2019
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary

Hawai‘i QUEST Integration
Welcome

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

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”.

Overview of the QUEST Integration Program and UnitedHealthcare Community Plan

QUEST Integration is the State of Hawai’i’s managed care Medicaid program. It brings together into a single program previous Medicaid programs such as QUEST, QUEST Expanded Access (QExA), QUEST-ACE and QUEST-Net as well as Medicaid Expansion under the Affordable Care Act (ACA). The program includes persons eligible for Medicaid and Children’s Health Insurance Program (CHIP).

The goals of the State of Hawai’i and UnitedHealthcare Community Plan are to:

• Improve the health status of the QUEST Integration member population
Welcome

- Minimize administrative burdens, streamline access to care for members with changing health status, and improve healthcare outcomes by integrating programs and benefits
- Align the program with the Affordable Care Act (ACA)
- Improve care coordination by establishing a “provider/medical home” for members through the use of assigned primary care providers (PCPs)
- Expand access to home and community based services (HCBS) and allow members to have a choice between institutional services and HCBS
- Maintain a managed care delivery system that assures access to high quality, cost-effective care that is provided whenever possible, in the member’s community, for all covered populations
- Establish contractual accountability among the State, UnitedHealthcare Community Plan, and providers
- Develop a program that is fiscally predictable, stable, and sustainable over time
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to a more appropriate utilization of the health care system
- Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals
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UnitedHealthcare Community Plan provides benefits and service to members, including:

- TANF – Temporary Assistance for Needy Families
- CHIP – Children's Health Insurance Program
- AABD – Assistance to the Aged, Blind, and Disabled
- LTC – Long-term Care
- DSNP – Dual Special Needs Plan

If you have questions about the information in this manual or about our policies, go to UHCprovider.com or call Provider Services at 888-980-8728.

How to Join Our Network

For instructions on joining the UnitedHealthcare Community Plan provider network, go to UHCProvider.com. 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 seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community partners to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. WPC examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

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

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

The goals of the WPC program are to:

- Lower avoidable admissions and unnecessary 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 Health Plan Employer Data and Information Set (HEDIS) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics.
• Empower the member to manage their complex/chronic illness or problem and care transitions.
• Improve coordination of care through dedicated staff resources and to meet unique needs.
• Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

The secure care provider website lets you:
• Verify member eligibility including secondary coverage.
• Review benefits and coverage limit.
• Check prior authorization status.
• Access remittance advice and review recoveries.
• Review your preventive health measure report.
• Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset.
• Search for CPT codes. Type the CPT code in the header search box on UHCprovider.com, and the search results will display all documents and/or web pages containing that code.
• Find certain web pages more quickly using vanity 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 vanity 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 vanity URL identified by 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 vanity URL into your web page address bar to quickly access that page.

**Care Provider Resources**

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

**Referring Your Patient**

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Provider Services at 888-980-8728.

**SECURE CARE PROVIDER WEBSITE**

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

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

**PROVIDER SERVICES**

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan. Provider Services can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

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

**NETWORK MANAGEMENT DEPARTMENT**

Within UnitedHealthcare Community Plan, the Network Management Department can help you with your contract, credentialing and in-network services. The department has network account managers and provider advocates who are available for visits, contracting, credentialing and other related issues.
If you need to speak with a network contract manager about credentialing or contracting, email our Network Management Team at Hawaii_PA_Team@uhc.com.

CULTURAL COMPETENCY RESOURCES

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

UnitedHealthcare Community Plan offers the following support services:

• **Language Interpretation Line:** Hawai‘i is the only state in the United States that has designated a native language, Hawaiian, as one of its two official state languages. To support this, we provide oral interpreter services 24 hours a day, seven days a week to our members free of charge. More than 250 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 regular business hours, contact the Provider Call Center at 888-980-8728. After hours you may contact 877-261-6608.

• **Sign Language Interpretation:** We provide sign language interpreters for our members. Please call Provider Services at 888-980-8728.

• **Cultural member materials:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

COMPLEMENTARY AND ALTERNATIVE HEALING PRACTICES

Many cultures engage in traditional health practices such as holistic medicine, acupuncture, medicinal herbs, mediation, spiritual counseling, therapeutic massage or martial arts.

When developing a treatment plan for members, consider:

• Inquiring whether the member has sought advice or treatment from friends, alternative healers or other practitioners
• Acknowledging the member’s choice for consultation of spiritual or traditional practitioners in addition to prescribing more western forms of treatment

CARE PROVIDER PRIVILEGES

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

DIRECT CONNECT

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

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

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

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

COMPLIANCE

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

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care Guidelines) for care determinations.
# How to Contact Us

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<tr>
<th>Topic</th>
<th>Contact</th>
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<tr>
<td>Administrative Office</td>
<td>1132 Bishop St., Suite 400 Honolulu, HI 96813</td>
<td>Open 7:45 a.m. to 4:30 p.m. Hawaii Standard Time (HST) Monday through Friday</td>
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<td><strong>NOTE:</strong> Please do not submit claims to this</td>
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<td>address. Use the claims address listed</td>
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<td>below under Claims.</td>
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<td></td>
<td>888-980-8728</td>
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<td></td>
<td>TTY: 711 (Hearing Impaired)</td>
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<td>Behavioral Health</td>
<td>providerexpress.com</td>
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<td></td>
<td>888-980-8728</td>
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<td></td>
<td>866-622-8054 (MA-DSNP)</td>
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<td></td>
<td>Fax: 877-840-5581</td>
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<td></td>
<td>Mailing Address:</td>
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<td><strong>Optum</strong></td>
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<td></td>
<td>P.O. Box 30757</td>
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<tr>
<td></td>
<td>Salt Lake City, UT 84130-0757</td>
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<td></td>
<td>Payer ID: 87726</td>
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<tr>
<td>Benefits</td>
<td>UHCprovider.com/benefits</td>
<td>Confirm a member’s benefits and/or prior authorization.</td>
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<td></td>
<td>888-980-8728</td>
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<tr>
<td>Cardiology Prior Authorization</td>
<td>For prior authorization or a current list of</td>
<td>Request prior authorization of the procedures and services outlined in this manual’s prior authorization requirements.</td>
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<td>CPT codes that require prior authorization,</td>
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<td>visit UHCprovider.com/hicomunityplan</td>
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<td></td>
<td>&gt; Prior Authorization and Notification</td>
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<td></td>
<td>866-889-8054</td>
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<tr>
<td>Claims</td>
<td>Use the Link Provider Portal at UHCprovider.com/claims</td>
<td>Ask about a claim status or about proper completion or submission of claims.</td>
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<td></td>
<td>888-980-8728</td>
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<td>Mailing address:</td>
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<td></td>
<td>UnitedHealthcare Community Plan QUEST Integration</td>
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<td></td>
<td>P.O. Box 31365</td>
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<td></td>
<td>Salt Lake City, UT 84131-0365</td>
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<td></td>
<td>Payer ID#: 87726 (EDI Claims Submission)</td>
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<td>Payer ID# 04567 (ERA use)</td>
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## Chapter 1: Introduction

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<tr>
<td>Behavioral Claim Disputes</td>
<td>888-980-8728</td>
<td>Ask about behavioral claim disputes.</td>
</tr>
<tr>
<td>Claim Overpayments</td>
<td>See the Overpayment section for requirements before sending your request. Sign in to <a href="https://uhcprovider.com/claims">UHCprovider.com/claims</a> to access Link, then select the UnitedHealthcare Online app 888-980-8728 Mailing address: <strong>UnitedHealthcare Community Plan</strong> ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800</td>
<td>Ask about claim overpayments.</td>
</tr>
<tr>
<td>Electronic Data Intake Claim Issues</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>
</tr>
<tr>
<td>Electronic Data Intake Log-on Issues</td>
<td>800-842-1109</td>
<td>Information is also available at <a href="https://uhcprovider.com">UHCprovider.com</a>.</td>
</tr>
<tr>
<td>Eligibility</td>
<td><a href="https://uhcprovider.com/eligibility">UHCprovider.com/eligibility</a> 888-980-8728</td>
<td>Confirm member eligibility.</td>
</tr>
<tr>
<td>Fraud and Abuse</td>
<td>800-455-4521 or 877-401-9430</td>
<td>Notify us of suspected fraud or abuse by a care provider or member.</td>
</tr>
<tr>
<td>Hāpai Mālama</td>
<td>Phone: 888-980-8728 (TTY users: 711) Fax: 800-267-8328</td>
<td>Refer high-risk OB members. Fax initial prenatal visit form.</td>
</tr>
</tbody>
</table>
| Medicaid [Department of Social Services] | [Medicaid.gov](https://www.medicaid.gov)  
Department of Human Services:  
(Oahu) 808-524-3370  
TTY/TDD #: 808-692-7182  
(Neighbor Islands) 800-316-8005  
TTY/TDD #: 800-603-1201  
Website: [medquest.hawaii.gov](https://medquest.hawaii.gov) | Contact Medicaid directly. |
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<th>Topic</th>
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<tr>
<td>Medical Claim Disputes</td>
<td>Sign in to <a href="https://UHCprovider.com/claims">UHCprovider.com/claims</a> to access Link, then select the UnitedHealthcare Online app 888-980-8728 Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 31350 Salt Lake City, UT 84131-0365 Appeals mailing address: Community Plan Grievances and Appeals 1132 Bishop Street Suite 400 Honolulu, HI 96813</td>
<td>Claim issues include 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>888-980-8728</td>
<td>Assist members with issues or concerns. Available 7:45 a.m. to 4:30 p.m. HST Monday through Friday.</td>
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<tr>
<td>Multilingual/Telecommunication Device for the Deaf (TDD) Services</td>
<td>888-980-8728 or TTY 711 for hearing impaired</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 Plan and Provider Enumeration System (NPPES)</td>
<td><a href="https://nppes.cms.hhs.gov">nppes.cms.hhs.gov</a> 800-465-3203</td>
<td>Apply for a National Provider Identifier (NPI).</td>
</tr>
<tr>
<td>NurseLine</td>
<td>888-980-8728 or TTY 711 for hearing impaired</td>
<td>Available 24 hours a day, seven days a week.</td>
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<td>Obstetrics and Baby Care</td>
<td>Hapai Malama</td>
<td>Links for pregnant moms and newborn babies.</td>
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<td>Phone: 888-980-8728 (TTY users: 711)</td>
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<td></td>
<td>Fax: 800-267-8328</td>
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<td></td>
<td><a href="#">Prenatal risk assessment form</a></td>
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<td>Optum Support Center</td>
<td><a href="mailto:LinkSupport@optum.com">LinkSupport@optum.com</a> 855-819-5909</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>Pharmacy Services</td>
<td><a href="UHCprovider.com/hicommunityplan">UHCprovider.com/hicommunityplan</a></td>
<td>OptumRx oversees and manages our network pharmacies.</td>
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<td>&gt; Pharmacy Resources and Physician Administered Drugs</td>
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<td></td>
<td>877-305-8952 (OptumRx)</td>
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<td></td>
<td>800-797-9791 (Help Desk)</td>
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<td>800-584-0265 (Bioscrip-Specialty Drug)</td>
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<tr>
<td>Prior Authorization/Notification for Pharmacy</td>
<td><a href="UHCprovider.com/priorauth">UHCprovider.com/priorauth</a></td>
<td>Request authorization for medications as required.</td>
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<td></td>
<td>800-310-6826</td>
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<td>Fax: 866-940-7328</td>
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<td>Prior Authorization/Notification of Health Services</td>
<td><a href="UHCprovider.com/hicommunityplan">UHCprovider.com/hicommunityplan</a> &gt; Prior Authorization and Notification</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></td>
<td>888-980-8728</td>
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<td>Fax: 800-267-8328</td>
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<td>Provider Services</td>
<td>888-980-8728</td>
<td>7:45 a.m. to 4:30 p.m. HST Monday through Friday</td>
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<td>For Medicare Advantage-Dual Special Needs Program (MA-DSNP): 866-622-8054</td>
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<td>Radiology Prior Authorization</td>
<td><a href="UHCprovider.com/hicommunityplan">UHCprovider.com/hicommunityplan</a> &gt; Prior Authorization and Notification</td>
<td>Request prior authorization of the procedures and services outlined in this manual's prior authorization requirements. Complete and current list of prior authorizations.</td>
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<td></td>
<td>866-889-8054</td>
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<td>Fax: 866-889-8061</td>
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<td>Referral submission/notifications</td>
<td>Provider Services 888-980-8728</td>
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<td>Tobacco Free Quit Line</td>
<td>800-784-8669</td>
<td>Ask about services for quitting tobacco/smoking.</td>
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<td>Transportation</td>
<td>Logisticare 866-475-5744</td>
<td>Schedule transportation or for transportation assistance. To arrange non-urgent transportation, please call three days in advance.</td>
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<td></td>
<td>866-288-3133 (Hearing Impaired)</td>
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<td>Utilization Management</td>
<td>Provider Services 888-980-8728</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>
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<tr>
<td>Topic</td>
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<td>Information</td>
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<tr>
<td>--------------------------------------------</td>
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<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Vaccines for Children (VFC) program</td>
<td>808-586-8300</td>
<td>Care providers must participate in the VFC Program administered by the DHSS and must use the free vaccine when administrating vaccine to qualified eligible children. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine.</td>
</tr>
<tr>
<td></td>
<td>Fax: 573-526-5220</td>
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<tr>
<td>Whole Person Care Model</td>
<td>888-980-8728</td>
<td>Refer high-risk members (e.g., asthma, diabetes) and members who need private-duty nursing.</td>
</tr>
<tr>
<td>Website for Hawaii Community Plan</td>
<td>UHCprovider.com/HICommunityplan</td>
<td>Access your state specific community plan information.</td>
</tr>
</tbody>
</table>
Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

NON-DISCRIMINATION

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

COMMUNICATION BETWEEN CARE PROVIDERS AND MEMBERS

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

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

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

PROVIDE OFFICIAL NOTICE

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

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

Call Provider Services 888-980-8728 or email Hawaii_PA_Team@uhc.com.

Sanctions

When we are notified of a provider’s exclusion from Medicare or Medicaid, we send them a letter with the date that they will be removed from our contract provider’s list. Except for post-stabilization, emergency, and urgently needed care, no payments will be made after that effective date. Members are notified of the provider’s status so they can choose a new care provider.

We immediately terminate any care provider(s) or affiliated care provider(s) whose owners, agents, or managing employees are found to be on the State or Federal exclusion list(s), including denial of credentialing for fraud related concerns, as they occur. If DHS requires removal of a care provider from its network, we remove that care provider from our network.

Care providers are also prohibited from employing or contracting with an individual who is excluded from...
participation in Medicaid, or with an entity that employs or contracts with such an individual, for the provision of health care, utilization review, medical social work or administrative services.

Upon reinstatement by DHS, the care provider is responsible for notifying us and applying for reinstatement.

**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 is available to help you and our members with the transition.

**ARRANGE SUBSTITUTE COVERAGE**

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

For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at [UHCprovider.com](http://UHCprovider.com).

**ADMINISTRATIVE TERMINATIONS FOR INACTIVITY**

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

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

**CHANGING AN EXISTING TIN OR ADDING A HEALTH CARE PROVIDER**

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form.

- 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](http://UHCprovider.com).
- 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](http://UHCprovider.com).

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 INFORMATION**

If you need to update your practice in any way, such as update your Tax Identification number, or add a new provider to your group, please call Provider Services Call Center 888-980-8728 or email Hawaii_PA_Team@uhc.com.

**AFTER-HOURS CARE**

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

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

**ADMITTING PRIVILEGES**

You must have admitting privileges to at least one in-network general acute care hospital on the island of service. For the island of Hawai‘i, it needs to be on the same side of the island- east or west.

**PARTICIPATE IN QUALITY INITIATIVES**

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

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

**PROVIDE ACCESS TO YOUR RECORDS**

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

**PERFORMANCE DATA**

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

**COMPLY WITH PROTOCOLS**

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

You may view protocols at [UHCprovider.com](http://UHCprovider.com).

**OFFICE HOURS**

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

**PROTECT CONFIDENTIALITY OF MEMBER DATA**

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

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

**FOLLOW MEDICAL RECORD STANDARDS**

Please reference Chapter 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. We provide an Aging with Dignity Pamphlet, “Five Wishes,” to help members determine their end of life care. Members can find Five Wishes and Hawai’i Provider Orders for Sustaining Treatment (POLST) forms for their use. The Kokua Mau website has information on advance care planning at [kokuamau.org/polst/](http://kokuamau.org/polst/). You can also obtain copies by calling 888-980-8728.

**YOUR AGREEMENT**

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

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

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member’s benefit contract or handbook. You may locate the Member’s Handbook at [UHCcommunityplan](http://UHCcommunityplan).
Chapter 2: Care Provider Standards & Policies

Appointment Standards (HI DHS Access and Availability Standards)

Comply with the following appointment availability standards:

**PRIMARY CARE**

PCPs should arrange appointments for:
- After-hours care phone number: 24 hours, seven days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Pediatric sick visits: Within 24 hours
- Adult sick visits: Within 72 hours
- Routine care appointment: within 21 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within six weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

**SPECIALTY CARE**

Specialists should arrange appointments for:
- Routine appointment type: within four weeks of request/referral

**BEHAVIORAL HEALTH**

Behavior health care providers should arrange appointments for:
- Care for non-life-threatening emergencies: within six hours
- Urgent care: within 48 hours
- Routine visits: within 10 business days

**PRENATAL CARE**

Prenatal care providers should arrange OB/GYN appointments for:
- First and second trimester: within seven calendar days of request
- Third trimester: within three days of request
- High-risk: within three calendar days of identification of high risk

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

Care Provider Directory

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

Following Centers for Medicare and Medicaid Services (CMS) guidelines, we are required to contact all participating care providers annually and independent physicians every six months. We require you to confirm your information is accurate or provide us with applicable changes.

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

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

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

Visit UHCprovider.com for the Provider Demographic Change Submission Form and further instructions.

Prior Authorization Request
Chapter 2: Care Provider Standards & Policies

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

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

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

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

You may also find information on UHCprovider.com/hicomunityplan > Prior Authorization and Notification.

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.

Requirements for Reporting Suspected Child or Adult Abuse

Report all cases of suspected child abuse to Child Protective Services:

• 808-832-5115, available 7:45 a.m. to 4:30 p.m. HST, Monday through Friday, except state holidays
• Additional information is available at humanservices.hawaii.gov/ssd/home/child-welfare-services.

Report all cases of suspected dependent adult abuse to Adult Protective Services:

• 808-832-5115, available 7:45 a.m. to 4:30 p.m. HST, Monday through Friday, except state holidays
• Additional information is available at humanservices.hawaii.gov/ssd/home/adult-services.

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

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

Medical doctors (M.D.s), doctors of osteopathy (DOs), Advanced Practice Registered Nurses (APRN) and physician assistants (PAs) from any of the following practice areas can be PCPs:

• General practice
• Internal medicine
• Family practice
• Pediatrics
• Obstetrics/gynecology
Members may change their assigned PCP by contacting Member Services at any time during the month. Customer Service is available 7:45 a.m. – 4:30 p.m. HST, Monday through Friday.

We ask members who don’t select a PCP during enrollment to select one.

• Medicare and Medicaid eligible members may choose an in-network or out-of-network PCP. Out-of-network PCPs will be identified on the member’s ID card as “Medicare PCP.”
• Non-Medicare Medicaid eligible members must choose an in-network PCP. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

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

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

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

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

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

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

• Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
• We recommend using these guidelines for preventive services:
  - Children: American Academy of Pediatrics
  - Adults: U.S. Preventive Services Task Force
• Submit all accurately coded claims or encounters timely.
• Provide all well baby/well-child services.
• Coordinate each UnitedHealthcare Community Plan member’s overall course of care.
• Accept UnitedHealthcare Community Plan members at your primary office location the same as any other coverage type (i.e. Commercial plan)
• Be available to members by telephone any time.
• Tell members about appropriate use of emergency services.
• Discuss available treatment options with members.

Responsibilities of PCPs and Specialists Serving in PCP Role

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

• Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
• Conduct a baseline examination during the UnitedHealthcare Community Plan member’s first appointment.
• Treat UnitedHealthcare Community Plan members’ general health care needs. Use nationally recognized clinical practice guidelines.
• Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare.
Chapter 2: Care Provider Standards & Policies

Community Plan Clinical, or Pharmacy Department as appropriate.

- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members’ advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members’ missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
- Complying with the Hawaii DHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Secondary Care Providers Responsibilities

- 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.

Rural Health Clinic or Federally Qualified Health Center as PCP

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

- Rural Health Clinic: The RHIC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHICs 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, physician assistant, nurse practitioner and/or social worker.
  - Mental health services.
  - Immunizations (shots).
  - Home nurse visits.

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
Chapter 2: Care Provider Standards & Policies

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 Hawaii DHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.

• Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week. Otherwise, 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.

A specialist must be available at the hospital to which UnitedHealthcare’s PCPs admit its QUEST Integration members. A specialist with an ambulatory practice who does not have admission and treatment privileges must have written arrangements with another provider with admitting and treatment privileges with an acute care hospital within UnitedHealthcare’s network on the island of service. For the island of Hawai‘i, this means that a care provider in East Hawai‘i who does not have admission and treatment privileges shall have a written arrangement with another care provider with admitting and treatment privileges in East Hawai‘i (same requirement applies to West Hawai‘i).

Prenatal Care Responsibilities

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

Notify UnitedHealthcare Community Plan as soon as a member confirms pregnancy. This helps ensure appropriate follow-up and coordination by the UnitedHealthcare Hāpai Mālama coordinator.

If you have questions, call Hāpai Mālama. To begin patient outreach, fax the prenatal assessment form.

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

Ancillary Care Provider Responsibilities

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

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

Ancillary Care Provider Checklist

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

• Verify the member’s enrollment before rendering services. Go to Link at UHCprovider.com or contact Provider Services. Failure to verify member
enrollment and assignment may result in claim denial.

- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Identify and bill other insurance carriers, when appropriate.
Chapter 3: Care Provider Office Procedures

Assignment to PCP Panel Roster

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

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP’s panel approaches the max limit, it is removed from auto-assignment. UnitedHealthcare Community Plan monitors PCP panel status.

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

Choosing a Primary Care Provider

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

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

Cost Sharing (Share of Cost)

Members may have to share in the cost of their health care services. This is based on Medicaid financial eligibility. The member’s Share of Cost (SOC) amount is determined by the member’s State of Hawai‘i Medicaid eligibility worker. Members must pay that amount to one of their providers (e.g., foster care home, nursing facility or a home and community-based provider such as a home health agency) or UnitedHealthcare Community Plan every month. Members are notified of their SOC amount or responsibility and any changes via mail by his or her State of Hawaii Medicaid eligibility worker.

Deductibles/Copayments

Deductibles and copayments are waived for covered services.

Medically Necessary Service

UnitedHealthcare Community Plan only pays for medically necessary services.

MEDICALLY NECESSARY DEFINITION

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

• Necessary to meet members’ basic health needs.
• Cost-efficient and appropriate for the covered services.
Chapter 3: Care Provider Office Procedures

Member Assignment

ASSIGNMENT TO UNITEDHEALTHCARE COMMUNITY PLAN

Hawaii DHS 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. Hawaii DHS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month’s end, but at times may occur mid-month.

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

Get eligibility information by calling the Medicaid Inquiry line.

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.

UNBORN ENROLLMENT CHANGES

Encourage your members to notify the Hawaii DHS when they know they are expecting. DHS notifies Managed Care Organizations (MCOs) daily of an unborn when Hawaii Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the Hawaii website to report the baby’s birth. With that information, DHS 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 DHS when the baby is born.

Members may call Hawaii Department of Human Services:
(Oahu) 
#: 808-524-3370
TTY/TDD #: 808-692-7182
(Neighbor Islands)
Toll-Free #: 800-316-8005
TTY/TDD #: 800-603-1201

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

PCP SELECTION

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

Member ID Card

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

If a fraud, waste and abuse event arises from a care provider or a member, notify UnitedHealthcare Community Plan in writing, as discussed in Chapter 12 of this manual. Or you may call the Fraud, Waste, and Abuse Hotline.
The member’s ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. Also document the call in the member’s chart.

**MEMBER IDENTIFICATION NUMBERS**

The Member ID printed on the UnitedHealthcare Community Plan Member Card is the same number that Hawaii DHS issues.

**PCP-Initiated Transfers**

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

1. To transfer the member, contact UnitedHealthcare Community Plan by mail with the specific events 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, current phone number and the care provider’s name.

   Mailing address:
   UnitedHealthcare Community Plan
   Attn: Health Services
   1132 Bishop Street, Suite 400
   Honolulu, HI 96813

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.

3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.

4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

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**Sample Health Member ID Card**

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**Verifying Member Enrollment**

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

- Provider Portal: access the Link portal through UHCprovider.com/eligibility
- UnitedHealthcare Provider Service is available from 7:45 a.m. – 4:30 p.m. Hawaii Standard Time (HST), Monday through Friday.
- Hawaii Medicaid Eligibility System (MES)

**UnitedHealthcare Dual Complete (HMO SNP)**

For information about UnitedHealthcare Dual Complete, please see Chapter 4 of the Administrative Guide for Commercial, Medicare Advantage and DSNP. For state-specific information, go to UHCprovider.com > Menu > Health Plans by State.
Chapter 4: Medical Management (Including Benefit Information)

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

**Ambulance and Transportation Services**

**AIR AMBULANCE**

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:
- Great distances or other obstacles keep members from reaching the destination.
- Immediate admission is essential or
- The pickup point is inaccessible by land.

**EMERGENCY AMBULANCE TRANSPORTATION**

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:
- Injury to their overall health.
- Impairment to bodily functions. Or
- Dysfunction of a bodily organ or part.

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

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

**NON-EMERGENT TRANSPORTATION**

UnitedHealthcare Community Plan members may get non-emergent transportation services through Logisticare 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).

If the member resides in an area not served by the public bus or cannot take the public bus because of their medical condition or disability, they may be able to take public para-transit transportation. Every island has different public para-transit transportation arrangements. The member’s Service Coordinator can see if the member is eligible.

For public para-transit eligible members, we (through Logisticare) provide ride coupons. Members should call Logisticare five days in advance so the coupons may be mailed. Members with recurring trips are given coupons based on the number of medical or authorized non-medical trips as determined by the Service Coordinator or PCP.

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

For non-urgent appointments, members must call for transportation no more than 48 hours in advance before their appointment. Requests can be made by phone at 866-475-5744 or fax 866-475-5745.
Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. They must be billed by the ambulance provider. This includes transporting the member to another facility for services (e.g., diagnostic testing) and returning them to the first hospital for more inpatient care.

For recurring appointments, such as dialysis or adult day care, the member’s Service Coordinator, PCP or the care provider must make the appointment request by calling Logisticare’s Facility Line at 866-475-5744 (or via the Facility fax number 866-475-5745). The request must be made once per quarter.

Discharges from a facility are considered an Urgent Transportation Request. Facilities may call Logisticare’s Facility Line at 866-475-5744 (or via the Facility fax number 866-475-5745) to arrange transport.

Members must call between 7:45 a.m. – 4:30 p.m. HST, Monday through Friday, to schedule transportation. If they have questions about their order, they may call Logisticare.

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.

Taxis are not utilized unless no other transport is available and the need is urgent.

**OFF-ISLAND TRANSPORTATION**

We must authorize all non-emergent off-island transports. Off-island transportation arrangements, to include air and land travel, are based on the specifics of the member’s appointment. The air transportation form is available on UHCprovider.com/hicomunityplan > For Healthcare Professionals > Hawaii > Manuals and Forms.

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Contact</th>
<th>Timeframe</th>
<th>Fax</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Air Transportation Requests</td>
<td>UnitedHealthcare Community Plan 888-362-3368</td>
<td>At least three business days advance notice.</td>
<td>800-267-8328</td>
<td>888-980-8728 TTY: 711</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(for hearing impaired)</td>
</tr>
<tr>
<td>Non-Emergency Air Transportation Requests</td>
<td>Logisticare (Transportation Vender)</td>
<td>At least 14 calendar days advance notice.</td>
<td>800-267-8328</td>
<td>866-475-5744</td>
</tr>
<tr>
<td>(including transportation needed as part of air transportation)</td>
<td></td>
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</tbody>
</table>

**Special Instructions:**

If ground transportation is needed as part of an air transportation request, please check the box at the bottom of the Transportation Form.

If the member also needs ground transportation from his/her home to and from the airport on the date of travel, please specify the member’s physical address to ensure timely pickup and drop off.
MEALS AND LODGING

We cover meals and lodging as part of an authorized medically necessary travel in-and-out of state.

For in-state travel, we give meal vouchers for the member and one escort.

For out-of-state travel, we reimburse meals for member and one approved escort. We require receipt or confirmation of expenses. Reimbursement for meals will not exceed $30.00 per person per day.

An escort is an individual who is needed to assist a member during transport or while at the place of treatment. An escort is allowed for members under the age of 19. The member must prove a need for an escort. Transportation for more than one escort must be prior authorized by the PCP or Service Coordinator. The PCP must submit the medical certification form before we authorize the escort. The certification must document that the member has a physical, cognitive or mental disability requires assistance.

TRANSPORTATION NOT COVERED

We will not reimburse or provide transportation for the following:

- Services in which prior authorization is required but was not obtained
- Services that are not medically necessary or which are not provided in compliance with the provisions of the UnitedHealthcare Community Plan QUEST Integration program
- Taxi service that is to/from ongoing or recurring services such as, but not limited to: Methadone Clinics, Community Mental Health Centers, physical, occupational and speech therapy appointments
- Pharmacies
- Supplemental Security Income (SSI) determination medical appointment
- Non-medical services
- Travel out of the country
- Return trip to the State of Hawai’i or inter-island unless the trip was pre-authorized in advance by the Plan; or
- Travel or associated expenses that are covered by another government agency, insurer, or private organization.

Durable Medical Equipment

Durable Medical Equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

See our Coverage Determination Guidelines at UHCprovider.com > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan

Emergency/Urgent Care Services

Emergency services are any covered inpatient and outpatient services that are furnished by a care provider that is qualified to furnish services and that are needed to evaluate or stabilize an emergency medical condition.

Inpatient and outpatient emergency health services are covered inside or outside of our service area. In the event of an emergency, the member should seek immediate care, or call 911 for assistance. Prior authorization is not required, and we will not deny payment if a contracted care provider instructs a member to seek emergency services.

UnitedHealthcare Community Plan provides coverage for the treatment of an emergency medical condition, which is defined by DHS as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
• serious impairment to bodily functions;
• serious dysfunction of any bodily organ or part;
• serious harm to self or others due to an alcohol or drug abuse emergency;
• injury to self or bodily harm to others; or
• with respect to a pregnant woman having contractions: 1) that there is not adequate time to effect a safe transfer to another hospital before delivery, or 2) that transfer may pose a threat to the health or safety of the woman or her unborn child.

An emergency medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

UnitedHealthcare Community Plan will base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and will cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency condition in the judgment of a prudent layperson. The ER physician or the treating provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

We do not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. We do not refuse to cover emergency services based on the ER provider, hospital or fiscal agent not notifying the member’s PCP or UnitedHealthcare Community Plan of the member’s screening and treatment within ten calendar days of presentation for emergency services.

We do not hold the member, who has an emergency medical condition, liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. We accept the emergency physician or provider’s determination of when the member is sufficiently stabilized for transfer or discharge.

UnitedHealthcare Community Plan includes coverage for post-stabilization services. Post-stabilization services are provided after a member is stabilized after a related emergency medical condition to maintain the stabilized condition or to improve or resolve the member’s condition. The attending physician or health care provider determines when the condition is no longer an emergency and the member is considered stabilized for discharge or transfer. Continuation of care after the condition is no longer an emergency will require coordination with UnitedHealthcare Community Plan.

Such automatic approval of post-stabilization services continues to be covered until UnitedHealthcare Community Plan has responded to the request and arranged for discharge or transfer.

UnitedHealthcare Community Plan includes coverage for urgently needed health services and symptomatic office visits. A symptomatic office visit is an encounter associated with a presentation of medical symptoms or signs, but not requiring immediate attention. Urgent care is the diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within 24 hours.

Urgent care is appropriately provided in a clinic, in a physician’s office, or in a hospital emergency department if a clinic or physician’s office is inaccessible. Urgent care does not include primary care services or services provided to treat emergency conditions. Urgently needed services are also covered when obtained from any provider within the UnitedHealthcare Community Plan service area in extraordinary cases in which UnitedHealthcare Community Plan contracted providers are unavailable or inaccessible due to an unusual event.

Our contracted care providers must notify us if a member is admitted to the hospital. The PCP should work with the attending physician to coordinate transfer to a contracted facility as soon as it is medically appropriate to do so.

**URGENT CARE (NON-EMERGENT)**

Urgent care services are covered.

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

**Emergency Care Resulting in Admissions**

Prior authorization is not required for emergency services.

Emergency care should be delivered without delay. Notify UnitedHealth Community Plan about admission. Call the **Prior Authorization Department** or fax your Prior Authorization Form within 24 hours, unless otherwise noted. The form is available at [UHCprovider.com/hicommunityplan > Prior Authorization and Notification](http://UHCprovider.com/hicommunityplan > Prior Authorization and Notification).
Nurses in the Health Services Department review emergency admissions within one business day of notification.

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting the Prior Authorization Department (UM Department, etc.).

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

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

## Family Planning

Family Planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included:

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Diagnosis and treatment of sexually transmitted diseases
- Contraceptive counseling
- Emergency contraception
- Laboratory services
- Pregnancy testing

Blood tests to determine paternity are covered **only** when the claim indicates tests were necessary for legal support in court.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy

**Note:** Diagnosis of infertility is covered. Treatment is not.

## 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 DHS Regulations for more information on sterilization.

## Health Education

Our health education program is led by our qualified, full-time health education manager. You are encouraged to collaborate with us to ensure health education services are provided to members. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
Chapter 4: Medical Management

- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

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

Programs are based upon the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization.

Laboratory, X-rays, Imaging Procedures

ADVANCED OUTPATIENT IMAGING PROCEDURES

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

Find a list of imaging procedures on UHCprovider.com/hicomunityplan > Prior Authorization and Notification. To get prior authorization, go to UHCprovider.com/priorauth > click on the Radiology tab > Online Portal link, or call 888-980-8728.

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

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

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

See the Billing and Encounters chapter for more information.

Maternity/Pregnancy/Well-Child Care

PREGNANCY/MATERNITY

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

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

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

1. the woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. if she has an established relationship with a non-participating obstetrician.
Chapter 4: Medical Management

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

Care providers should notify UnitedHealthcare Community Plan immediately of a member’s confirmed pregnancy to help ensure appropriate follow-up and coordination by the Hāpai Mālama program.

To notify UnitedHealthcare Community Plan of pregnancies, care providers should call Hāpai Mālama at 888-980-8728 (TTY users: 711) or fax the notification to 800-267-8328.

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

**MATERNITY ADMISSIONS**

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

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

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

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

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

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

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

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

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

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

**POST MATERNITY CARE**

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of two visits 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.

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 GUIDELINE**

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 Guideline provides guidance for all preventive care screenings and well-child visits. The state of Hawaii Med-QUEST division recommends using Bright Futures into your daily practice. The AAP/Bright Futures periodicity schedule and guideline are at brightfutures.aap.org.

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care according to Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Settings for Bright Futures include private practices, hospital-based or hospital affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, and community health centers.

The state of Hawaii Med-QUEST division supports the Bright Futures’ Medical home model and recommends using the State’s Rainbow Book Resource Guide. It is a medical home resource directory for children and youth with special health care needs. The Rainbow Book is on hilopaa.org/rainbow-book.

**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.

Find the form medquest.hawaii.gov.

**Exception:** Hawaii DHS 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 Hawaii consent procedures for abortion.

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

**STERILIZATION AND HYSTERECTOMY PROCEDURES**

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

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

STERILIZATION INFORMED CONSENT
A member has only given informed consent if the Hawaii 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 Hawaii 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.

You may also find the form on medquest.hawaii.gov.

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)**

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

**NEONATAL RESOURCE SERVICES**

The NRS program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth (including babies who are transferred from PICU) and/or any infants readmitted within their first 30 days of life and previously managed in the NICU. The 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, the care providers, and the facility discharge planner to help ensure timely discharge and service delivery.
- Develop care management strategies and interventions based on infant and family needs.
- Coordinate services prior to discharge and after discharge if the member is under NRS case management.

The NRS nurse case manager’s role includes:

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

**INHALED NITRIC OXIDE**

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

**Non-Medical Transportation**

This is a service offered to enable individuals to gain access to community services, activities, and resources, specified by the service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.

**Pharmacy**

Visit UHCprovider.com/hicommunityplan > Pharmacy Resources and Physician Administered Drugs for pharmacy prior authorization forms, Preferred Drug Lists (PDLs), and other important pharmacy information.

**HOME DELIVERY (MEDICARE-MEDICAID ELIGIBLE)**

We offer mail order – home delivery – pharmacy services to Medicare and Medicaid Eligible (MME) members.

To assist members in arranging mail order pharmacy services, please have the member contact OptumRx at 877-889-6358.

**Radiology Prior Authorization Program**

We use a Radiology Prior Authorization Program to improve compliance with evidence-based and professional society guidance for radiology procedures. You must obtain a prior authorization before ordering CT scans, MRIs, MRAs, PET scans, nuclear medicine and nuclear cardiology studies in an office or outpatient setting. The following images do not require prior authorization:

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

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

To get or verify prior authorization:

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

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, refer to UHCprovider.com/hicommunityplan > Prior Authorization and Notification.

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

SBIRT services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice.
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed.
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to four sessions per patient, per provider per calendar year.
WHAT IS INCLUDED IN SBIRT?

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

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

Referral to treatment: Refer members whose screening indicates a severe problem or dependence so to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.

SBIRT services will be covered when all of the following are met:
- The billing provider and servicing provider are SBIRT certified.
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is V65.42
- The treatment or brief intervention does not exceed the limit of four 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 Hawaii:
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. 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)
Chapter 4: Medical Management

Specialty Pharmacy Medications

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

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

Specialty pharmacy medications are available through our specialty pharmacy network.

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

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.

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

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

RESPONSIBILITIES

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

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 ‘Something Else’ to speak to a representative.
Medical Management Guidelines

ADMISSION AUTHORIZATION AND PRIOR AUTHORIZATION GUIDELINES

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional and TIN/NPI.
- ICD 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 contact Optum Behavioral Health.

Locate the Prior Authorization Fax Request Form at UHCprovider.com/hicomunityplan > Prior Authorization and Notification. If you have questions, please 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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<tbody>
<tr>
<td>Non-urgent Pre-service</td>
<td>Within five working days of receipt of medical record information required but no longer 14 calendar days of receipt</td>
<td>Within 24 hours of the decision</td>
<td>Within two business days of the decision</td>
</tr>
<tr>
<td>Urgent/Expedited Pre-service</td>
<td>Within three days of request receipt</td>
<td>Within three days of the request</td>
<td>Within three days of the request</td>
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<tr>
<td>Concurrent Review</td>
<td>Within 24 hours or next business day following</td>
<td>Notified within 24 hours of determination</td>
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<tr>
<td>Retrospective Review</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>
Chapter 4: Medical Management

Carved-Out Services

These services are not covered by UnitedHealthcare Community Plan but are offered through the state or other local agency. See Chapter 6: Benefits: Covered, Excluded and Value-Added for more information on these services.

- Behavioral Health Services
- Developmental Disabled/Intellectually Disability (DD/ID) Services
- Dental Services
- School Based Services
- Zero to Three Services
- State of Hawai‘i Organ and Transplant (SHOTT) Program

Case Management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Medical Case Management Department assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for case management by calling Care Management at 888-980-8728. Additionally, UnitedHealthcare Community Plan provides the Hāpai Mālama program, which manages women with high-risk pregnancies.

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 an on-site facility review or 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 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.
Chapter 4: Medical Management

Determination of Medical Necessity

Medically necessary services or supplies are those necessary to:

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

Support the opportunity for an enrollee receiving LTSS to have access to benefits of community living, to achieve person-centered goods, and to live and work in the setting of their choice.

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.

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.

Hāpai Mālama

Hāpai Mālama is a specialized case management program designed to improve the health and well-being of all pregnant members. It gives particular attention to those with a High Risk Pregnancy and special health care needs. It tracks the member’s adherence to the recommended prenatal treatment plan. It also highlights activities and treatments that prevent prenatal and postpartum medical and behavioral health-related complications.

HĀPAI MĀLAMA CARE MODEL

The Hāpai Mālama care model strives to:

- Identify pregnant members and to provide education on the importance of initiating prenatal care within the first trimester of pregnancy (or within 42 days of member health plan enrollment)
- Raise the number of pregnant members who are enrolled in the program
- Base member stratification on medical, behavioral health, long-term care and special healthcare needs
- Work with obstetrical care providers on condition monitoring, managing co-morbidities, and adherence to treatment plans
- Increase member awareness of pregnancy management, preventive health behaviors, importance of recognizing and reporting symptoms of early labor and/or pregnancy complications, and compliance with the service plan
- Raise adherence to prescribed medications
- Reduce environmental barriers to care related to transportation, translation services, and phone access in order to assure compliance with required appointments, laboratory and prenatal testing procedures
- Identify more members who use tobacco and refer them for smoking cessation
- Raise the percentage of pregnant members who get their post-partum exam 21-56 days post-partum
- Lower the rate of preterm deliveries annually
- Reduce the rate of low birth weight and very low birth weight infants
- Cut back the annual NICU admission rate and NICU length of stay
- Teach the importance of routine health exams and EPSDT check-ups
• Apply an integrated approach that uses Service Coordinators, Community Health Workers, Behavioral Health Advocates, Clinical Program Managers, Inpatient Care Managers, UM Managers, Quality Clinical Practice Managers, Medical Directors, and Nonclinical Support Staff, in a collaborative effort to increase timeliness of prenatal and postpartum care.

Call us when a member becomes pregnant: 888-980-8728.

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 UHCprovider.com, contacting UnitedHealthcare Community Plan’s Provider Services Department, or the Hawaii Medicaid Eligibility System.
• Submit documentation needed to support the medical necessity of the requested procedure.
• Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
• Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

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

Second Opinion Benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Hawaii DHS. 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 Hawaii: 888-980-8728.
• 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.

Service Coordination

Members receiving long-term services and supports (LTSS) and those with special health care needs (SHCN) are assigned a service coordinator.

Once the eligible member is identified, the Service Coordinator contacts member. If the member wishes to participate, they complete a comprehensive assessment of the member’s health status. With member input and participation, the Service Coordinator develops the member’s Service Plan. This includes:
  • Making long-term and short-term goals
  • Finding barriers to meeting goals or following the plan
  • Documenting in the automated care management system
  • Implementing automated tasks and reminders to ensure follow-up

The Service Coordinator utilizes evidence-based clinical practice guidelines for ongoing management and evaluation.

Service Coordinators sends copies of the LTSS/SHCN member service plans and reassessments to the PCP. They make calls to the PCP if they have specific concerns.

For PCPs with a higher volume of our LTSS/SHCN members, we have a more targeted approach. This include case reviews with the medical director with the PCP and other members of the care team and faxed service plans to PCP for their input and review.

ROLE OF PCP IN SERVICE COORDINATION

The PCP serves as the point of initial contact and as the “medical home” for the member. They are responsible for:
  • Providing medical oversight to the service coordination process
  • Being fully aware of all services delivered
  • Conducting face-to-face medical assessments
  • Providing primary care medical services and coordinating care with in-network specialist physicians (out-of-network physicians via the prior authorization process), as needed
  • Participating in the creation and maintenance of the service plan including establishing goals with the needs of the member
  • Providing clinical education to the care team
  • Working with the care team to provide the member and their family education in disease self-management
  • Implementing care that is consistent with best practice guidelines and customizing for the member
  • Collaborating with the Service Coordinator
  • Supporting and facilitating connections with local community care and service providers

ROLE OF OTHER CARE PROVIDERS

Specialists, behavioral health providers, therapists, home and community based providers, assisted living services providers, and other care providers are included in the service planning process. They provide input into the development of the member’s service plan.

Service Coordinators work with these care providers to coordinate services and provide results of member assessments.

WHEN TO CONTACT SERVICE COORDINATORS

You must contact a member’s Service Coordinator when:
  • You cannot contact the member
  • You cannot provide or arrange for medically necessary services
  • There is a significant change in the member’s condition
  • The member unexpectedly leaves their place of residence
  • The member is admitted to the hospital
  • The member suffers a fall
  • There are skin integrity issues
  • There are behavioral health issues
  • The member elects hospice
  • There is a bed hold and therapeutic leave request (Nursing Facilities only)
• The member needs outpatient therapies including PT/OT/ST/RT
• The member dies

You may contact your member’s service coordinator by calling Member Services at 888-980-8728. If you feel the member could benefit from Service Coordination but does not have currently have this benefit, you may refer that member to the Service Coordination Team for an assessment. You may call the Member Services Call Center at 888-980-8728 or use the Service Coordination Referral Form found at UHCprovider.com.

Services Not Covered by UnitedHealthcare Community Plan

For a complete list of exclusions, contact Provider Services at 888-980-8728.

Certain services and service categories are excluded from coverage under the UnitedHealthcare Community Plan QUEST Integration Program. Certain Medicaid covered services may also be carved out and are provided by the state and/or other local agencies. The Member Handbook for the UnitedHealthcare Community Plan QUEST Integration Program also lists the excluded services for our members.

In addition to specific excluded or non-covered services, here is a list of some services excluded from the QUEST Integration program:

Services typically excluded but, in extenuating circumstances and upon request, we will review for medical necessity:
• Services that are not medically necessary (as defined in Hawai‘i statute);
• Services that are experimental or investigatory;
• Non-emergent or non-urgent services provided out of state that have not been authorized in advance (post-stabilization services following emergent admission are covered);
• Non-emergent or non-urgent services provided by out-of-network care providers that have not been authorized in advance (post-stabilization services following emergent admission are covered; services provided by non-participating providers at an in-network facility are covered);
• Surgery for the member’s appearance, excluding authorized reconstructive surgery;
• Routine, restorative and cosmetic dental services (see Section on Services Available from other Agencies.), excluding certain authorized medical procedures related to dental work;
• Reversal of sterilization;
• Artificial insemination, in-vitro fertilization or any other treatment to create a pregnancy;
• Treatment of impotence;
• Hysterectomies that are performed solely or primarily for rendering a member permanently incapable of reproducing;
• Hysterectomies that are performed for the purpose of cancer prophylaxis;
• Physical exams or other services for work, school, sports or athletic events;
• Services that a member received before or after member’s eligibility with UnitedHealthcare Community Plan QUEST Integration program (inpatient hospital facility coverage will continue until the member is discharged or there is a change in level of care);
• Personal hygiene, luxury, or convenience items;
• Foot care for comfort or appearance, like flat feet, corns, calluses, toenails;
• Drugs for:
  - hair growth
  - cosmetics
  - controlling your appetite
  - treatment of impotence
  - treatment of infertility
  - erectile dysfunction or similar “lifestyle” products
  - Drugs that the Food and Drug Administration (FDA) says are:
    • DESI – this means that research says they are not effective
    • LTE – this means that research says they are less than effective
    • IRS – this means that the drugs are identical, related, or similar to LTE drugs;
• Environmental modifications or home
adaptations that solely add to the square footage of the home, are of general utility, or are in excess of standard modification costs;

- Laboratory and diagnostic tests that are experimental, investigational or generally unproven; chromosomal evaluations; IgG4 testing; and procedures related to storing, preparation and transfer of oocytes for in vitro fertilization; and

- Certain vision services such as orthoptic training, prescription fees, progress exams, radial keratotomy, visual training, and Lasik procedure.

EXCLUSIONS

- Services that are covered by another payer, such as Medicare;
- Any services outside of the United States;
- Autopsy or necropsy;
- Any services if the member is in local, state, or federal jail or prison;
- Any services otherwise provided to member by a local, state or federal agency or facility;
- Services that are covered by workers compensation insurance;
- UnitedHealthcare Community Plan QUEST Integration Medicaid hospice services provided to members receiving Medicare hospice services that is duplicative of Medicare hospice benefits. Examples include personal care and homemaker services. This is only covered when the service need is not related to the hospice diagnosis; and
- UnitedHealthcare Community Plan QUEST Integration Medicaid home health services when they are already covered by Medicare home health benefits (this exclusion applies only to members who also have Medicare).

PHARMACY

To receive prior authorization for prescriptions, you must contact UnitedHealthcare Pharmacy Prior Notification Services at 800-310-6826 or fax the prior authorization form to 866-940-7328.

The prior authorization forms are on UHCprovider.com/HICommunityplan > Pharmacy Resources and Physician Administered Drugs.

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 888-980-8728 to discuss the guidelines and utilization management.

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

Services Requiring Prior Authorization

For a list of services that require prior authorization and related forms, go to UHCprovider.com/HICommunityplan > Prior Authorization and Notification.
MEDICAL DIRECTOR

You can discuss the requested services with the physician who will make the decision by calling our Medical Director at 888-980-8728, select option 1, and then option 1 again (for Medicaid) or 800-410-1925, select option 1 (for Medicare).

UTILIZATION MANAGEMENT (UM) APPEALS

These appeals contest UnitedHealthcare Community Plan’s UM decisions. They are appeals of UnitedHealthcare Community Plan’s admission, extension of stay, level of care, or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. See Appeals in Chapter 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. Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

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

To find the Healthy Child Forms, go to: medquest.hawaii.gov/en/resources/forms.html.

Find details on how to fill out the Healthy Child form at: medquest.hawaii.gov/en/resources/forms.html.

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 Department of Health Early Intervention Program (DOHEIP) for evaluation and early intervention services. 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 the DOHEIP. 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.

Contact the DOHEIP referral line at 808-594-0066 for Oahu or 800-235-5477 for Neighbor Islands. To make a referral by fax, please download the EI referral form and instructions.

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

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

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

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

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

Safe/Care Examinations
Medicaid covers Sexual Assault Findings Examination (SAFE) and Child Abuse Resource Education (CARE) Examinations. It also covers related laboratory studies that determine sexual or physical abuse. The exam is performed by SAFE-trained providers certified by the Department of Health and Senior Services. Children enrolled in a managed health care plan receive SAFE-CARE services through Hawaii Medicaid on a fee-for-service basis. Call Hawaii Medicaid for more information.

Oahu
Kapiolani Medical Center for Women & Children,
The Sex Abuse Treatment Center 808-524-7273
(24-hour hotline)

Kauai
YWCA of Kauai, Sexual Abuse Treatment Program
808-245-4144 (24-hour hotline)

Maui
Child and Family Service, Maui Sexual Assault Center
808-873-8624 (24-hour hotline)
Targeted Case Management

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

**Identification** – The five target populations include:
- Children under the age of 21 at risk for medical compromise
- Medically fragile individuals
- Individuals in frail health, over the age of 18 and at risk of institutionalization
- Members in jeopardy of negative health or psychosocial outcomes
- Members infected with a communicable disease, including tuberculosis, HIV/AIDS, etc., or who have been exposed to communicable diseases, until the risk of exposure has passed

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

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

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: 808-586-8300
Fax: 573-526-5220

Any child through 19 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 receive their vaccinations from a federally qualified health center, rural health clinic, or a private health care provider using a VFC supplied vaccine.
Chapter 6: Benefits-Covered, Excluded and Value-Added

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 888-980-8728 unless otherwise noted.

Benefit Information

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>BENEFIT DESCRIPTION</th>
<th>FREQUENCY, LIMITATION AND EXCLUSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMBULANCE, EMERGENT AND URGENT CARE</strong></td>
<td></td>
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</tr>
<tr>
<td>Ambulance</td>
<td>Emergency transport.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Non-emergent medical transport.</td>
<td>NA</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Covered seven days a week at any emergency room. Emergency and post-stabilization services (including observation services).</td>
<td>Limitation: Covered only in the USA</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered seven days a week at any emergency room. Emergency and post-stabilization services (including observation services).</td>
<td>Limitation: Covered only in the USA</td>
</tr>
<tr>
<td><strong>INPATIENT SERVICES</strong> – Inpatient hospital and inpatient behavioral health; observation care for behavioral health and residential substance abuse treatment; hospice, long term care and transplants.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital (Medical)</td>
<td>Inpatient care needed for medical, surgical, maternity (including newborn care), intensive care or other acute inpatient services. Also includes post-stabilization services and rehabilitative services.</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient Hospital (Behavioral Health)</td>
<td>Inpatient Behavioral health Care includes: psychiatric / mental health or substance abuse treatment inpatient stays in a facility.</td>
<td>None</td>
</tr>
<tr>
<td>BENEFIT</td>
<td>BENEFIT DESCRIPTION</td>
<td>FREQUENCY, LIMITATION AND EXCLUSIONS</td>
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<tr>
<td>Observation – Behavioral Health</td>
<td>Partial hospitalization for mental health or substance abuse.</td>
<td>None</td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>Alcohol and Chemical Dependency Services – substance abuse services in a treatment setting accredited according to the standards established by the State of Hawaii Department of Health Alcohol and Drug Abuse Division (ADAD). Substance abuse counselors shall be certified by ADAD. Includes detoxification.</td>
<td>None</td>
</tr>
<tr>
<td>Hospice</td>
<td>End of life care – Care for the terminally ill and are expected to live less than six months. Hospice care maybe done in a hospital, other facility or in the member’s home. Children under the age of 21 years can receive treatment to manage or cure their disease while concurrently receiving hospice services.</td>
<td>None</td>
</tr>
<tr>
<td>Long Term Services and Support and Facility Stays</td>
<td>Long term care includes skilled nursing care, intermediate care, sub-acute, and custodial care in a facility or alternative setting such as at home. Facility can be a nursing facility, hospital or other facility licensed for long term care. These services are for members who need assistance with almost all activities of daily living, required skilled monitoring and support.</td>
<td>Limitation: Services are based on member’s service plan.</td>
</tr>
<tr>
<td>Transplants by us</td>
<td>Cornea transplants and bone grafts. Bone grafts are covered as an orthopedic procedure.</td>
<td>Exclusions: Experimental and investigational transplants and those covered by SHOTT</td>
</tr>
<tr>
<td>Transplants by the State of Hawaii Organ and Transplant (SHOTT) Program</td>
<td>Refer the member to the SHOTT who covers the following transplants: Liver, heart, heart-lung, lung, kidney, kidney-pancreas and allogenic and autologous bone marrow transplants. Children under 21 years of age: small bowel with or without liver is covered.</td>
<td>See benefit description section to the left</td>
</tr>
<tr>
<td>Inpatient Professional / Medical Services</td>
<td>Hospital, skilled nursing facility or alternate facility – Covered during an authorized facility stay including emergent admissions.</td>
<td>None</td>
</tr>
</tbody>
</table>
### OUTPATIENT SERVICES – Outpatient surgery, outpatient lab, imaging services and diagnostic tests; outpatient radiation therapy; blood and blood administration; outpatient therapy, cancer treatment and dialysis; outpatient behavioral health and specialized behavioral health programs.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>BENEFIT DESCRIPTION</th>
<th>FREQUENCY, LIMITATION AND EXCLUSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-patient Surgery</td>
<td>Surgeries performed in an outpatient hospital or ambulatory surgical center.</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Laboratory Tests, Imaging Services and Diagnostic Tests</td>
<td>Laboratory tests, EKG, pulmonary function tests, sleep studies, treadmill stress tests, CT/PET/MRI/MRA, other imaging services and diagnostic tests.</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Radiation Treatment</td>
<td>Therapeutic radiology treatment. Radium and Isotope therapy including technician, materials and supplies.</td>
<td>None</td>
</tr>
<tr>
<td>Blood and Blood Administration</td>
<td>Blood, blood components and blood clotting factors are covered as part of the Emergency/Urgent Care, Inpatient, or Outpatient Surgery benefits or as medically necessary.</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Therapy and Rehabilitation Services</td>
<td>Includes outpatient therapy and rehabilitation services such as physical, occupational, audiology, speech, and respiratory therapy.</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Cancer Services</td>
<td>Includes diagnosis and treatment of cancer – physician services, other practitioner services, outpatient hospital services, chemotherapy, radiation therapy, or other services related to the diagnosis and treatment of cancer.</td>
<td>None</td>
</tr>
<tr>
<td>Renal Dialysis Services</td>
<td>Dialysis services include equipment, supplies, diagnostic/lab tests, drugs. Members with chronic dialysis needs are reviewed for possible change or determination for disability through the ADRC process.</td>
<td>None</td>
</tr>
<tr>
<td>BENEFIT</td>
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<tr>
<td>Outpatient Behavioral Health</td>
<td>Includes professional services for evaluation, testing and treatment of mental illnesses and/or substance abuse including therapy and medication management; individual and group therapy sessions. See specific services listed below for additional information.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Standard outpatient behavioral health services such as visits to a psychiatrist, psychologist, or behavioral health advance practice nurse practitioner (APRN)</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Mental health individual therapy sessions / medication management.</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Detoxification</td>
<td>Outpatient medically managed detoxification treatment.</td>
<td>None</td>
</tr>
<tr>
<td>Methadone Management Services</td>
<td>Methadone/LAAM services for adult members are covered for acute opiate detoxification as well as maintenance.</td>
<td>None</td>
</tr>
<tr>
<td>Serious and Persistent Mental Illness (“SPMI”) Members</td>
<td>Services with a diagnosis of Serious and Persistent Mental Illness (SPMI), additional outpatient services are available such as behavioral health intensive case management, psychosocial rehabilitation, therapeutic living program, mental health support and crisis management.</td>
<td>Limitation: SPMI members only; if member is in the Community Care Services (CCS) program, the additional services will be provided through CCS.</td>
</tr>
<tr>
<td>Behavioral Health Intensive Case Management Services</td>
<td>Includes case assessment, planning, outreach, ongoing monitoring and service coordination, including disease and self management to promote illness management and recovery.</td>
<td>Limitation: SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation / Clubhouse Services</td>
<td>Therapeutic day rehab social skill building services, such as group skill building activities that focus on development of problem solving skills, medication education, and symptom management, which results in opportunities to improve the quality of life through meaningful work, positive relationships, and gainful employment.</td>
<td>Limitation: SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.</td>
</tr>
</tbody>
</table>
### Benefits: Covered, Excluded and Value-Added

<table>
<thead>
<tr>
<th>BENEFIT</th>
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</thead>
<tbody>
<tr>
<td>Therapeutic Living Program</td>
<td>Services in settings such as group living arrangements or therapeutic foster homes. Therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home.</td>
<td>Limitation: SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.</td>
</tr>
<tr>
<td>Mental Health Support and Crisis Management</td>
<td>Includes 24-hour access line, mobile crisis response, crisis stabilization, and crisis management.</td>
<td>Limitation: SPMI members only; if member is in the CCS program, the additional services will be provided through CCS.</td>
</tr>
</tbody>
</table>

**PHYSICIAN SERVICES** – Primary and specialty care provider services; physical exams and preventive services; home health, hearing, chiropractic, podiatry, vision and dental services.

<table>
<thead>
<tr>
<th>BENEFIT</th>
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</thead>
<tbody>
<tr>
<td>Primary Care Provider Services</td>
<td>Services by a Primary Care Provider (PCP). In addition to medical and related services, the PCP can help refer members to a specialist for specialty care services. A PCP can be a family practice, general practice, internal medicine, pediatrician, OB/GYN, advance practice nurse practitioner with prescriptive authority (APRN-Rx), physician assistant or community clinic provider.</td>
<td>None</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Services provided by physicians other than a PCP (including specialty care). These are services that a PCP cannot provide.</td>
<td>None</td>
</tr>
<tr>
<td>Physical Examinations</td>
<td>Exams to determine the member’s health status (typically provided by the PCP).</td>
<td>None</td>
</tr>
<tr>
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<tr>
<td>Preventive Services</td>
<td>Includes, for example, well-visits, immunizations, and screening visits. Preventive services are usually done by the PCP and include the services listed below and the specified frequency to the right. The frequency can be exceeded based on PCP recommendation. See below for frequency per specified benefit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Total cholesterol measurement</td>
<td>Frequency: For females age 45-65 and males 35-65, one exam every five years.</td>
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<tr>
<td></td>
<td>• Pap smears and screening pelvic examinations</td>
<td>Frequency: One every one to two year(s)</td>
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<tr>
<td></td>
<td>• Annual Mammogram (Breast Cancer)</td>
<td>Frequency: Age 31 and older, every one to two years starting at age 40</td>
</tr>
<tr>
<td></td>
<td>• Bone mass measurement (bone density full body)</td>
<td>None</td>
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<tr>
<td></td>
<td>• Glaucoma screening</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Colorectal cancer screening</td>
<td>Frequency: Age 50+, one exam per every two years</td>
</tr>
<tr>
<td></td>
<td>• Prostate cancer screening</td>
<td>Frequency: Age 50+, one exam per year</td>
</tr>
<tr>
<td></td>
<td>• HIV/AIDS testing</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Immunizations and vaccines</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Blood pressure measurement</td>
<td>Frequency: Every two years if normal</td>
</tr>
<tr>
<td></td>
<td>• Weight/height measurement</td>
<td>Frequency: Every two years if normal</td>
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<tr>
<td></td>
<td>• Nutrition Counseling — includes diabetes self-management training (DSMT) programs as part of an American Diabetes Association (ADA)/American Association of Diabetes Educators (AADE) recognized DSMT programs, nutrition counseling for obesity, and when medically necessary for other metabolic conditions. Requires physician's order and must be part of a treatment program to mitigate the effects of an illness or condition.</td>
<td>NA</td>
</tr>
<tr>
<td>BENEFIT</td>
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<td>FREQUENCY, LIMITATION AND EXCLUSIONS</td>
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<tr>
<td>Home Health Services</td>
<td>Services include medical equipment, medial supplies, therapy or rehabilitative services, skilled nursing care, audiology, speech-language pathology and home health aides.</td>
<td>None</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Services include screening, evaluation, diagnostic, or corrective services, equipment, or supplies provided by, or under the direction of an otorhinolaryngology or an audiologist to whom a patient is referred by a physician.</td>
<td>Frequency/Limitation: Initial Eval/Selection: Every 24 months Electroacoustic Eval: Three years or less is four times per year; greater than four years is two times per year Fitting/Orientation/ Hearing Aid Check: &lt;21 years is two times every three years; &gt;21 years is once every three years</td>
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<tr>
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<td></td>
<td>Limitation: One hearing aid per ear every two years. Limit can be exceeded if medically necessary</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Not a covered benefit.</td>
<td>Exclusion</td>
</tr>
<tr>
<td>Podiatry Care</td>
<td>Includes foot and ankle care related to the treatment of infection or injury provided in the office/outpatient clinic setting, surgical procedures involving the ankle and below, diagnostic radiology procedures limited to the ankle and below, bunionectomies when bunion is present with overlying skin ulceration or neuroma secondary to the bunion. Also includes professional services not involving surgery provided in the office/clinic or related to diabetic foot care in the outpatient/inpatient hospital.</td>
<td>None</td>
</tr>
<tr>
<td>BENEFIT</td>
<td>BENEFIT DESCRIPTION</td>
<td>FREQUENCY, LIMITATION AND EXCLUSIONS</td>
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</tr>
<tr>
<td>Vision Services</td>
<td><strong>Medically Necessary Eye Exams</strong>&lt;br&gt;• Eye/Vision exams for medical diagnosis</td>
<td>Limited to exams to diagnose and treat diseases and conditions of the eye (not to correct poor vision/visual acuity).</td>
</tr>
<tr>
<td></td>
<td><strong>Routine Eye Exams</strong> (to correct poor vision/visual acuity, must be provided by a qualified optometrist)&lt;br&gt;• Vision exams&lt;br&gt;• Refraction</td>
<td>Adults: Limit to one routine eye exam every 24 months&lt;br&gt;Children under the age of 21: Limit to one eye exam every 12 months</td>
</tr>
<tr>
<td></td>
<td><strong>Visual Aids</strong> – must be prescribed by ophthalmologists or optometrists&lt;br&gt;• Eye glasses&lt;br&gt;• Contact lenses&lt;br&gt;• Miscellaneous vision supplies including prosthetic eyes, lens, frames or other parts of the glasses as well as fittings and adjustments&lt;br&gt;• Replacement glasses or contact lenses</td>
<td>Adults/Children: Limit to one pair of glasses or contact lenses every 24 months&lt;br&gt;Individuals under 40 years of age require medical justification for bi-focal.</td>
</tr>
<tr>
<td></td>
<td>Orthopedic training, prescription fee; progress exams, radial keratotomy, visual training, Lasik procedure, and contact lenses for cosmetic reasons.</td>
<td>Exclusion</td>
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<tr>
<td></td>
<td>Cataract removal: covered under the outpatient surgery benefit.</td>
<td>None</td>
</tr>
</tbody>
</table>
## Chapter 6: Benefits: Covered, Excluded and Value-Added

<table>
<thead>
<tr>
<th>BENEFIT</th>
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<th>FREQUENCY, LIMITATION AND EXCLUSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services</td>
<td><strong>Routine Dental</strong></td>
<td>Carved out to the State:</td>
</tr>
<tr>
<td></td>
<td>• Exams</td>
<td>• Covered only for Children under 21 years old.</td>
</tr>
<tr>
<td></td>
<td>• X-rays</td>
<td>• Call Community Case Management Corporation (CCMC) at 808-792-1070 or 888-792-1070. We can also make a referral to CCMC.</td>
</tr>
<tr>
<td></td>
<td>• Preventative care and treatment</td>
<td></td>
</tr>
<tr>
<td>Emergency Dental Services</td>
<td><strong>Emergency Dental Services</strong></td>
<td>Carved out to the State:</td>
</tr>
<tr>
<td></td>
<td>• Services to relieve dental pain, eliminate infections, and treat acute injuries to teeth and jaw</td>
<td>• Covered for Adults age 21 years and older</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Call Community Case Management Corporation (CCMC) at 808-792-1070 or 888-792-1070.</td>
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<td></td>
<td><strong>Dental Services Covered by us</strong></td>
<td>Exclusion: Services provided in private dental offices, government sponsored or subsidized dental clinics, and hospital outpatient dental clinics.</td>
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<tr>
<td></td>
<td>• Dental services that are medically necessary to treat a medical condition</td>
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<td></td>
<td>• Dental or medical services resulting from a dental condition provided in a facility (hospital or an ambulatory surgery center) and are the result of a dental or medical condition</td>
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<td></td>
<td>• Dental services performed by a dentist or physician due to a medical emergency (e.g., car accident) where services provided are primarily medical</td>
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<td></td>
<td>• Dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections or oral origin, cyst and tumor management) and craniofacial reconstructive surgery (performed on an inpatient basis in an acute care hospital setting)</td>
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</tr>
<tr>
<td>BENEFIT</td>
<td>BENEFIT DESCRIPTION</td>
<td>FREQUENCY, LIMITATION AND EXCLUSIONS</td>
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</tr>
<tr>
<td><strong>DME PROSTHETICS AND DIABETIC MONITORING SUPPLIES</strong> – Includes DME/Medical equipment and supplies; diabetic equipment, services and supplies.</td>
<td></td>
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</tr>
<tr>
<td>Durable Medical Equipment and Medical Supplies</td>
<td>Include but are not limited to the following:</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Oxygen tanks and concentrators</td>
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<td></td>
<td>• Ventilators</td>
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<tr>
<td></td>
<td>• Wheelchairs</td>
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<tr>
<td></td>
<td>• Crutches and canes</td>
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<td></td>
<td>• Orthotic devices</td>
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<tr>
<td></td>
<td>• Prosthetic devices</td>
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<tr>
<td></td>
<td>• Pacemakers</td>
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<td></td>
<td>• Breast pumps</td>
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<tr>
<td></td>
<td>• Incontinence</td>
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<td></td>
<td>• Foot appliances (orthoses, prostheses)</td>
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<td></td>
<td>• Orthopedic shoes and casts</td>
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<tr>
<td></td>
<td>• Orthodigital prostheses and cases</td>
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<tr>
<td></td>
<td>• Medical supplies as surgical dressings, ostomy, etc.</td>
<td></td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td>Insulin pump and glucose monitoring devices.</td>
<td>None</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>All diabetic supplies, including but not limited to alcohol swabs, syringes, test strips and lancets. Diabetic supplies can be from a participating pharmacy or can be delivered to the Member's home (from our mail order pharmacy, OptumRx).</td>
<td>Limitation: Glucometers are obtained by calling the manufacturer, not through retail pharmacy.</td>
</tr>
<tr>
<td></td>
<td>Mail order pharmacy is provided through our pharmacy benefit manager Optum RX; they can be reached at 877-889-6510.</td>
<td>Limitation: Quantity Limits apply. Please see the QUEST Integration formulary at <a href="http://UHCprovider.com/HIcommunityplan">UHCprovider.com/HIcommunityplan</a> &gt; Pharmacy Resources and Physician Administered Drugs</td>
</tr>
</tbody>
</table>
### SPECIAL SERVICES
- Includes disease management programs; translation and interpreter services; 24x7 NurseLine and Nurse Chat services; smoking cessation services, care management services, pain management services; transportation (non-ambulance) and related services.

<table>
<thead>
<tr>
<th>BENEFIT</th>
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</thead>
<tbody>
<tr>
<td>Disease Management Programs</td>
<td>We use screening and evaluation procedures for the early detection, prevention, and treatment of chronic illnesses under our disease management programs. This helps members to manage their chronic disease or condition. Our disease management programs include diabetes, congestive heart failure, asthma and high-risk pregnancy.</td>
<td>None</td>
</tr>
<tr>
<td>Translation and Interpreter</td>
<td>Services for non-English speaking members and for members with visual and hearing impairments. Contact us to access services or for assistance.</td>
<td>None</td>
</tr>
<tr>
<td>NurseLine &amp; Nurse Chat Services</td>
<td>Available for Members, 24-hours, seven days a week. NurseLine can help with minor injuries, common illnesses, self-care tips and treatment options, recent diagnoses and chronic conditions, and much more.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>NurseLine: 877-512-9357</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Access Nurse Chat at <a href="https://myuhc.com">myuhc.com</a>.</td>
<td>None</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Counseling • Practical counseling (problem-solving/skills) • Social support</td>
<td>Limitation: At least four in-person sessions per quit attempt</td>
</tr>
<tr>
<td></td>
<td>Medications • Nicotine • Non-nicotine</td>
<td>Limitation: Included as part of the Quit Attempts</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Professional management, medication and other services as medically necessary to help manage chronic pain.</td>
<td>None</td>
</tr>
<tr>
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| Transportation and Related Services (for emergency transport, see Ambulance Benefit) | Ground and/or air transportation to and from covered medically necessary appointments.  
We provide an attendant if the member requires assistance.  
All Transportation and Related Services are provided by Logisticare.  
Members should call Logisticare to schedule all trips at least 48 hours in advance of their health care appointment.  
Logisticare Contact Information:  
• Reservations 877-564-5909  
• Ride Assistance 877-564-5910  
• Hearing Impaired 866-288-3133 | Limitation: Covered only for members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation.  
The following is not covered:  
• Transport services when a Prior Authorization is required but not obtained.  
• Transport related to services that are not medically necessary.  
• Transport to a pharmacy.  
• Transport for personal errands such as shopping or visiting.  
• Transport to a SSI Determination Medical Appointment or Medicaid eligibility.  
• Transport to classes, support groups, community events, etc., unless included as part of the service plan.  
• Transport for any services not covered under QUEST Integration. |
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>BENEFIT DESCRIPTION</th>
<th>FREQUENCY, LIMITATION AND EXCLUSIONS</th>
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</thead>
<tbody>
<tr>
<td>Transportation and Related Services (Continued)</td>
<td>Transportation for individuals that have Medicare or other insurance coverage that is primary to Medicaid. Medicare or other primary insurance and Medicaid have different benefits and coverage policies. Under the member’s primary insurance coverage, members may be able to seek health care services on a different island from the one that they live on. However, Medicaid requires that members receive care on the island where they live if those services are available. If the member travels to another island or to the mainland and those health care services are available on the island that member resides in, we will not pay for transportation.</td>
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### Transportation and Related Services (Continued)
(for emergency transport, see Ambulance Benefit)

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<tr>
<th>BENEFIT DESCRIPTION</th>
<th>FREQUENCY, LIMITATION AND EXCLUSIONS</th>
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<tr>
<td>Lodging and meals/food are covered if needed due to Inter-Island or Out-of-State. Meals/Food limit will be based on the case scenarios specified under limitations to the right. Reimbursement: No member reimbursement will be allowed without a receipt for all food/meal purchases.</td>
<td>Inter-island (same day doctor visit/one day visit): Limit to $15 per member and per authorized companion. Inter-island (multiple doctor visits/days per duration): Limit to $30 per day per member and per authorized companion. Out-of-State (all visits): Limit to $30 per day per member and per authorized companion.</td>
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### MATERNITY CARE

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<tr>
<th>MATERNITY CARE</th>
<th>BENEFIT DESCRIPTION</th>
<th>FREQUENCY, LIMITATION AND EXCLUSIONS</th>
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</table>
| Maternity Care | Covered throughout pregnancy right up to and after delivery and may be provided by physicians and other practitioners as licensed and in their scope of practice, including certified nurse midwives or licensed midwives. Services include:  
• Prenatal care (which should begin as soon as possible)  
• Radiology, lab and other diagnostic testing  
• Prenatal vitamins  
• Doctor/Practitioner visits  
• Up to three ultrasounds without needing authorization  
• Other necessary services that impact pregnancy outcomes  
• For high risk pregnancies, you can get additional support and help from one of our Plan’s care managers  
• Delivery of your baby  
• Postpartum care (up to 60 days from the date of delivery)  
• Health education and screening | None |
| Newborn Care | Includes newborn hearing assessment, laboratory screening, delivery, inpatient hospital related services, outpatient services, EPSDT services, circumcision and other needed newborn care services. | Circumcision: Once in a lifetime. |
| Genetic Testing | Tests such as chromosomal analysis to determine potential for genetic conditions that may be passed from parent to child. | None |
## Family Planning

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Description</th>
<th>Frequency, Limitation and Exclusions</th>
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</thead>
<tbody>
<tr>
<td>Infertility Testing and Treatments</td>
<td>Not Covered</td>
<td>Can be reviewed upon request for medical necessity on a case-by-case basis.</td>
</tr>
</tbody>
</table>

### Family Planning Services

Services available on a confidential and voluntary basis to all members by in-network and out-of-network care providers and includes, at a minimum the following:

- Family planning drugs, supplies and devices to include but not limited to generic birth control pills, medroxyprogesterone acetate (Depo-Provera), intrauterine device (IUD), and diaphragms.
- Education and counseling necessary to make informed choices and understand-contraceptive methods
- Emergency contraception
- Follow-up, brief and comprehensive visits
- Pregnancy testing
- Contraceptive supplies and follow-up care; and
- Diagnosis and treatment of sexually transmitted diseases

**Note:** Care providers who do not provide family planning services on the basis of religious beliefs must refer the member to a care provider who will provide such services.

### Intentional Termination of Pregnancy (ITOP) (Abortions)

**Services we do not cover**

The State of Hawaii (DHS) covers all procedures, medications, transportation, meals, and lodging associated with ITOPs (abortions). Providers must bill the State of Hawaii DHS' fiscal agent directly for services related to ITOPs.

**Services we cover**

We cover treatment of medical complications resulting from ITOPs (abortions). We cover treatments for spontaneous, incomplete or threatened terminations for ectopic pregnancies.

Carved out to the State: Contact DHS' Fiscal Agent at 808-952-5570 (Oahu) or 800-235-4378 (Neighbor Islands).

Limitation: Only related services for treatment of medical complications resulting from an ITOP.
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<tr>
<th>BENEFIT</th>
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<th>FREQUENCY, LIMITATION AND EXCLUSIONS</th>
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<tbody>
<tr>
<td>Sterilizations and</td>
<td>Sterilization is any medical procedure or treatment for the purpose of rendering a man or woman incapable of reproducing. Sterilization is only covered when: 1. Member has given informed consent (DHS Form 1146) 2. Member is at least 21 years old at the time of consent 3. Consent is at least 30 days but not more then 180 days before the procedure 4. The provider signs the informed consent form (DHS Form 1146) 5. In the case of emergency abdominal pain, at least 72 hours have passed since informed consent was given 6. In the case of premature birth, informed consent was given at least 30 days in advance of the expected delivery date 7. Interpreter services have been given to non-English speaking members or other assistance to communicate with members with hearing or vision impairments or other disability.</td>
<td>Exclusions: If member is institutionalized in a correctional facility, mental hospital or other rehabilitative facility.</td>
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<tr>
<td>Hysterectomies</td>
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<tr>
<td>Hysterectomy</td>
<td>Hysterectomy is a medical procedure to remove a women’s reproductive system (all or part of the uterus). A hysterectomy is only covered when: 1. Member has given informed consent (DHS Form 1145) 2. The member has been informed verbally and in writing that a hysterectomy will render her permanently incapable of reproducing. This not needed if member is already sterilized or in the case of an emergency hysterectomy. 3. The member has signed and dated the consent form (DHS Form 1145) in advance of the hysterectomy 4. Interpreter services have been given to non-English speaking members or other assistance to communicate with members with hearing or vision impairments or other disability.</td>
<td>Exclusions: If member is institutionalized in a correctional facility, mental hospital or other rehabilitative facility. A hysterectomy is NOT covered: • For the sole or primary purpose of rendering a member permanently incapable of reproducing. • There is more than one purpose for performing hysterectomy but the primary purpose is to render the member permanently incapable of reproducing. • If performed for the purpose of cancer prophylaxis (prevention).</td>
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### Benefits: Covered, Excluded and Value-Added

**Prescription Drugs**

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<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Limitation</th>
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<tbody>
<tr>
<td>Pharmacy Benefit Manager (Includes home delivery)</td>
<td>The pharmacy benefit manager is Optum Rx (a UnitedHealth Group company).</td>
<td>Contact Optum RX</td>
</tr>
<tr>
<td>Home Delivery (Mail Service-Dual Members Only): 877-889-6358</td>
<td></td>
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<tr>
<td>Pharmacies Only: 877-889-6510</td>
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<tr>
<td>Prescription Drugs</td>
<td>Drugs prescribed by a physician. This includes education about how to take the drugs.</td>
<td>Limitation See our QUEST Integration drug formulary at: UHCprovider.com/ HIcommunityplan &gt; Pharmacy Resources and Physician Administered Drugs</td>
</tr>
</tbody>
</table>

#### Ambulance and Transportation Services

Additional information on these services is in **Chapter 4: Medical Management**.

#### Behavioral Health Services

Members whose behavioral diagnostic, treatment or rehabilitative services that we determine not be medically necessary or are not covered.

**FOR ADULTS WITH SERIOUS MENTAL ILLNESS**

The Department of Health covers eligible mental health services which include care management, housing, shelter, crisis services, and more. Services are available on all islands. The 24-hour Crisis/Help ACCESS Line is available at 808-832-3100.

Members who have been determined eligible for these services may be referred by the member’s Service Coordinator to the Community Care Services (CCS), which is part of the Department of Human Services. CCS is managed by Ohana Health Plan.

**DEPARTMENT OF HEALTH’S CHILD AND ADOLESCENT MENTAL HEALTH DIVISION (CAMHD) FOR CHILDREN AGES THREE THROUGH 20**

Members who are determined eligible for these services are referred to the Department of Health's CAMHD. This offers children emotional and behavioral help. CAMHD services are available through their Family Centers. Contact information is listed below:
EXCLUSION

We do not provide behavioral health services to those members who have:

- Requested services that were determined to be not medically necessary
- Transferred to the Department of Human Services (DHS) Community Care Services (CCS) Program (currently managed by “Ohana CCS Program”).
- Transferred to the DOH Child and Adolescent Mental Health Division
- Criminally committed in an inpatient setting under the provisions of Chapter 706, HRS

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 – We use 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.

Cognitive Rehabilitation Services

These are services provided to cognitively impaired persons. They assess and treat communication skills, cognitive and behavioral ability and cognitive skills related to daily living. Reassessments are completed at regular intervals, determined by the care provider and according to the member’s assessed needs, treatment goals and objectives.
**Corneal Transplants**

We cover these transplants in accordance with **HAR 17-1737-92**.

**Dental Services**

Some dental services may be covered by the state, especially for members under the age of 21. Community Case Management Corporation (CCMC) can help find a dentist and assist with transportation and translators. Contact CCMC at **888-792-1070**.

For more details, go to [UHCprovider.com](http://UHCprovider.com).

**DEVELOPMENTAL DISABLED/INTELLECTUALLY DISABILITY (DD/ID) SERVICES**

The DD/ID program, through contracted providers, serves people with mental or developmental disabilities including housing, living skills, home chores, alarm system, behavioral help nursing and personal care that is not covered by UnitedHealthcare Community Plan QUEST Integration.

Non-medical transport is also available.

The DD/ID Case Manager is the primary Case Manager and works with the UnitedHealthcare Community Plan QUEST Integration Service Coordinator.

Contact DD/ID at **808-733-9303** (Oahu), **808-241-3406** (Kauai), **808-243-4625** (Maui, Lanai, and Molokai), **808-974-4280** (East Hawai‘i) or **808-877-8114** (North Hawai‘i).

**Early Intervention Program**

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

**Habilitative Services**

These services and devices develop, improve or maintain skills and functioning for daily living that were never learned. Habilitative services and devices include:

- Audiology services
- Occupational therapy
- Physical therapy
- Speech-language therapy
- Vision services
- Devices associated with these services including augmentative communication devices, reading devices, and visual aids but exclude those devices used specifically for activities at school.

We cover these services and devices only when medically necessary and if not otherwise covered in the benefits package.

Habilitative services do not include routine vision services.

**Long Term Support Services**

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
- Grocery shopping
- Personal care services (such as bowel and bladder care, bathing, grooming and paramedical services)
- Accompaniment to medical appointments
- Protective supervision for the mentally impaired

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

**Eligibility** – Members must be older than 65 years of age, or disabled, or blind. In some cases, disabled children are also eligible for LTSS. Additional eligibility requirements:

- Hawaii resident physically residing in the United States
- Meet Medicaid recipient eligibility criteria
- Reside in own home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered “own home”)
- Submit a completed Health Care Certification form completed by a licensed health care professional indicating the member is: Unable to perform more than one activity of daily living independently, and is at risk of out-of-home care placement without ILTSS.
Referral – Anyone may initiate an LTSS application on behalf of a member. Adult members are encouraged to self-refer.

Contact information for referrals-
Member Services: 888-980-8728. Available 7:45 a.m. – 4:30 p.m. HST.

Obtain the Service Coordination Referral Form online at UHCprovider.com.

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

Home and Community Based Services (HCBS)

These are long-term services and supports provided to members who meet nursing facility level of care to allow those individuals to remain in their home or community. When not meeting institutional level of care, we provide these HCBS services:

Adult Day Care. This is a regular supportive care provided to four or more disabled adult participants. Services include observation and supervision by center staff; coordination of behavioral, medical, and social plans and implementation of the instructions as listed in the participant’s care plan. Therapeutic, social, educational, recreational, and other activities are also provided. Adult day care staff may not perform health care related services such as medication administration, tube feedings, and other activities which require health care related training. All health care related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency.

Adult Day Health. This is an organized day program of therapeutic, social, and health services provided to adults with physical or mental impairments, or both, which require nursing oversight or care. The purpose is to restore or maintain, to the fullest extent possible, an individual’s capacity for remaining in the community. Each program must have nursing staff sufficient in number and qualifications to meet the needs of participants.

Nursing services are provided under the supervision of a registered nurse. In addition to nursing services, adult day health may also include: emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech language pathology, and transportation services.

Assisted Living Services. This is personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) given to members who reside in an assisted living facility. An assisted living facility is licensed by the Department of Health. It allows residents to maintain an independent assisted living lifestyle. Payment for room and board is prohibited.

Community Care Management Agency (CCMA). These services are provided to members living in Community Care Foster Family Homes (CCFFH) and other approved community settings. CCMAs:
1. Communicate with a member’s physician(s) regarding the member’s needs including changes in medication and treatment orders;
2. Work with families regarding service needs of members and serve as an advocate for their members; and
3. Be accessible to the member’s caregiver 24 hours a day, seven days a week.

Community Care Foster Family Home (CCFFH). Care providers give personal care and supportive services, homemaker, chore, attendant care, companion services, and medication oversight in a certified private home by a principal care provider who lives in the home. CCFFH services are currently furnished for up to three adults who receive these services in conjunction with residing in the home. All care providers must give individuals with their own bedroom unless the member consents to sharing a room with another resident. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four members. Members receiving CCFFH services must be receiving ongoing CCMA services.

Counseling and Training. This is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member. Counseling and training services are given individually or in groups. This service may be provided at the member’s residence or an alternative site. Activities
include member care training for members, family, and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care, and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling; and/or nutritional assessment and counseling on coping skills to deal with stress caused by member’s deteriorating functional, medical or mental status.

**Environmental Accessibility Adaptations.** These are physical adaptations to the home, required by the individual’s service plan, which are necessary to ensure the health, welfare, and safety of the individual. It also enables the individual to function with greater independence in the home, and without which the individual would require institutionalization. Adaptations may include the installation of ramps and grabbars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are needed for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member.

Excluded are those adaptations or improvements to the home that are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, and central air conditioning. Adaptations which add to the total square footage of the home are excluded from this benefit. All services are provided following State or local building codes.

**Home Delivered Meals.** These are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute a full day’s nutritional regimen (i.e., no more than two meals per day). Home delivered meals are provided to the individuals who cannot prepare nutritional meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and prevent institutionalization.

**Home Maintenance.** These are services necessary to maintain a safe, clean, and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of services to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.

**Moving Assistance.** This is provided in rare instances when the Service Coordinator determines that an individual needs to relocate to a new home. The following are circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheelchair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; home unable to support the member’s additional needs for equipment; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include the packing and moving of belongings. Whenever possible, the member’s family, landlord, community, or third party resources that can provide this service without charge should be utilized.

**Non-Medical Transportation.** This enables individuals to gain access to community services, activities, and resources, specified by the service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.

**Personal Assistance Services – Level I.** This is for individuals who need help with independent activities of daily living but do not meet an institutional level of care. This prevents a decline in health status and maintain individuals safely in their homes and communities.

Personal assistance services Level I may be self-directed and consist of:

- Companion Services. Companion services are preauthorized by the Service Coordinator in the member’s service plan and include non-medical care, supervision, and socialization provided to a
member who is assessed to need these services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping/errands, but do not perform these activities as discrete services. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual.

- Homemaker Services. Homemaker services are covered when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for the member. Homemaker services, pre-authorized by the Service Coordinator in the member’s service plan, do not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker services covers only those activities that need to be provided for the member and not for other members of the household:
  - Routine housecleaning
  - Care of clothing and linen
  - Shopping for household supplies and personal essentials (not including the cost of supplies)
  - Light yard work
  - Simple home repairs, such as replacing light bulbs
  - Preparing meals
  - Running errands, such as paying bills and picking up medication
  - Escort to clinics, physician office visits, or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available
  - Standby/minimal assistance or supervision of activities of daily living
  - Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments
  - Reporting to assigned provider, supervisor, or designee, observations about changes in the member’s behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service

These services may be limited to 10 hours per week. There may also be a maximum threshold of members who are not at a nursing facility level of care who may receive Personal Assistance Level I services.

**Personal Assistance Services—Level II.** These are for individuals who require moderate/substantial to total assistance to perform activities of daily living and health maintenance activities. Services are provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nursing Aide (CNA) or Nurse Aide (NA) with applicable skills competency. They may be self-directed.

The following activities may be included as a part of personal assistance services Level II:

- Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing
- Assistance with bowel and bladder care
- Assistance with ambulation and mobility
- Assistance with transfers
- Assistance with medications, which are ordinarily self-administered when ordered by the member’s physician
- Assistance with routine or maintenance health care services by a personal care provider with specific training, satisfactorily documented performance, Service Coordinator consent and when ordered by the member’s physician
- Assistance with feeding, nutrition, meal preparation, and other dietary activities
- Assistance with exercise, positioning, and range of motion
- Taking and recording of vital signs, including blood pressure
- Measuring and recording intake and output, when ordered
- Collecting and testing specimens, as directed
- Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision
- Proper utilization and maintenance of member’s medical and adaptive equipment and supplies
- Checking and reporting any equipment or supplies that need to be repaired or replenished
- Reporting changes in the member’s behavior, functioning, condition, or self-care abilities which necessitate more or less service
- Maintaining documentation of observations and services provided
When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified in the service plan that are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member’s family, may also be provided.

**Personal Emergency Response Systems (PERS).** This is a 24-hour emergency assistance service that gives the member immediate assistance during an emotional, physical, or environmental emergency. Service is limited to those members who live alone or who are alone for long periods of time. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button. The system is connected to the member’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals.

These are allowable types of PERS items:
- 24-hour answering/paging
- Beepers
- Med-alert bracelets
- Medication reminder services
- Intercoms
- Life-lines
- Fire/safety devices, such as fire extinguishers and rope ladders
- Monitoring services
- Light fixture adaptations (e.g., blinking lights)
- Telephone adaptive devices not available from the telephone company
- Other electronic devices/services designed for emergency assistance

PERS services will only be provided to a member residing in a non-licensed setting except for an Assisted Living Facility (ALF).

**Residential Care Services.** These are personal care services, homemaker, chore, attendant care companion services, and medication oversight given in a licensed private home by a principal care provider who lives in the home.

Residential care is furnished:
1. in a Type I Expanded Adult Residential Care Home (E-Arch) to a maximum of six individuals, no more than three of whom may be a nursing facility level of care; or
2. in a Type II E-Arch, for seven or more individuals; no more than 20% of the home’s licensed capacity may be individuals meeting a nursing facility level of care who receive these services in conjunction with residing in the home.

**Respite Care Services.** These are provided to individuals unable to care for themselves. They are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three different levels: hourly, daily, and overnight. Respite care may be provided in these locations:
- Home or place of residence
- Foster home/expanded-care adult residential care home
- Medicaid certified nursing facility
- Licensed respite day care facility
- Other community care residential facility approved by the State.

Respite care services are authorized by the member’s PCP and approved through the Service Coordinator. Respite services may be self-directed.

**Skilled (or Private Duty) Nursing.** This service is for members requiring ongoing nursing care listed in the care plan. It is provided by licensed nurses within the scope of State law. Skilled nursing services may be self directed under Personal Assistance Level II.

**Specialized Medical Equipment and Supplies.** These supplies let members maintain or increase their daily living activities. This involves the purchase, rental, lease, warranty cost, installation, repairs, and removal of devices, controls or appliances specified in the service plan, that enables individuals to increase and/or maintain their abilities to perform activities of daily living, and/or to control, participate in, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items must meet applicable standards of manufacture, design, and installation and may include:
- Specialized infant car seats
- Modifications of a parent-owned motor vehicle to accommodate the child (e.g., wheelchair lift)
- Intercoms for monitoring the member’s room
Chapter 6: Benefits: Covered, Excluded and Value-Added

Specialized medical equipment and supplies must be recommended by the member’s PCP.

Hospice Services

These are services that provide care to terminally ill patients who are expected to live less than six months. Care providers must meet Medicare requirements. We do not cover hospice services provided to dual eligible members that are covered by Medicare. In these instances, only when the service need is not related to the hospice diagnosis, can the service be covered.

Hospice services provided to dual eligible members that are covered by Medicare (e.g., personal care services, homemaker services) are not covered (i.e., duplicated) by UnitedHealthcare Community Plan QUEST Integration. In these instances, only when the service need is not related to the hospice diagnosis can the service be covered by UnitedHealthcare Community Plan QUEST Integration.

Institutional Services

Nursing Facility Services. These services are provided to members who require care, including activities of daily living and instrumental activities of daily living, 24 hours a day from medical personnel on a long-term basis. Nursing facility services are provided in a free-standing or a distinct part of a licensed facility. The care that is provided includes:

- Independent and group activities
- Meals and snacks
- Housekeeping and laundry services
- Nursing and social work services
- Nutritional monitoring and counseling
- Pharmaceutical services
- Rehabilitative services.

Acute Waitlisted ICF/SNF. This is either ICF or SNF level of care services provided in an acute care hospital in an acute care hospital bed. We work with the facilities to identify these individuals who are acute waitlisted for discharge to a more appropriate location for treatment.

Subacute Facility Services. These are provided in either a licensed nursing facility or a licensed and certified hospital in accordance with Hawaii Administrative Rules. Subacute facility services provide the patient with services that meet a level of care that is needed by the patient not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of the patients at a skilled nursing facility level of care. The Subacute level of care is designated either as Level I or II.

- **Level I** – Patients who require continuous ventilation for at least 50% of each day and are medically stable.
- **Level II** – Patients who do not require continuous mechanical ventilation for at least 50% of each day, are medically stable, and require the following services:
  - Tracheostomy care with suctioning at least once per hour
  - Any combination of mechanical ventilation, tracheostomy care with suctioning, and inhalation treatment at least once every eight hours
  - Total prenatal nutrition (TPN)
  - Continuous intravenous therapy or intermittent intravenous therapy at least once every eight hours

Home Health Services

This is part-time or intermittent care for members who do not require hospital care. This service is provided under the direction of a physician to prevent rehospitalization or institutionalization. Care providers must meet Medicare standards. We do not cover home health services provided to members who are covered by Medicare.

- Shower seat
- Portable humidifiers
- Electric bills specific to electrical life support devices (e.g., ventilator, oxygen concentrator)
- Medical supplies
- Heavy duty items including but not limited to patient lifts or beds that exceed $1,000 per month
- Rental of equipment that exceeds $1,000 per month, such as ventilators
- Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month
Chapter 6: Benefits: Covered, Excluded and Value-Added

- Stable newborns/premature infants under age one year who are inpatients in an acute care hospital for at least one week and require manual stimulation for bradycardia/apnea or nasogastric or gastrostomy feedings
- Stable patients who are admitted to an acute hospital for an infection for training of intravenous antibiotic administration or for close monitoring of oral antibiotics OR two or more of the following services:
  - Tracheostomy care with suctioning at least once every eight hours
  - Traction (excluding Buck’s traction) and pin care
  - Medically necessary isolation precautions
  - Treatment of State III and above pressure ulcers or wound infections
  - Ventilation or inhalation therapy services at least daily
  - Complex skilled nursing care of patients with conditions such as HIV/AIDS, terminal disease, and chronic dialysis who are at high risk of medical complications if discharged
  - Complex skilled nursing care of patients who are receiving radiation therapy, hydration, or parenteral pain control medications who are at high risk for significant medical complications
  - Complex skilled nursing care of psychiatric patients at high risk for imminent life threatening complications to themselves or others if discharged or with bulimia/anorexia nervosa who are at high risk of medical complications if discharged

All claims for ITOP procedures, medications, transportation, meals, and lodging associated with ITOPs must be submitted directly to Xerox at:

Xerox State Healthcare
Attention: Claims
P.O. Box 1220
Honolulu, Hawaii 96807-1220

KidsHealth

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

Mobile Apps

Apps are available at no charge to our members.
- Health4Me enables users to review health benefits, access claims information and locate in-network providers.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call 888-980-8728 to reach a nurse.

Outpatient Hospital Services

These include 24 hours a day, seven days a week, emergency services, ambulatory center services, urgent care services, medical supplies, equipment and drugs, diagnostic services, and therapeutic services including chemotherapy and radiation therapy.
**Peer Support Services**

This is only available as an additional service for behavioral health members. Our peer support services 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 substance use disorder (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.

**Prescription Drugs**

We cover prescription drugs when medically necessary to optimize the member’s medical condition. Behavioral health prescription drugs are covered for children receiving services from the Children and Adolescent Mental Health Division. Medication management and patient counseling are also included. More pharmacy resources and information is available at UHCprovider.com/Hlcommunityplan > Pharmacy Resources and Physician Administered Drugs.

**School Based Services**

The Department of Education provides some services to students. It promotes caring relationships among students, teachers, families, and agencies and seeks to ensure timely intervention to provide optimum classroom climate, family involvement, and specialized help. Contact them at 808-735-6225 or fax 808-733-9890.

**State of Hawai’i Organ and Transplant (SHOTT) Program**

This is a carved-out service. The Department of Human Services provides transplants which are not experimental or investigational and not covered by UnitedHealthcare Community Plan QUEST Integration. The SHOTT program covers adults and children for liver, heart, heart-lung, lung and bone marrow transplants. In addition, children are covered for transplants of the small bowel with or without liver. Children and adults must meet medical criteria as determined by the State and the SHOTT program contractor.

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

This program provides free:

- Nutritious food such as milk, eggs, cereal, etc.
- Education on nutrition best for your family.
- Support for mothers related to breastfeeding.
- Health care referrals.

**Contact Information:**

Oahu #: 808-586-8175

Neighbor Islands #: 888-820-6425

[http://health.hawaii.gov/wic/program_details/#qualify](http://health.hawaii.gov/wic/program_details/#qualify)

**Zero to Three Services**

The Zero to Three Program helps children with conditions that may result in developmental delay. Members with children who may qualify can call the Hawai‘i Keiki Information Service System (H-KISS) at 800-235-5477 or 808-594-0066 (Oahu).

H-KISS is the central point for referrals. Referrals may be from any source. This includes hospitals, doctors, parents, day care, education or public agencies, or other providers. The Department of Health coordinates services with local agencies.

**Benefit Exclusions**

Certain services and service categories are excluded from coverage under the UnitedHealthcare Community Plan QUEST Integration Program. Certain Medicaid covered services may also be carved out and are provided by the state and/or other local agencies.

For a complete list of exclusions, contact Provider Services at 888-980-8728.
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 medquest.hawaii.gov/en/plans-providers/become-a-medicaid-provider.html.

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 (acute and sub-acute).
- Psychiatric residential treatment facility.
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Social detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy
  - Multi-systemic therapy
Chapter 7: Mental Health and Substance Use

- Functional family therapy
- Electroconvulsive therapy
- Telemental health
  • Rehabilitation services
  • Day treatment/intensive outpatient
  • Dual-disorder residential
  • Intermediate residential (SUD)
  • Short-term residential
  • Community support
  • Psychiatric residential rehabilitation
  • Secure residential rehabilitation

Eligibility

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

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to UHCprovider.com/priorauth, calling 866-604-3267, or faxing 844-881-4772.

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 the customer Service Center at 866-815-5334 to verify eligibility and benefit information (available 8 a.m. – 5 p.m. Central Time, Monday through Friday).

Website: providerexpress.com

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

Appeals and Grievances

Call 888-380-0809 and a customer service representative will assist you with the Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the notice of action. Send written requests to:

1132 Bishop Street, Suite 400
Honolulu, HI 96813

Claims

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

Monitoring Audits

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

Addressing the Opioid Epidemic

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

BRIEF SUMMARY OF FRAMEWORK

• Prevention:
  - Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.
• Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment.

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

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

• Strategic community partnerships and approaches:
  - Tailor solutions to local needs.

• Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery.

• Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress.

INCREASING EDUCATION & AWARENESS OF OPIOIDS

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

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

PRESCRIBING OPIOIDS

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

PHARMACY LOCK-IN

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

Quarterly, our data analyst’s team identifies members with potentially inappropriate patterns of medication utilization. This program is specific to pharmacy lock-in only and allows member to access ER/Urgent Care Services. It does include emergency overrides if the pharmacy is closed or there is an issue with the medication being in stock.

Members that meet the criteria and that have been approved for lock-in are sent a notification letter prior to starting. If the member does not choose an approved pharmacy within 30 days following the notice, we select a pharmacy for them. Pharmacy selection is based on the location to the member’s home and based on previous usage. We also evaluate for potential case management.

The member continues to be restricted to the designated pharmacy until the member shows a pattern of safe utilization. A member can be placed back on restriction if there is evidence of recurrent over-utilization or abuse of medical services during that period.
New to Therapy Short-Acting Opioid Supply and Daily Dose Limits

We have a short-acting opioid supply limit of seven days and less than 50 Morphine Equivalent Dose (MED) per day for patients new to opioid therapy. Requests for opioids beyond these limits require prior authorization.

HOW THIS AFFECTS YOU AND YOUR PATIENTS

Long-term opioid use can begin with the treatment of an acute condition. For this reason, we recommend you consider prescribing the following:

• The lowest effective dose of an immediate-release opioid; and
• The minimum quantity of an opioid needed for severe, acute pain that requires an opioid

By adhering to these guidelines, you’ll be working to help minimize unnecessary, prolonged opioid use.

WHY WE’RE MAKING THE CHANGE

Studies have shown chronic opioid use often starts with a patient prescribed opioids for acute pain. The length and amount of early opioid exposure is associated with a greater risk of becoming a chronic user. For this reason, the Centers for Disease Control and Prevention recommends when a patient is prescribed opioids for acute pain, they receive the lowest effective dose for no more than the expected.

For more information on this change to UnitedHealthcare Community Plan, please call 888-362-3368.

Expanding Medication Assisted Treatment (MAT) Access & Capacity

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

To find a behavioral MAT provider in Hawaii:

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

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

To find medical MAT providers, see the MAT section in the Medical Management chapter.
Chapter 8: Member Rights and Responsibilities

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

Privacy Regulations

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

ACCESS TO PROTECTED HEALTH INFORMATION

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

AMENDMENT OF PHI

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

ACCOUNTING OF DISCLOSURES

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

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

RIGHT TO REQUEST RESTRICTIONS

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

Member Rights and Responsibilities

The following information is in the Member Handbook at the following member website: uhccommunityplan.com.

MEMBER RIGHTS

Members may:

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

• Get more information upon request, such as on how our health plan works and a care provider’s incentive plan, if they apply.

**MEMBER RESPONSIBILITIES**

Members should:

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

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

• Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care.
• Follow care to which they have agreed.
• Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible.
# Chapter 9: Medical Records

## Medical Record Charting Standards

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

<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>
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<tr>
<td></td>
<td>• Release of information.</td>
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<td></td>
<td>• Record retention.</td>
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<tr>
<td></td>
<td>• Availability of medical record if housed in a different office location.</td>
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<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>
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<tr>
<td></td>
<td>• Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be:</td>
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<tr>
<td></td>
<td>- In order.</td>
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<td></td>
<td>- Fastened, if loose.</td>
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<td></td>
<td>- Separate for each member.</td>
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<td></td>
<td>- Filed in a manner for easy retrieval.</td>
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<td></td>
<td>- Readily available to the treating care provider where the member generally receives care.</td>
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<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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<tr>
<td>Topic</td>
<td>Contact</td>
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<td>-----------------------</td>
<td>-------------------------------------------------------------------------</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 |
**Chapter 9: Medical Records**

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

*Critical element*
SCREENING AND DOCUMENTATION TOOLS

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

Medical Record Review

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

- Problem list with:
  - Biographical data with family history.
  - Past and present medical and surgical intervention.
  - Significant medical conditions with date of onset and resolution.
  - Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Entries dated and the author identified.

- Legible entries.
- Medication allergies and adverse reactions (note if none are known).
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
- History of physical examination (including subjective and objective findings).

- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
- Member education, counseling and/or coordination of care with other care providers.
- Notes regarding the date of return visit or other follow-up.
- Consultations, lab, imaging and special studies initiated by primary care provider to indicate review.
- Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

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

**Provider Name**

<table>
<thead>
<tr>
<th>Provider ID#</th>
<th>Provider Specialty</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reviewer Name</th>
<th>Review Date</th>
<th>Score</th>
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<tr>
<th>Member Name/Initials</th>
<th>Member ID#</th>
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### Confidentiality & Record Organization & Office Procedures

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<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
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<th>Yes</th>
<th>No</th>
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</table>

1. The office has a policy regarding medical record confidentiality that addresses office staff training on confidentiality; release of information; record retention; and availability of medical records housed in a different office location (as applicable).

2. Staff is trained in medical record confidentiality.

3. The office uses a Release of Information form that requires member signature.

4. There is a policy for timely transfer of medical records to other locations/care providers.

5. There is an identified order to the chart assembly.

6. Pages are fastened in the medical record.

7. Each member has a separate medical record.

8. Medical records are stored in an organized fashion for easy retrieval.

9. Medical records are available to the treating practitioner where the member generally receives care.

10. Medical records are released to entities as designated consistent with federal regulations.

11. Records are stored in a secure location only accessible by authorized personnel.

12. There is a mechanism to monitor and handle missed appointments.
### History

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
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<th>N/A</th>
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<tbody>
<tr>
<td>1. Medical and surgical history is present.</td>
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<td>2. The family history includes pertinent history of parents and/or siblings.</td>
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<td>3. The social history minimally includes pertinent information such as occupation, living situation, etc.</td>
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### Preventive Services

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<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>1. Evidence of current age appropriate immunizations.</td>
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<td>2. Annual comprehensive physical (or more often for newborns).</td>
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<td>3. Documentation of mental &amp; physical development for children and/or cognitive functioning for adults.</td>
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<td>4. Evidence of depression screening.</td>
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<td>5. Evidence of screening for high-risk behaviors such as drug, alcohol and tobacco use, sexual activity, exercise and nutrition counseling</td>
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<td>6. Evidence that Medicare members are screened for functional status and pain.</td>
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<td>7. Evidence of tracking and referral of age and gender appropriate preventive health services.</td>
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<td>8. Use of flow sheets or tools to promote adherence to clinical practice guidelines/preventive screenings.</td>
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### Problem Evaluation and Management

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<td>Documentation for each visit includes:</td>
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<td>1. Appropriate vital signs (i.e., weight, height, BMI measurement annually).</td>
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<td>2. Chief complaint.</td>
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<td>Problem Evaluation and Management</td>
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<td>4. Diagnosis.</td>
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<td>5. Treatment plan.</td>
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<td>6. Treatment plans are consistent with evidence-based care and with findings/diagnosis.</td>
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<td>7. Appropriate use of referrals/consults, studies, tests.</td>
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<td>8. X-rays, labs, consultation reports are included in the medical record with evidence of practitioner review.</td>
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<td>9. Timeframe for follow-up visit as appropriate.</td>
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<td>10. Follow-up of all abnormal diagnostic tests, procedures, X-rays, consultation reports.</td>
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<td>11. Unresolved issues from the first visit are followed-up on the subsequent visit.</td>
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<td>12. There is evidence of coordination of care with behavioral health.</td>
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<td>13. Education, including counseling, is documented.</td>
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<td>14. Member input and/or understanding of treatment plan and options is documented.</td>
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<td>15. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies as ordered by the practitioner are documented.</td>
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If a care provider scores less than 85%, review five more charts. Only review those elements the care provider received a “NO” on in the initial phase of the review. Upon secondary review, if a data element scores at 85% or above, that data element is recalculated as a “YES” in the initial scoring. If upon secondary review, a data element scores below 85%, the original calculation remains.

*Items are MUST PASS*
Chapter 10: Quality Management (QM) Program and Compliance Information

What is the Quality Improvement Program?

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

The program consists of:

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

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

We require your cooperation and compliance to:

- Provide requested timely medical records.
- Cooperate with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participate 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.
- Provide requested medical records for quality activities 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.
- Respond timely to practitioner appointment access and availability surveys.
- Allow the plan to use your performance data.
- Offer Medicaid members the same number of office hours as commercial members (or don’t restrict office hours you offer Medicaid members.)

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.
• Completing practitioner appointment access and availability surveys.

Quality Improvement Program

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

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

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

Care Provider Satisfaction

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

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

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

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

Credentialing Standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Hawaii 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.

Credentialing and Recredentialing Process

UnitedHealthcare Community Plan’s credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Credentialing and Re-Credentialing activities are delegated to MDX Hawaii for all providers except for Behavioral Health providers and Home and Community Based providers (ie: Community Care Adult Foster Home, Adult day, Adult Health, Respite, chore services etc.)

CARE PROVIDERS SUBJECT TO CREDENTIALING AND RECREDENTIALING

UnitedHealthcare Community Plan evaluates the following practitioners:

• MDs (Doctors of Medicine)
• DOs (Doctors of Osteopathy)
• DDS (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)

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.

ADVANCE DIRECTIVES
As part of re-credentialing, we may audit records of primary care providers, hospitals, home health agencies, personal care providers and hospices. This process helps us determine whether you are following policies 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 of the review.

REcredentialing PROCESS
UnitedHealthcare Community Plan recredentials practitioners every three years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan’s guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application with MDX Hawaii Inc. 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 to correct your information at any time. If erroneous information is found, 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. You also have the right to receive the status of your credentialing or recredentialing application by calling 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.

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

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

UnitedHealthcare Community Plan Central
Escalation Unit
P.O. Box 5032
Kingston, NY, 12402-5032

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

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

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

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

HIPAA Compliance – Your Responsibilities

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

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

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

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

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

PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION
The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members’ medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

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

Covered entities must meet basic security measures:

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

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

Find additional information on HIPAA regulations at [cms.hhs.gov](http://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 will work with the State of Hawaii 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 Hawaii 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 Hawaii 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 Hawaii program standards.

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

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

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

**DELEGATING AND SUBCONTRACTING**

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

**Office Site Quality**

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

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

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

**CRITERIA FOR SITE VISITS**

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.
### Chapter 10: Quality Management (QM) Program and Compliance Information

<table>
<thead>
<tr>
<th>QOS Issue</th>
<th>Criteria</th>
<th>Threshold</th>
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| Issue may pose a substantive threat to patient’s safety                   | Access to facility in poor repair to pose a potential risk to patients  
Needles and other sharps exposed and accessible to patients  
Drug stocks accessible to patients  
Other issues determines to pose a risk to patient safety                  | One complaint            |
| Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space | Access to facility in poor repair to pose a potential risk to patients  
Needles and other sharps exposed and accessible to patients  
Drug stocks accessible to patients  
Other issues determines to pose a risk to patient safety                  | Two complaints in six months |
| Other                                                                     | All other complaints concerning the office facilities                                                                                | Three complaints in six months |
Chapter 11: Billing and Submission

Our Claims Process

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare. For a complete description of the process, go to UHCprovider.com/guides > View online version > Chapter 9 Our Claims Process.

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions. If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call Provider Services.

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

General Billing Guidelines

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

Fee Schedule

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

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.

Submit the claim within one year from the date of service or date of discharge. The member and the State are not responsible for late claims. We may require additional information for some services, situations or state requirements.

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

Care Provider Coding

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

Electronic Claims Submission and Billing

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

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.
- All claims are set up as “commercial” through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don’t successfully transmit.

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.

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.
Chapter 11: Billing and Submission

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.

**Completing the UB-04 Form**

Bill all hospital inpatient, outpatient and emergency room services using revenue codes and the UB-04 claim form:
- Include ICD CM diagnosis codes.
- Identify other services by the CPT/HCPCS and modifiers.

**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. Use this chart to help determine when you bill to us:

---

**e-Business Support**

UnitedHealthcare Community Plan offices are open 7:45 a.m. – 4:30 p.m. HST, 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/edi](#).

**IMPORTANT EDI PAYER INFORMATION**

- Claim Payer ID: 87726
- ERA Payer ID: 04567

**Completing the CMS 1500 Claim Form**

Companion documents for 837 transactions are on [UHCprovider.com/edi](#).

Visit the [National Uniform Claim Committee](#) website to learn how to complete the CMS 1500 form.
<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
<th>Process</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Fee-for-Service</td>
<td>QUEST Integration</td>
<td>An automatic crossover should occur from Medicare to UnitedHealthcare. UnitedHealthcare will use the crossover information received from Medicare to coordinate the member’s benefits.</td>
<td>Do not submit a secondary claim to UnitedHealthcare unless otherwise requested.</td>
</tr>
<tr>
<td>UnitedHealthcare Medicare (All UnitedHealthcare Medicare Plans)</td>
<td>QUEST Integration</td>
<td>An automatic crossover should occur within the UnitedHealthcare systems to coordinate both the Medicare/QUEST Integration benefits.</td>
<td></td>
</tr>
<tr>
<td>AARP/Medicare Complete Choice and Complete Essential (Insured by UnitedHealthcare – Group# 77000-77007 and 77003/77008); External Medicare Advantage Plans; Commercial; No-Fault; and Other Third Party Liability (TPL) plans</td>
<td>QUEST Integration</td>
<td>No crossover will occur.</td>
<td>Submit a secondary claim with a copy of the primary EOB to UnitedHealthcare to ensure proper coordination of benefits.</td>
</tr>
</tbody>
</table>
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.
Hospital-Acquired Conditions (HAC)

We follow State of Hawai‘i and Medicare guidelines for reimbursement protocols for hospitals and care providers for HAC. Services related to HAC are typically non-reimbursable under Medicare and Medicaid programs.

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.

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

Find Link training on UHCprovider.com.

Resolving Claim Issues

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

Mail paper claims and adjustment requests to:

Medical Services:
UnitedHealthcare Community Plan
P.O. Box 31365
Salt Lake City, Utah 841-0365
Behavioral Health Services:
P.O. Box 30757
Salt Lake City, Utah 84130-0757

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 365 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.

All primary claims must be filed to us within one year from the date of service. All claims involving coordination of benefits must be submitted within one year of the primary/secondary payer’s EOB. Corrected claims must be submitted within one year of the original denial date.

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

Refer to the following chart for additional scenarios. 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.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Can the Provider bill the Member? (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-payment due to your failure to follow UHC’s policies and procedures (i.e. obtain a Prior Authorization, etc.)</td>
<td>No, you may not bill the member.</td>
</tr>
<tr>
<td>Non-payment due to the member’s failure to follow UHC’s policies and procedures (i.e. self-referral without obtaining a Prior Authorization, etc.)</td>
<td>Yes, however, you must first inform the member of our prior authorization requirement. You also need written agreement from the member regarding the cost of the procedure and the payment terms prior to rendering services.</td>
</tr>
<tr>
<td>Non-payment due to non-covered services</td>
<td>Yes, however, you must first inform the member of the non-covered services. You must get a written agreement from the member regarding the cost of the procedure and the payment terms prior to rendering services.</td>
</tr>
</tbody>
</table>

If you don’t know who your provider advocate is, email Hawaii_PA_Team@uhc.com. A provider advocate will get back to you.
Chapter 12: Claim Reconsiderations, Appeals and Grievances

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

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

<table>
<thead>
<tr>
<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>Member Appeal</td>
<td>A request to change an adverse benefit determination that we made.</td>
<td>Member</td>
<td>UnitedHealthcare Community Plan Attention: Grievance and Appeals Department 1132 Bishop St., Ste 400 Honolulu, HI 96813</td>
<td>UHCprovider.com</td>
<td>888-380-0809 <a href="mailto:HI_AG@uhc.com">HI_AG@uhc.com</a></td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>All appeals = 60 calendar days</td>
<td>Urgent appeals We will respond within 72 hours Standard appeals = 30 days</td>
</tr>
<tr>
<td>Member Grievance</td>
<td>A member’s written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.</td>
<td>Member</td>
<td>UnitedHealthcare Community Plan Attention: Appeals Department 1132 Bishop St., Ste 400 Honolulu, HI 96813</td>
<td>UHCprovider.com</td>
<td>888-380-0809</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>N/A</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>
## APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>DEFINITION</th>
<th>WHO MAY SUBMIT?</th>
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<th>UnitedHealthcare Community Plan RESPONSE TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Provider Claim</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>Care Provider</td>
<td>UnitedHealthcare Community Plan QUEST Integration P.O. Box 31350 Salt Lake City, UT 84131-0350</td>
<td>UHC provider.com</td>
<td>888-980-8728</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>must receive within 365 calendar days</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Resubmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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>Care Provider</td>
<td>UnitedHealthcare Community Plan QUEST Integration P.O. Box 31350 Salt Lake City, UT 84131-0350</td>
<td>UHC provider.com</td>
<td>888-980-8728</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>must receive within 365 calendar days</td>
<td>45 calendar days</td>
</tr>
<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, Attention: Appeals Department 1132 Bishop St., Ste. 400 Honolulu, HI 96813</td>
<td>UHC provider.com</td>
<td>888-380-0809 <a href="mailto:HI_AG@uhc.com">HI_AG@uhc.com</a> Fax 844-700-7938</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>60 calendar days</td>
<td>60 calendar days</td>
</tr>
<tr>
<td>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 Attention: Grievance &amp; Appeals Department 1132 Bishop St., Ste. 400 Honolulu, HI 96813</td>
<td>UHC provider.com</td>
<td>888-380-0809 <a href="mailto:HI_AG@uhc.com">HI_AG@uhc.com</a> Fax 844-700-7938</td>
<td>Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link</td>
<td>N/A</td>
<td>60 calendar days</td>
</tr>
</tbody>
</table>
The above definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

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

### Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

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

- **Time limit expired.** This is when you don’t send the claim in time.

### Claim Correction

**What is it?**

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

**When to use:**

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

**How to use:**

Use the claims reconsideration application on Link. To access Link, sign in to [UHCprovider.com](http://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 84131-0365

**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.
Claim Reconsideration (step one of dispute)

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

When to use:
Submit a claim reconsideration when you think a claim has not been properly processed.

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

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

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

- **Electronically**: Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone**: Call Provider Services at 888-980-8728 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 31350  
  Salt Lake City, Utah 84131-0350  
  This form is available at [UHCprovider.com](http://UHCprovider.com).

Valid Proof of Timely Filing Documentation (Reconsideration)

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

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

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

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

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

**Appeals (step two of dispute)**

What is it?
An appeal is a second review of a reconsideration claim.

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

How to use:
Submit related documents with your appeal within 60 days of the date of the health plan’s notice of action or decision. These may include a cover letter, medical records and additional information. Send your information electronically, by mail or fax. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims**: Use the Claims Management or ClaimsLink application on Link. You may upload attachments.
- **Mail**: Send the appeal to:
  
  UnitedHealthcare Community Plan  
  Grievances and Appeals  
  1132 Bishop Street, Ste. 400  
  Honolulu, Hi 96813  
  **Fax**: Send the appeal to 844-700-7938.

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

**TIPS FOR SUCCESSFUL CLAIMS RESOLUTION**

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call [Provider Services](#) if you can’t verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call [Provider Services](#).

- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

**Overpayment**

What is it?
An overpayment happens when we overpay a claim you don’t dispute.

How to use:
If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.
If you prefer we recoup the funds from your next payment, call Provider Services.

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

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.

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>14A0000000001</td>
<td>01/31/14</td>
<td>115.03</td>
<td>115.03</td>
<td>Double payment of claim</td>
</tr>
<tr>
<td>2222222</td>
<td>02/02/14</td>
<td>14A0000000002</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>14A0000000003</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>14A0000000004</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>14A0000000005</td>
<td>06/15/14</td>
<td>332.63</td>
<td>332.63</td>
<td>Member terminated</td>
</tr>
</tbody>
</table>
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 888-980-9728, 7:45 a.m. to 4:30 p.m. HT, Monday through Friday.
• Fax: 844-700-7938.
• Mail: Send care provider name, contact information and your grievance to:

UnitedHealthcare Community Plan
Grievances and Appeals
1132 Bishop St., Ste. 400
Honolulu, HI 96813

Member Appeals and Grievances Definitions and Procedures

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

NOTICE OF ACTION (NOA)
If we decide to reduce, put on hold, or stop a service the member is receiving, they receive a written NOA at least 10 days before the action takes place. If the member does not agree, they may file an appeal or they may have their care provider file an appeal on their behalf with the member’s written consent.

We give the member and the referring care provider a written notice of any action. This notice includes:
• The action we have or plan to take
• The reasons for the action such as changes in regulation, Federal or State law
• The member’s or care provider’s right to request an appeal
• Procedures for filing an appeal
• The member may represent himself or herself, use legal counsel or an authorized representative
• The circumstances under which an expedited resolution is available and how to request it
• The member’s right to have benefits continue pending resolution of an appeal, how to request that the benefits be continued, and the circumstances under which a member may be required to pay the costs of these services

We mail the notice within these time frames:
• For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten days prior to the date the adverse action is to start except for the following reasons:
  - We have factual information confirming the death of a member
  - We receive a clear written statement signed by the member that they no longer want services or gives information that requires termination or reduction of services and understands that this must be the result of supplying that information
  - The member has been admitted to an institution that makes them ineligible for further services
  - The member’s address is unknown and the post office returns our mail directed to the member indicating no forwarding address
  - The member has been accepted for Medicaid services by another local jurisdiction
  - The member’s care provider prescribes a change in the level of medical care
  - There has been an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions
- In the case of adverse actions for nursing facility transfers, the safety or health of individuals in the facility would be endangered, the member’s health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member’s urgent medical needs, or the member has not resided in the nursing facility for 30 days.
- The period of advanced notice is shortened to five days if there is alleged fraud by the member and the facts have been verified, if possible, through secondary sources.
- For denial of payment: at the time of any action affecting a claim.
- For standard service authorization decisions that deny or limit services: as expeditiously as the member’s health condition requires, but not more than 14 days following receipt of request for service, with a possible extension of up to 14 additional days (total time frame allowed with extension is 28 days from the date of the request for services) if: 1) the member or provider requests an extension or, 2) we justify a need for additional information and how the extension is in the member’s interest. If we extend the time frame, we must: 1) give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with the decision to extend the time frame and 2) issue and carry out its determination as expeditiously as the member’s health condition requires but no later than the date the extension expires.
- For expedited authorization decisions: as expeditiously as the member’s health condition requires but no more 72 hours after receipt of the request for service.
- Service authorization decisions not reached within the time frames specified constitute a denial.

- 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 certification of the appeal as appropriate.

**Where to send:**
Call, mail or email the information within 30 calendar days of the NOA:

UnitedHealthcare Community Plan
Attention: Grievance and Appeals Department
1132 Bishop St., Ste 400
Honolulu, HI 96813

Toll-free: 888-980-8728 (TTY 711). An oral appeal may be submitted but must be followed by a written request.
Email: HI_AG@uhc.com

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

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- The member or representative may review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.
- Ask for an expedited appeal if waiting for this health service could harm the member’s health. You have two business days to represent evidence and allegations of fact or law in person and in writing.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service.

**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:

- Makes a harmful determination or limits a requested service(s). This includes the type or level of service.
Chapter 12: Claim Reconsiderations, Appeals and Grievances

• We must resolve a standard appeal 30 calendar days from the day we receive it.
• We must resolve an expedited appeal 72 hours from when we receive it. With approval from DHS, we may extend the response up to 14 calendar days if the following conditions apply:
  1. Member requests we take longer.
  2. We request additional information and explain how the delay is in the member’s interest.

MEMBER GRIEVANCE

What is it?
Grievances are complaints related to UnitedHealthcare Community Plan policy, procedures or payments.

When to use:
You may file a grievance as the member’s representative.

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

Mailing address:
UnitedHealthcare Community Plan
Attention: Appeals Department
1132 Bishop St., Ste 400
Honolulu, HI 96813

We will send an answer no longer than 30 working days from when you filed the complaint/grievance.

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

Med-QUEST Division (MQD)
Health Care Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190

Or call 808-692-8094.

The MQD will review the grievance and contact the member within 90 days from the date the request for a grievance review is received. The determination made by MQD is final.

State Administrative Hearing

What is it?
A State Administrative Hearing lets members share why they think Hawaii Medicaid services should not have been denied, reduced or terminated.

When to use:
Members have 120 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:

State of Hawai‘i Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

• The member may ask UnitedHealthcare Community Plan Customer Service for help writing the letter.
• The member may have someone attend with them. This may be a family member, friend, care provider or lawyer.
• Hearings are held on the phone. Members may go to the local Family Support Division office for the hearing or can take part from home.
• Expedited hearings are heard and determined within three business days after the date the member files the request for an expedited hearing.

Processes Related to Reversal of Our Initial Decision

If the State Administration Hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the member’s health condition
CONTINUATION OF BENEFITS DURING AN APPEAL OR STATE ADMINISTRATIVE HEARING

We continue the member’s benefits if:

- The member requests an extension of benefits
- The appeal or request for a State Administrative Hearing is filed in a timely manner, meaning on or before the later of the following:
  - Within ten days of us mailing the notice of adverse action; or
  - The appeal or request for State Administrative Hearing involves the termination, suspension, or reduction of a previously authorized course of treatment; and
  - The services were ordered by an authorized care provider.

If we continue or reinstate the member’s benefits while the appeal or the State Administrative Hearing is pending, we continue all benefits until:

- The member withdraws the appeal;
- The member does not request a DHS Administrative Hearing within ten days from when we mail a notice of adverse action; or
- A State Administrative Hearing decision adverse to the member is made.

If the final resolution of the State Administrative Hearing upholds our denial, we may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.

If we or the DHS reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, we authorize or provide these disputed services promptly, and as quickly as the member’s health condition requires.

If we or the State reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, we will pay for those services.

Fraud, Waste and Abuse

Call the toll-free Fraud, Waste and Abuse Hotline to report questionable incidents involving plan members or care providers.

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

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

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

Find the UnitedHealth Group policy on Fraud, Waste and Abuse at uhc.com/fraud or call 888-980-8728.

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

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

**EXCLUSION CHECKS**

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

- [Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)](https://www.oig.hhs.gov/oei/exclusions/)
- [General Services Administration (GSA) System for Award Management](https://www.sam.gov)

**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.
The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and Hawaii’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.

**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. 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. We do this to create program awareness, promote compliance and problem resolution. To schedule a visit, please call Provider Services at 888-980-8728.

**Care Provider Newsletters and Bulletins**

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Hawaii 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 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 Hawaii DHS forms on the state's website at https://medquest.hawaii.gov/en/resources/forms.html:

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)
Chapter 14: Glossary

AABD
Assistant to the aged, blind and disabled

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

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

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

Acute Inpatient Care
Care provided to members sufficiently ill or disabled requiring:
- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Advance directive
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 a decision that denies a benefit or payment (either in whole or in part).

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

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

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

Carved-Out Service
Services not provided or covered under the UnitedHealthcare Community Plan QUEST Integration program but are available through the State or other local agencies.

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.
CHIP
Children’s Health Insurance Program.

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, dental 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.

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
A disagreement involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

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

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)
A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance abuse, mental health and hearing. They also include any medically necessary services found during the preventive exam.

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

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

Electronic Medical Record (EMR)
An electronic version of a member’s health record and the care they have received.
Eligibility Determination
Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care
The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

Encounter
A record of health care-related services by care providers registered with Medicaid to an patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to Hawaii Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee
Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment
The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-Based Care
An approach that helps care providers use the most current, scientifically accurate research to make decisions about members’ care.

Expedited Appeal
An oral or written request by a member or member’s representative received by UnitedHealthcare Community Plan requesting a faster reconsideration of an action. This speed is necessary when taking the time for a standard resolution could seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance
A grievance where delay in resolution could harm the member’s health or life.

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

FHC
Family Health Center

Fraud
A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance
An oral or written complaint a member or their representative has and communicates to UnitedHealthcare Community Plan.

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

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

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

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

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

Medical Emergency
An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:
• Their health would be put in serious danger; or
• They would have serious problems with their bodily functions; or
• They would have serious damage to any part or organ of their body.

Medically Necessary
Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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.

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, drugs or DME 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 HI DHS.

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

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

TANF
Temporary Assistance to Needy Families. A state program that gives cash assistance to low-income families with children.

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

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

Title XIX
Section of Social Security Act describing the Medicaid program coverage for eligible persons.
UnitedHealthcare Community Plan
An affiliate of United-Health Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Utilization Management (UM)
Involves coordinating how much care members get. It also determines each member’s level or length of care. The goal is to help ensure members get the care they need without wasting resources.
Comments

UnitedHealthcare Community Plan welcomes providers’ comments and suggestions about this guide. If a provider needs information about the material covered in this guide or expansion on topics not addressed or finds incorrect or inaccurate information, please complete this form, and mail or fax to:

UnitedHealthcare Community Plan
Attn: Director of Network Programs
1132 Bishop Street, Suite 400
Honolulu, HI 96813

Comments and Recommendations (attach a separate sheet(s) if necessary):
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Please provide the following information so we can contact you if we need to clarify your request.

Name: ________________________________________________________________

Provider Name (if different from above): ________________________________

Address:
____________________________________________________________________

Phone: ______________________________________________________________