com/FL.