2018
Care Provider Manual

Physician, Health Care Professional, Facility and Ancillary Provider

New York

UnitedHealthcare Community Plan for Families/Kids
UnitedHealthcare Dual Advantage (Medicaid)
UnitedHealthcare Dual Complete (Medicare)
UnitedHealthcare Managed Long Term Care
Children’s Health Insurance Program (CHIP)
Welcome

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

Click the following links to access different manuals:

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

Easily find information in this manual using the following steps:

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

If available, use the binoculars icon on the top right hand side of the PDF.

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

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

Important Information about the use of this manual

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

We amend the manual as policies change.
Welcome to UnitedHealthcare Community Plan

This manual is designed as a comprehensive reference source for the information you and your staff need to conduct your interactions and transactions with us in the quickest and most efficient manner possible. Much of this material, as well as operational policy changes and additional electronic tools, are available at UHCprovider.com.

Our goal is to help ensure our members have convenient access to high-quality care provided according to the most current and efficacious treatment protocols available. We are committed to working with and supporting you and your staff to achieve the best possible health outcomes for our members.

If you have any questions about the information or material in this manual or about any of our policies or procedures, please do not hesitate to contact the Provider Services Line at 866-362-3368. We greatly appreciate your participation in our program and the care you provide to our members.

Important Information Regarding the Use of This Manual

If there’s a conflict between the manual and the agreement, the manual controls unless the agreement dictates otherwise. If there is a conflict or inconsistency between your participation agreement, this manual and applicable federal and state statutes and regulations, the applicable federal and state statutes and regulations will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure that its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

For the most up-to-date information regarding UnitedHealthcare Community Plan Operational and Payment Policies, please refer to UHCprovider.com.
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<tr>
<td>Provider Services Line</td>
<td>866-362-3368</td>
<td>To review a patient’s eligibility or benefits, check claims status, submit claims or review Directory of Physicians and Health Care Professionals. You may register at the site.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To ask questions about online capabilities or receive assistance</td>
</tr>
<tr>
<td>Prior Authorization Notification</td>
<td>866-604-3267</td>
<td>To inquire about a patient’s eligibility or benefits, to check claim status or make a claim adjustment request</td>
</tr>
<tr>
<td></td>
<td>Fax 866-950-4490</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>UHCprovider.com</strong></td>
<td>To notify us of the procedures and services outlined in the notification requirements section of this guide</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td><em>UHCprovider.com</em></td>
<td>To view the Preferred Drug List (PDL) or request a copy of the PDL</td>
</tr>
<tr>
<td></td>
<td>800-310-6826 866-940-7328</td>
<td>For medications/injectable requiring prior approval</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>For New York City Adults, call 866-604-3267 or fax 866-950-4490. For the rest of the state, call 888-291-2506</td>
<td>To inquire about a patient’s eligibility or benefits, to check claim status or make a claim adjustment request</td>
</tr>
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# Care Provider Update Forms

<table>
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<th>Services Needed</th>
<th>Contact</th>
</tr>
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<tr>
<td>Behavioral Health-Ambulatory After 1st Visit</td>
<td>New York City Adults can call 866-604-3267 or fax 866-950-4490. For the rest of the state, call 888-291-2506.</td>
</tr>
<tr>
<td>Cardiology services</td>
<td>866-889-8054</td>
</tr>
<tr>
<td>Cosmetic and Reconstructive Surgery</td>
<td>866-604-3267 or Fax 866-950-4490. For more information on covered CPT codes go to <a href="http://UHCprovider.com">UHCprovider.com</a></td>
</tr>
<tr>
<td>Durable Medical Equipment &gt; $500 Per Item</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>Prosthetics and Orthotics &gt; $500 Per Item</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>Gastric Bypass Evaluations and Surgery</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>• Medication or Infusion</td>
<td></td>
</tr>
<tr>
<td>• All Other</td>
<td></td>
</tr>
<tr>
<td>Hospice Services – Inpatient and Outpatient</td>
<td>For Medicaid call: 866-604-3267 or fax 866-950-4490. For CHP call: 866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>Hospital Services – Inpatient</td>
<td>New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506.</td>
</tr>
<tr>
<td>• Acute (Medical, Surgical, Level 2 Through Level 4 Nursery, and Maternity)</td>
<td>Exception SSI – certain services covered by Medicaid FFS</td>
</tr>
<tr>
<td>• Subacute, Rehab &amp; SNF</td>
<td></td>
</tr>
<tr>
<td>MRI, MRA and PET Scans (Ambulatory and Non-emergency)</td>
<td>CareCore Radiology at 868-889-8054, Fax 866-889-8061</td>
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<tr>
<td>Non-Contracted Physician Services (Hospital and Professional)</td>
<td>866-604-3267 or Fax 866-950-4490</td>
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<td>Skilled Nursing Facility</td>
<td>866-604-3267 or Fax 866-950-4490</td>
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<td>Substance Abuse</td>
<td>New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506</td>
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<td>Transplantation Evaluations</td>
<td>866-604-3267 or Fax 866-950-4490</td>
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# PROVIDER PRACTICE DATA UPDATE FORM

**States Include: CT, NJ, NY**

Complete all information pertaining to your practice and **fax to 866-561-3966**. Please ensure that ALL pertinent information is completed as we will be unable to process incomplete forms.

## Section I  
**Group Demographics**

Physician Name: ___________________________ Current provider/practice tax ID (TIN): ___________________________

Practice Name: _____________________________

Name of individual completing this form: _____________________________ Telephone Number: __________________

☐ NPI #: _____________________________ Email: __________________

☐ Please check here if you have multiple NPIs representing your practice or organization. Refer to Section III (page 2) of this fax form

☐ Participating with Oxford  ☐ Participating with UnitedHealthcare

Oxford Provider ID#: _____________________________

☐ Check this box if you do not have a private office and only see patients at the hospital

## Section II  
**Practice/Organization Information Changes**

Please make the following changes to our practice/organization information:

☐ We have moved. Our new address is effective:

This new address is a: ☐ Practice Address ☐ Billing Address  ☐ Both Practice and Billing Address

Should this new address print in the directory? ☐ Yes  ☐ No

**New:**

<table>
<thead>
<tr>
<th>Old:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: ___________________________</td>
</tr>
<tr>
<td>Fax: ___________________________</td>
</tr>
<tr>
<td>Email: ___________________________</td>
</tr>
</tbody>
</table>

Please list all additional practice locations for this tax ID (use a separate page if necessary):

<table>
<thead>
<tr>
<th>Old:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: ___________________________</td>
</tr>
<tr>
<td>Fax: ___________________________</td>
</tr>
<tr>
<td>Email: ___________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Old:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: ___________________________</td>
</tr>
<tr>
<td>Fax: ___________________________</td>
</tr>
<tr>
<td>Email: ___________________________</td>
</tr>
</tbody>
</table>

**Signature of person completing this form:** _____________________________

**Title:** _____________________________ **Date:** _____________________________
### Section III

**National Provider Identification-Requested Information**

For organization care providers we would like to capture the “basis” or reason for each NPI; if the organization has more than one or has sub-parts who will have NPIs. Please use the grid below as a reference when filling in the “Basis for NPI; and Level Information columns in the data collection grid further below.

<table>
<thead>
<tr>
<th>If the Basis for Your NPI is:</th>
<th>Then Supply This Information Into the Level Information Column</th>
<th>Instructional Information</th>
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<td>C = Entity whose name is on the W-9</td>
<td>Tax ID and Name Field on W-9</td>
<td>If the organization or sub-part was enumerated strictly on the basis of the name associated with the Tax ID on the W-9 form, then use a “C” in the “Basis for NPI” column. (You will need to indicate whether the Tax ID is a social security number or if it is an employer identification number.) Place the Tax ID in the “Level Information” column.</td>
</tr>
<tr>
<td>D = Department</td>
<td>Department Name</td>
<td>If the organization or sub-part was enumerated on the basis of a particular department, provide the Department Name that the NPI was based on, and designate this with a “D” in the “Basis for NPI” column. Insert the Department Name in the “Level Info”</td>
</tr>
<tr>
<td>L = License</td>
<td>License Number and State or (State Code)</td>
<td>If the organization or sub-part was enumerated by License, provide the State or (State Code) and License Number that the NPI was based on, and designate this with an “L” in the “Basis for NPI” column. Insert the License Number and State or (State Code) in “Level Information” column.</td>
</tr>
<tr>
<td>P = Place of Service Address</td>
<td>Place of Service Address (Street, City, State, Zip + 4)</td>
<td>If the organization was enumerated by place of service address level, provide the street address that the NPI was based on and designate this with a “P” in the “Basis for NPI” column. Insert the Place of Service address in the “Level Information” column.</td>
</tr>
<tr>
<td>T = Tax ID Number and Provider Name</td>
<td>Tax ID and Provider Name, where provider is not the name on the W-9, but bills using this TIN</td>
<td>If the organization or sub-part was enumerated by Tax ID Level and Provider Name, where the provider is not the name listed on the W-9, but uses this TIN, then designate this with a ‘T” in the “Basis for NPI” Column. Place the Tax ID in the “Level Information” column and indicate whether the Tax ID is a social security number or if it is an employer identification number.</td>
</tr>
<tr>
<td>X = Taxonomy</td>
<td>NUCC Taxonomy Code</td>
<td>If the organization or sub-part was enumerated by a NUCC Taxonomy code, please provide the Taxonomy Code that the NPI was based on and designate this with an “X” in the “Basis for NPI” column. Place the NUCC Taxonomy Code in the “Level Information” column.</td>
</tr>
<tr>
<td>O = Other</td>
<td>Specify details for selecting ‘Other’</td>
<td>Provide any other basis for NPI in the “Basis for NPI” column and designate as “0”, with a description of the basis for that NPI in the “Level Information” column.</td>
</tr>
<tr>
<td>M = Name</td>
<td>Provider Name</td>
<td>This is intended for use by physicians and allied health professionals (people providers). Insert the name in the “Level Information” column.</td>
</tr>
</tbody>
</table>
NPI Collection Grid

In the grid below please insert your Organization or Sub-Part Name, NPI, and Taxonomy Code(s) associated with that NPI. Please indicate the basis for that particular NPI with the appropriate letter from the grid above in the “Basis for NPI” column. Indicate the appropriate “Level Information”. If the number of NPI’s exceeds this sheet, please instead access a formatted spreadsheet (NPI Tracking Template) on UHCprovider.com to list your NPIs. It is found in the “UnitedHealthcare News” section.

<table>
<thead>
<tr>
<th>NPI Number</th>
<th>Organization/Sub-Part Name</th>
<th>Taxonomy Code (Codes Associated With Each Individual NPI)</th>
<th>Basis for NPI</th>
<th>Level Information</th>
<th>NPI Issue Date MM/ DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Name of individual completing this form

Telephone: ___________________________ E-mail: ___________________________
Provider Information Update Form
Return form by Fax to: 855-312-1651 or e-mail Ox_HPDemo@uhc.com

UnitedHealthcare Community Plan Region: ________________________________

Provider Name: ____________________________ UnitedHealthcare ID#: ________________

National Provider ID (NPI) #: Individual: ____________________________ Organization: ________________

Dear UnitedHealthcare Community Plan Provider,

In order to ensure prompt service, in the space below, please fill out all information concerning your practice.
(Please print or type)

Is this an additional location? □ Yes □ No Effective Date: ______________________________
Is this a change to an existing location? □ Yes □ No Effective Date: ______________________________
Specialty at this location: ______________________________

If you are requesting a change to an existing location, please indicate only the information to be updated.

If this is a new location, please complete the entire form.

Site Name (If different than provider): ______________________________
Site Address: ______________________________

Medical Group Name: ________________________________ E-mail: ______________________________
Office Manager: ____________________________ Office Phone: ____________________________
Office Phone: ____________________________ Office Fax: ____________________________
Gender of Provider: □ Male □ Female
Wheelchair Accessible: □ Yes □ No Languages: ______________________________
Age Range of Patients Served: ________ to _________

Specify any additions or deletions to your practice’s health care services provided at this site:

Payee Tax ID: ____________________________ (attach a copy of a W-9 form if you tax ID has changed)
Make Check Payable to (if different than provider name): ______________________________
Billing Address: ______________________________
City/State/Zip: ______________________________
Billing Contact: ____________________________ Billing E-mail: ____________________________
Billing Phone: ____________________________ Billing Fax: ____________________________
Provider Information Update Form

Return form by Fax to:
866-561-3966 or e-mail Ox_HPDemo@uhc.com

Office Hours

<table>
<thead>
<tr>
<th></th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
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<tr>
<td>To:</td>
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</tbody>
</table>

Hospital Privileges: ☐ Yes ☐ No

Name of Hospital: ____________________________________________________________

Hospital Address: __________________________________________________________

Covering Physician (must be a UnitedHealthcare Community Plan contracted provider):

Name: ___________________________________________ Provider ID#: __________________

Address: ___________________________________________ Phone: __________________

Provider’s signature: ___________________________ Date: _______________________

Contact Name of person who completed this form: _____________________________

Contact Phone of person who completed this form: _____________________________

Internal Use Only: Reviewed by: ___________________________ Date: ________________
Our claims process
You want to be paid promptly for the services you provide. Here’s what you can do to help ensure prompt payment:

1. Review and copy both sides of the member’s ID card. UnitedHealthcare members receive an ID card containing information that helps you process claims accurately. These ID cards display information such as claims address, copayment information (if applicable), and telephone numbers such as those for Behavioral health, substance abuse and Member Services.

2. Notify Health Services of planned procedures and services on our Prior Authorization list.

3. Prepare a complete and accurate electronic or paper claim form (see “complete claims” at right). Complete a CMS 1500 (formerly HCFA) or UB-04 form.

4. Submit claims electronically on UHCprovider.com/claims. Be sure to use our electronic payer (ID 87726) to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315. If you do not have access to internet services, you can mail the completed claim to:

   UnitedHealthcare Community Plan
   P.O. Box 5240
   Kingston, NY 12402-5240

Complete claims
A complete claim includes the following:
• Patient’s name, date of birth, address and ID number,
• Name, signature, address and phone number of physician or physician performing the service, as in your contract document,
• National Provider Identifier (NPI) number,
• Physician’s tax ID number,
• CPT-4 and HCPCS procedure codes with modifiers where appropriate,
• ICD-10 diagnostic codes,
• Revenue codes (UB-04 only),
• Date of service(s), place of service(s) and number of services (units) rendered,
• Referring physician’s name (if applicable),
• Information about other insurance coverage, including job-related, auto or accident information, if available,
• Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers,
• Attach an anesthesia report for claims submitted with QS modifier; and
• Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable).

How to contact us
UHCprovider.com
Verify member eligibility, check status of claims, submit claim adjustment requests

Provider Services Helpline
866-362-3368
This is an automated system. Please have your National Provider Identifier number and your Tax ID ready or the Member ID ready, or, you may hold to speak to a representative. The call center is available to physicians to:
867-Answer general questions
868-Verify member eligibility
869-Check status of claims
870-Ask questions about your participation or notify us of demographic and practice changes
871-Request information regarding credentialing.

Prior Authorization
Prior authorization (or via iExchange) For a complete and current list of prior authorizations, go to UHCprovider.com/priorauth or call 866-604-3267.
Fax your prior authorizations to Case Management 866-219-5159
Case Management Intake – Pain Management; Medication; Utilization

Disease Management
866-398-3661
Diabetes, hemophilia, sickle cell, HIV/AIDS, schizophrenia, Coronary Artery Disease, Asthma/COPD

Pharmacy
800-310-6826
Fax 877-265-4976
For medications requiring prior approval and for pharmacy injectables

Behavioral Health (a PCP referral is not required)
New York City Adults can call 866-604-3267.
The rest of the state should call 888-291-2506

Member Services Helpline
800-493-4647 (MCD/CHP)
Medicare - 800-514-4912
24 hours, seven days a week service available to assist members with any issues or concerns.

*See reverse side for more important contact information.
New York Care Provider
Resource Kit

Other Important Information

Medical Claims Mailing Address
UnitedHealthcare Community Plan
Attention: Claims Administrative Appeals
PO Box 31364
Salt Lake City, UT 84131-03641

Claim Appeals Mailing Address
UnitedHealthcare Community Plan
Attention: Claims Administrative Appeals
PO Box 31364
Salt Lake City, UT 84131-03641

Provider Utilization Management (UM) Appeals Address:
PO Box 31364
Salt Lake City, UT 84131-03641

Fraud and Abuse Division
UnitedHealthcare
Special Investigations Unit
Four Gateway Center
100 Mulberry Street - 4th Floor
Newark, New Jersey 07102
877-401-9430

National Credentialing Center: 877-842-3210

Personal Care Model (Care Management): 866-219-5159
To refer high-risk members (high risk OB, asthma, diabetes, other chronic conditions)

Dental Services: 800-304-0634
Routine dental services are covered Dental Benefits Plan (DBP) anesthesia and facility charges associated with dental procedures performed at a hospital facility or Ambulatory Surgery Center (ASC) must meet Medical Necessity and be prior authorized for services to be considered.

Non-Emergency Transportation (for members going to and from appointments): 800-493-4647

Vision Services: 888-493-4070
Routine vision services is managed by March Vision Care. Prior authorization is required for all routine eye exams; authorizations must be obtained from March Vision Care.

Notify Health Services within the following timeframes:

Emergency Admission
Within one business day of an emergency or urgent admission.

After Ambulatory Surgery
Within one business day of an inpatient admission after ambulatory surgery.

Non-Emergency Care (except maternity)
At least five business days prior to non-emergent, non-urgent hospital admissions and/or outpatient services.

Return calls from Health Service Coordinators and Medical Directors and provide complete health information within one business day.

Compliance

HIPAA mandates the adoption and use of NPI in all standard transactions (claims, eligibility, remittance advice, claims status request / response, and auth request / response) for all health care providers who conduct business electronically.

UnitedHealthcare
Community Plan
For updated Medicaid Policies please visit [emedny.org/providermanuals](emedny.org/providermanuals).
This table provides information about some of the most commonly asked questions regarding our products. This product list is provided for your convenience and is subject to change over time. If additional product/benefit information is needed, you can find it at UHCprovider.com/NYcommunityplan or call 866-362-3368.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Medicaid Managed Care</th>
<th>CHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient Stay Pending Alternate Level of Medical Care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Nurse Practitioner Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Midwifery Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Second Medical/Surgical Opinion</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula</td>
<td>Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit, except Risperdal Consta.</td>
<td>Prescription and Non Prescription (OTC) Drugs are covered with written Prescription. Enteral formula is covered. Medical Supplies are limited to Diabetic supplies.</td>
</tr>
<tr>
<td>Smoking Cessation Products and Counseling</td>
<td>Covered/Products and effective 3/1/14 for 8 Counseling Sessions</td>
<td>Covered - Products</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>Covered</td>
<td>Short term for PT and OT (two Months)</td>
</tr>
<tr>
<td>EPSDT Services/Child Teen Health Program (C/THP)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Covered</td>
<td>Covered, with Limitations</td>
</tr>
<tr>
<td>Private Duty Nursing Services</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Hospice</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Emergency Services, Post-Stabilization Care Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Foot Care* Services</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Eye Care and Low Vision Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Audiology, Hearing Aids Services &amp; Products</td>
<td>Covered except for hearing aid batteries</td>
<td>Covered</td>
</tr>
<tr>
<td>Family Planning and Reproductive Health Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>

*Foot care includes routine foot care provided by qualified care provider types when any member’s (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections. Services provided by a podiatrist for persons younger than 21 are covered upon referral of a physician, registered physician assistant, certified nurse practitioner or licensed midwife. Services provided by a podiatrist for adults with diabetes mellitus are covered.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Medicaid Managed Care</th>
<th>CHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Emergency Transportation</td>
<td>Covered in Nassau, Niagara, and Suffolk Counties. All other Counties covered through Medicaid FFS.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency Transportation</td>
<td>Covered in Chautauqua, Genesee, Nassau and Suffolk counties. All other counties covered through Medicaid FFS.</td>
<td>Covered</td>
</tr>
<tr>
<td>Dental and Orthodontic Services</td>
<td>Covered</td>
<td>Routine Dental Care Covered, but Orthodontic Services are not covered.</td>
</tr>
<tr>
<td>Court-Ordered Services</td>
<td>Covered, pursuant to court order</td>
<td>Covered</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Services/Orthopedic Footwear</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Detoxication Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Chemical Dependence Inpatient Rehabilitation and Treatment Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Chemical Dependence Outpatient</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Experimental and/or Investigational Treatment</td>
<td>Covered on a case by case basis.</td>
<td>Covered on a case by case basis.</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Residential Health Care Facility Services (Rf-ICF)</td>
<td>Covered except for individuals in permanent placement.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Covered. When only Level I services provided, limited to 8 hours per week.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Consumer Directed Personal Assistance Services</td>
<td>Covered as of November 1, 2012</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Observation Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>Covered only for those members transitioning from the LTHHCP and who received Medical Social Services while in the LTHHCP.</td>
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</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Covered only for those members transitioning from the LTHHCP and who received Home Delivered Meals while in the LTHHCP.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>Covered – see following section for details</td>
<td>Covered</td>
</tr>
</tbody>
</table>
Coverage of Medical Language Interpreter Services

UnitedHealthcare Community Plan reimburses Article 28, 31, 32 and 16 outpatient departments, hospital emergency rooms (HERs), diagnostic and treatment centers (D&TCs), federally qualified health centers (FQHCs) and office-based practitioners to provide medical language interpreter services for Medicaid members with limited English proficiency (LEP) and communication services for people who are deaf or hard of hearing. This payment is made in accordance with rates established in provider agreements or at the rates listed below.

<table>
<thead>
<tr>
<th>HCPCS Procedure Code T1013</th>
<th>Office-Based Practitioners</th>
<th>Article 28, 31, 32 and 16 facilities that bill with APGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Unit: Includes a minimum of eight and up to 22 minutes of medical language interpreter services</td>
<td>$11.00</td>
<td>$11.00</td>
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<tr>
<td>Two Units: Includes 23 or more minutes of medical language interpreter services</td>
<td>$22.00</td>
<td>$22.00</td>
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</tbody>
</table>

Patients with LEP are defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff.

The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third-party interpreter, who is either employed by or contracts with the participating care provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI). Reimbursement of medical language interpreter services is payable with HCPCS procedure code T1013- sign language and oral interpretation services and is billable during a medical visit. Medical language interpreter services are included in the prospective payment system rate for those FQHCs that do not participate in APG reimbursement.
Chapter 1: Services

Behavioral Health

Optum is a specialty managed behavioral health care organization that provides all aspects of mental health, substance abuse services and case management. UnitedHealthcare Community Plan members are allowed to self-refer to a participating care provider for one mental health/substance abuse visit per year. Subsequent visits require prior authorization through Optum.

Referring a Patient to Optum

For UnitedHealthcare Community Plan Members, call Optum to access Optum mental health and substance abuse services. A patient is not required to have a referral from his or her primary physician to access mental health and substance abuse services. Patients will be evaluated by a clinical mental health professional that identifies the appropriate treatment pathway to meet the patient’s individual needs. Optum provides service directly through its own multidisciplinary staff or arranges for service through Optum’s network of participating physicians and other health care professionals.

Crisis Services

Optum clinicians are available 24 hours a day, 7 days a week for urgent and emergency services. If a patient needs crisis services, call Optum. New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506. In the case of an emergency, call 911.

Questions or Concerns

Call Optum for assistance in interpreting mental health and substance abuse benefits or to address concerns regarding services. New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506.

Pharmacy Services

All Medicaid members receive their pharmacy benefits from the Plan.

Physician and member involvement is critical to the success of the pharmacy program. Please follow these guidelines when prescribing medication to UnitedHealthcare Community Plan members to help your patient obtain the maximum benefit.

- Prescribe drugs from the UnitedHealthcare Community Plan Prescription Drug List (PDL). The UnitedHealthcare National Pharmacy and Therapeutics Committee, which includes local physician representation, develops and maintains the PDL first according to therapeutic efficacy and then on the basis of cost effectiveness. The PDL is updated as needed to be sure it remains responsive to clinical needs.
- Prescribe generic drugs whenever therapeutic equivalent drugs are available and appropriate, and/or let your patient know an equivalent generic drug may be substituted for brand drugs under the benefit program. UnitedHealthcare Community Plan members may be responsible for paying a higher copayment when a brand name medication is generically available is prescribed.
- If phoning a prescription to a pharmacy, verify it is a participating pharmacy.
- The PDL is supported in an online, real-time environment in all participating pharmacies. Additionally, the system links the PDL to each member’s benefit design. This allows the pharmacist to assist you in identifying those drug products which are currently on the PDL, their generic equivalents, those that have notification requirements, quantity level limitations or any potential drug-drug, drug-age, or drug gender compatibility issues.
- Accept calls from the participating pharmacy notifying you of a possible problem with a prescribed drug. This is offered as a service to both you and your patient.

The PDL is standardized nationally for all products to provide greater ease in prescribing and administering.

Some prescription medications require notification or are subject to quantity level limitation, as noted in the PDL. To request drug coverage review, call 800-310-6826.

The pharmacy benefit includes all FDA approved prescription drugs, as well as some over-the-counter drugs and medical supplies.

In an effort to promote clinically appropriate utilization of pharmaceuticals in a cost-effective manner, the UnitedHealthcare Community Plan has an established Preferred Drug List based on safety, effectiveness and clinical outcomes.

Preferred Drug List (PDL): The UnitedHealthcare Community Plan PDL can be reviewed on our website at com. The website allows you to see the entire document, and to search for the status of particular agents. Additionally, you can view our PDL through ePocrates. The PDL will assist you in determining whether a medication requires prior authorization (PA), is subject to step therapy (ST), or has set quantity limits (QTY). Generally, preferred medications available as generic are preferred in the generic
Branded formulations of medications available as generic require a clinical review for medical necessity by prior authorization. A printed copy of the PDL is available upon request, call 800-310-6826.

**Prior Authorization Process:** If a current UnitedHealthcare Community Plan member under your care is receiving a nonpreferred medication, a medical necessity review process is available. Any physician wishing to utilize the medical necessity process will be asked to provide information detailing requested drug along with current clinical rational supporting the inability for the member to be effectively treated with a preferred medication.

Clinical rational can be provided to The Pharmacy Prior Notification Service by phone or fax.

- **Phone** 800-310-6826
- **Fax** 866-940-7328

**Transition Period:** It is important to note that during the first 90 days of the transition period, the UnitedHealthcare Community Plan pharmacy system will be programmed to allow a 30 day transitional supply of all members' medication to process at the pharmacy. The UnitedHealthcare Community Plan pharmacy department will be reviewing the paid claims for all members. Members that are utilizing nonpreferred medications from the following therapeutic classes will not be asked to change medications:

- Antipsychotics
- Immunosuppressants
- Antidepressants
- Antiretrovirals

Members utilizing non-preferred medications in classes including but not limited to, proton pump inhibitors, cholesterol lowering medications, hypertension medications, over the counter medications, and narcotic pain medications will be identified and notified of the non-preferred status of their current medication(s). These members will be sent a letter giving them 30 days to work with their physician to change their drug therapy to a preferred drug or submit for authorization for continued use.

**Specialty Products:** Self-administered injectables (except for heparin and insulin) require prior authorization and are dispensed through contracted specialty vendors. Call our the PNS at 800-310-6826. Some specific information on Specialty Products includes:

- Lovenox will process at the pharmacy for the first two weeks of therapy. Therapy beyond two weeks requires prior authorization and will be dispensed through Specialty.
- Synagis (in season) requires pharmacy prior authorization.
- Xolair requires pharmacy prior authorization.

Injectables administered at prescriber sites are generally covered by the medical benefit and can be purchased and billed along with the administration. Our specialty network is also available to supply many of these products. Call Bioscrip at 866-940-7328 to order for UnitedHealthcare Community Plan members.

**Diabetic Supplies:** UnitedHealthcare Community Plan offers several preferred glucose testing devices. Members can order preferred Bayer BREEZE®2 and CONTOUR® products by calling 888-877-8306 or Roche Accu-Chek® Aviva and Compact Plus products by calling 877-411-9833. Other diabetic supplies including test strips, insulins (Novolin products are preferred), syringes, etc. can be obtained through our retail network. Quantity limits apply for test strips — 100 per 90 days for noninsulin dependent users and 100 per month for insulin dependent members. Additional supplies can be authorized by calling the PNS at 800-310-6826. Medical supplies (ostomy, bandages, enteral supplies, tubing), previously available through the State’s pharmacy network will now be available through the UnitedHealthcare DME/medical supply network. Our network is listed in the UnitedHealthcare Provider Directory and on our website [UHCprovider.com](http://UHCprovider.com) > Menu > Find a Care Provider. Prior authorization is required for medical supplies costing more than $500 per month. Please call Medicaid Prior Notification at 866-604-3267. You can arrange for medical supplies by giving the patient a prescription or by calling a par vendor. For questions or clarification, please call Provider Services at 866-362-3368.

**Questions**

All pharmacy related questions should be directed to the UnitedHealthcare Community Plan Pharmacy department at 800-310-6826. Medical Supply questions or other general questions should be directed to the UnitedHealthcare Community Plan Provider Services line at 866-362-3368.

**Reminder Notice to Physicians, Infusion Companies and Pharmacies**

When injectable medication is administered at home for UnitedHealthcare Community Plan for Families and UnitedHealthcare Community Plan for Kids members, you should continue to bill UnitedHealthcare Community Plan directly for both the pharmacy and skilled care.

If a RDL medication can be safely administered at home, this should be the primary site of Infusion therapy. When it is medically necessary to administer a RDL medication at either a physician’s office or at an outpatient center, a request should be made for prior approval prior to infusion.
<table>
<thead>
<tr>
<th>Program Title</th>
<th>Program Definition</th>
<th>Program Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHAP – Infant Child Health Assessment Program</td>
<td>The ICHAP serves in ‘finding’ and tracking at-risk children and facilitates referrals to EIP.</td>
<td>Help identify infants and toddlers up to the age of three years who are at risk of developmental disabilities as early as possible.</td>
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<tr>
<td></td>
<td></td>
<td>• Help ensure that identified children are referred to designated county officials for an evaluation and receipt of appropriate services.</td>
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<td></td>
<td></td>
<td>• Coordinate disability related services with child PCP and other preventive services covered by UnitedHealthcare Community Plan.</td>
</tr>
<tr>
<td>2. EIP – Early Intervention</td>
<td>The EIP provides for an evaluation and the referral to needed services when a child is suspected of having a developmental delay.</td>
<td></td>
</tr>
<tr>
<td>3. PSHSP – Pre-School Health Supportive Services</td>
<td>The PSHSP are special needs services made available for children at risk from three to four years of age.</td>
<td>• Help ensure that children from age three to 21 years who are at risk or have a developmental disability are evaluated and receive special education and disability health services.</td>
</tr>
<tr>
<td>4. SSHSP – School Health Supportive Services</td>
<td>The SSHSP are special needs services made available for children at risk from five to 21 years of age.</td>
<td>• Assist all county health departments in obtaining third party reimbursement for certain educationally related medical services provided by approved preschool special education programs for children with disabilities.</td>
</tr>
</tbody>
</table>

Any persons who suspect a child residing in NYS as having a disability can make a referral to The Early Childhood Direction Centers (ECDC). The ECDC, funded by the New York State Education Department, provide free confidential information and referrals to parents, professionals and agencies about services for young children with diagnosed or suspected special needs. In NYC there is an ECDC in each borough; children who are referred to the ECDC should reside in the borough and be between birth and four years of age. All children five years and older (school age) are referred through their school system.
ECDC Borough Locations

1. Bronx – 718-584-0658
   2488 Grand Concourse #405, Bronx, NY 10458
2. Brooklyn – 718-437-3794
   160 Lawrence Avenue, Brooklyn, NY 11230
3. Manhattan – 212-746-6175
   435 East 70th Street #2A, New York, NY 10021
4. Queens – 718-374-0002 ext. 465
   82-25 164th Street, Jamaica, NY 11432
5. Staten Island – 718-226-6670
   256C Mason Avenue, 3rd flr. S.I, NY 10305

Services provided by the ECDC

1. Linking children and families to available services and programs in NYC.
2. Referrals to agencies and professionals providing services to young children with special needs and their families.
3. Referrals of infants and toddlers to the NYC EIP.
4. Referrals of children to the Committee on Preschool Special Education (CPSE).
5. Follow up telephone contact with families until their child reaches age 5.
6. Parent education workshops.
7. Workshops for professionals.

Identifying Members – All children who are ‘at risk’ of a developmental delay are referred. ‘At Risk’ describes children who are not suspected of having a disability and do not have a diagnosed condition with a high probability of delay, but who are at an increased risk of developing a disability because of specific identified biomedical or other risk factors. Some examples are:

- Gestational age < 33 weeks
- Infants with birth weight < 1501 grams (3lbs, 5oz)
- Infants in the NICU > 10 days
- Infants with Blood Lead Levels > 19 mcg/dl
- Infants with vision concerns
- Infants born without prenatal care
- Infants of teenage mothers
- Infants not seen by a doctor in six months
- Infants without immunizations

Who can make the referral – As a primary referral source, all UnitedHealthcare Community Plans are contractually obligated to refer children with, or ‘at risk’ of a disability as appropriate. Other referral sources can be from the child health care provider, hospitals, local health units, local school districts, and all approved care providers of early intervention services.

Preventive Health Care Standards

UnitedHealthcare Community Plan’s goal is to partner with physicians to help ensure members receive preventive care.

UnitedHealthcare Community Plan endorses and monitors the practice of preventive health standards recommended by recognized medical and professional organizations. Preventive Health care standards and guidelines are available at ahrq.gov.

UnitedHealthcare Community Plan monitors the provision of these services through chart reviews and also through a care provider profiling system highly dependent on the accuracy of the primary care practitioner’s submissions of claims and encounters. Such things as: well child, adolescent and adult visits, childhood and adolescent immunizations, lead screening, and cervical and breast cancer screening are included. The profile is risk adjusted for the members’ comorbidities to also profile on hospital, emergency room, specialist and pharmacy utilization.

Clinical Practice Guidelines for Chronic Conditions

UnitedHealthcare Community Plan has posted the Clinical Practice Guidelines on the provider portal for your use UHCprovider.com > Policies and Protocols > Clinical Guidelines.

Communicable Disease Monitoring

The Department of Health requires all licensed Medicaid managed health care plans to actively monitor and provide oversight for reporting communicable and other designated reportable diseases by its participating physician.

All communicable diseases must be reported to the New York City Department of Health (NYCDOH). health.ny.gov.

Members may self-refer to all public health agency facilities for anything they treat.
HIV/AIDS

Medicaid Managed Care for People With HIV and AIDS

Beginning Sept. 2010, most HIV-positive Medicaid recipients living in New York City will be required to join a Medicaid managed care plan. Individuals may request to stay in regular Medicaid if they qualify for another exemption (such as homelessness). This change is currently only for NYC residents.

Implementing Mandatory Medicaid Managed Care for People With HIV in New York City

Mandatory managed care enrollment began on Sept. 1, 2010, and is being phased-in by borough. Mailings began in Brooklyn, to be followed by the Bronx and then Manhattan. Mailings in Queens and Staten Island will occur last. Approximately 2,500 beneficiaries will receive mandatory enrollment notices each month.

Beneficiaries will have the option to enroll in a Medicaid managed care plan within a period of time specified in the mailing. Non-SSI beneficiaries with HIV/AIDS will have 60 days to choose a plan but may request an additional 30 days to make a choice by calling New York Medicaid CHOICE at 800-505-5678. SSI beneficiaries will be given 90 days to choose a managed care plan. Individuals who do not choose a plan will be automatically assigned to a mainstream managed care plan. However, individuals who are autoassigned will have an opportunity to switch to another plan or an HIV SNP of their choice.

As of Sept. 1, 2010, no new exemptions will be granted for HIV in New York City. Therefore, new Medicaid applicants and current Medicaid consumers who are recertified or have another change to their Medicaid case will need to select a managed care plan to receive their benefits regardless of their borough. Persons living with HIV/AIDS who have Medicaid, but are not currently enrolled in managed care can enroll at any time, but will not be required to make a decision until they receive a mandatory notice.

HIV/AIDS Case Management

UnitedHealthcare Community Plan is committed to ensuring that our HIV-positive members receive uninterrupted, comprehensive, quality care.

To that end, the Plan has a dedicated HIV Case Management Program which provides medical case management, as well as overall review of members’ complex needs, and referrals to appropriate community and other resources. You may call our Case Management Hotline to make referrals for members with HIV (and other complex, chronic conditions) by calling: 866-219-5159. Members may also call this line directly.

In addition, we are committed to ensuring that we have a comprehensive network of care providers who are experienced in treating HIV disease.

Please Help Us Properly Identify You as an HIV/AIDS Specialist!

UnitedHealthcare Community Plan wants to be sure we properly identify all of our network care providers who specialize in the care of HIV/AIDS. As there is no current credentialing or certification for HIV specialization, the Plan relies on the criteria established by the HIV Medical Association (HIVMA) to determine expertise in HIV (i.e., and therefore, a physician who can act as a primary care doctor for members with HIV/AIDS).

Please take a moment to send an email to angela_t_crowe@uhc.com to let us know if you meet this criteria:

HIVMA believes that an HIV-qualified physician should manage the longitudinal HIV treatment of patients with HIV disease. In defining HIV-qualified physicians, it is important to take into account the training and expertise of infectious disease specialists and pediatric infectious diseases specialists, as well as the expertise and experience of internists, family medicine practitioners and other specialties who have made a significant professional commitment to HIV/AIDS care and who care for nearly 50 percent of patients with HIV.

There is ample evidence in the research literature that care by experienced HIV care providers translates into improved clinical outcomes and that HIV medicine does not fall under the purview of any one medical specialty. We recommend that credentialing processes to identify HIV negative qualified physicians be based on a combination of patient experience and the demonstration of ongoing education and training in HIV care, especially in the area of antiretroviral therapy.

Qualifications

HIV physicians should demonstrate continuous professional development by meeting the following qualifications:

- In the immediately preceding 36 months, provided continuous and direct medical care, or direct supervision of medical care, to a minimum of 25 patients with HIV; and
- In the immediately preceding 36 months has successfully completed a minimum of 40 hours of Category 1 continuing medical education addressing diagnosis of HIV infection, treatment for HIV disease and co-morbidities, and/or the epidemiology of HIV disease, and earning a minimum of 10 hours per year; and
- Be board certified or equivalent in one or more medical specialties or subspecialties recognized by the American
Chapter 1: Services

Board of Medical Specialties or the American Osteopathic Association. Or,

- In the immediately preceding 12 months, completed recertification in the subspecialty of infectious diseases with self-evaluation activities focused on HIV or initial board certification in infectious diseases. In the 36 months immediately following certification, newly certified infectious diseases fellows should be managing a minimum of 25 patients with HIV and earning a minimum of 10 hours of Category 1 HIV-related CME per year.
- In the absence of a primary care provider (PCP) meeting these criteria in a given community, an established consultative relationship between a PCP and at least one HIV expert is a viable alternative.

HIV Case Reporting and Partner Notification
State law requires that physicians report the following results to the New York State Department of Health:

- Positive HIV Tests
- Diagnosis of HIV-related illness
- Viral Load Tests
- Tests Showing T-cell Counts Under 500
- AIDS

To report HIV/AIDS, call 212-442-3388. The law further requires that physicians report names of known spouses and sexual or needle sharing partners (contacts). The law states that contacts should not be given the name of the HIV positive patient. Patients have the right to not reveal the names of contacts.

Qualified care providers of OB/Gyn care must offer HIV pre-test counseling, with the clinical recommendation of testing for all pregnant women. Care providers and members may contact the Plan’s HIV Case Manager Program at 866-219-5159 to help ensure access to services for positive management of HIV disease, psychosocial support, and case management for medical, social and addictive services.

HIV Confidentiality
HIV counseling and testing is a routine part of medical care. As such all Plan members are eligible to receive HIV education, counseling and HIV testing with their written consent in accordance with Article 27-F of the Public Health Law (PHL). A refusal of testing must be documented in the member’s medical record.

All physicians are prohibited from disclosing HIV related information without the requisite consent from the member. An exception to this disclosure is that all network physicians are required to report positive HIV test results and diagnoses and known contacts of such persons to the New York State Commissioner of Health. In New York City, these will be reported to the New York City Commissioner of Health. Access to partner notification services must be consistent with 10 NYCRR Part 63.

An HIV positive member will be treated by a qualified physician in accordance with the CDC and New York State HIV/AIDS Program guidelines. All network physicians are required to develop policies and procedures to assure confidentiality in general and HIV-related information in particular in accordance with applicable Federal and State requirements including Section 2782 of NYS Public Health Law (see information that follows that details those requirements). Policies and Procedures must include:

a. initial and annual in-service education of staff, contractors;
b. identification of staff allowed access and limits of access;
c. procedure to limit access to trained staff (including contractors);
d. protocol for secure storage (including electronic storage);
e. procedures for handling requests for HIV-related information;
f. protocols to protect persons with or suspected of having HIV infection from discrimination.

Network physicians are required to offer HIV pre-test counseling with clinical recommendation of testing for all pregnant women, provide counseling to all pregnant women in their care and offered a prenatal HIV test. Network physicians are to refer any HIV positive women in their care to clinically appropriate services for both the women and their newborns. Counseling and education regarding perinatal transmission of HIV available treatment options for the mother and newborn infant will be made available during the pregnancy and/or to the infant within the first months of life.

As part of its annual review of HIV practice guidelines, the Plan’s medical director will inform physicians of any changes to local HIV prevention and control programs. The plan can provide specific information about HIV-reporting requirements and the role of physicians in working with HIV infected patients to inform their contacts. Additionally, the plan can provide information to network physicians on how to obtain information about the availability of experienced HIV care providers and HIV specialist PCPs by accessing the UHCNY website or calling the provider service call center at the number listed at the beginning of this manual.

For assistance with questions regarding HIV confidentiality and disclosure of HIV related information, physicians should contact the Legal Action Center by calling 212-243-1313. The Center is funded by the NYS Department of Health AIDS Institute to provide HIV-related technical assistance to health care
Chapter 1: Services

physicians statewide. For the full text of NYS Regulation Part 63 (HIV/AIDS Testing, Reporting and Confidentiality of HIV-Related Information), go to the following link: health.ny.gov/

**Rapid HIV Tests**
The following information about CLIA Waived Rapid HIV tests is from the New York State Department of Health.

Rapid HIV test technology is evolving and it is expected that there will be a number of tests to choose from in the future. What the Rapid HIV test product agency uses is based on a variety of issues such as cost, ease of use, and population served. Currently there are two CLIA waived products available in New York State.

1. OraQuick® Rapid HIV Antibody Test: OraQuick® is currently being distributed by two companies, OraSure Technologies and Abbott. Product information may be obtained directly from:
   - OraSure Technologies, Inc. at: 800-869-3538 or via the Internet at orasure.com; or from
   - Abbott Laboratories at: 800-323-9100 or abbott.com

The Centers for Disease Control and Prevention (CDC) offers “Frequently Asked Questions: OraQuick® Rapid HIV-1 Antibody Test” on their website at: cdc.gov/

2. Uni-Gold Recombigen HIV Antibody Test: Uni-Gold HIV antibody test is directly distributed by Trinity Biotech. Product information may be obtained directly from:
   - trinitybiotech.com/diseases/hiv-product/

There are other rapid tests for HIV that can be used in New York State. Some rapid HIV tests are designated as moderately complex by CLIA, and due to their complexity, they must be performed in a traditional clinical laboratory. This entails fulfilling requirements that are likely beyond the means of nonclinical physicians, unless they have an affiliation or partnership with a clinical physician.

More information on rapid tests for HIV can be found at the CDC website. “General and Laboratory Consideration: Rapid HIV Tests Currently Available In the United States” can be found at cdc.gov/hiv/.

**Patients with HIV at Risk of Domestic Violence**
Before the Department of Health speaks with contacts, the physician must interview the index patient to find out whether the patient, children of the patient, or contacts of the patient are at risk of domestic violence. If any of these are at risk of serious physical injury, the Department cannot carry out notification unless the risk is eliminated. The index patient will be asked to voluntarily sign a form to let the government have information about the violence. The index patient does not have to sign the form.

**Domestic Violence Hotline/Resources: 800-621-HOPE.**

**The Clinical Education Initiative**
New York has a statewide network of HIV Clinical Education Programs to provide practitioners with the latest information on best practices for patients with HIV infection. It provides community-based physicians with:

- Access to experienced faculty from State Designated AIDS Centers.
- Continuing education for HIV experienced clinicians.
- Information on early identification, diagnosis, treatment and prevention for less experienced clinicians.
- Ongoing consultative support from HIV specialists.

For a copy of the NYS Dept. of Health HIV Educational Materials Consumer Catalog, call: 212-417-4553 or (518) 474-9866 or visit: hivguidelines.org.

Selected HIV/AIDS materials for physicians are also available, in downloadable format, at the following web locations: The HIV Clinical Resource website: hivguidelines.org and the New and the New York State Department State Department of Health website: health.state.ny.us/nysdoh/hivaidshivpartner/infoprov.htm#consent or health.state.ny.us/nysdoh/aids/index.htm.

Physicians are encouraged to visit the following websites for clinical practice guidelines:

- health.ny.gov → Information for Providers → Clinical Guidelines & Standards of Care → Clinical Guidelines & Quality of Care
- hivguidelines.org → Guidelines for preventing and treating HIV
Recommended Childhood Immunization Schedules

The childhood and adolescent immunization schedule and the catch-up immunization schedule has been approved by Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP).

Government Childhood and Adolescent Immunizations Guide:
cdc.gov/az/v.html

Government Quick Reference Guide:
cdc.gov/az/v.html

Source: CDC and Advisory Committee on Immunization Practices

Additional Health Links

<table>
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<tr>
<th>TOPIC</th>
<th>URL</th>
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<tbody>
<tr>
<td>Diabetes</td>
<td>care.diabetesjournals.org/cgi/reprint/29/suppl_1/s4</td>
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<tr>
<td>HTN JNC7 Prevention, Detection, Evaluation and Treatment of HBP</td>
<td>nhlbi.nih.gov/guidelines</td>
</tr>
<tr>
<td>High Blood Cholesterol ATP III Guidelines at-a-Glance Quick Desk Reference</td>
<td>nhlbi.nih.gov/guidelines</td>
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<tr>
<td>Asthma</td>
<td>nhlbi.nih.gov/health/health-topics/topics/asthma</td>
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<tr>
<td>CHF</td>
<td>acc.org/clinical/guidelines/failure/hf_index.htm</td>
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<tr>
<td>COPD</td>
<td>goldcopd.org/GuidelinItem.asp?intId=1116</td>
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<td>Section 85.40 - Prenatal Care Assistance Program</td>
<td>health.ny.gov/community/pregnancy/health_care/prenatal/helpful_links.htm</td>
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<tr>
<td>Major Depression / Major Depressive Disorder</td>
<td>nimh.nih.gov/health/topics/depression/index.shtml</td>
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<tr>
<td>Adult HIV</td>
<td>hivguidelines.org/Content.aspx</td>
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<tr>
<td>Childhood Immunization</td>
<td><a href="https://www.cdc.gov/vaccines/index.html">https://www.cdc.gov/vaccines/index.html</a></td>
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<tr>
<td>Vaccines for Children Program (VFC)</td>
<td>www1.nyc.gov/site/doh/providers/nyc-med-cir/vaccines-for-children-program.page</td>
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<tr>
<td>Adult Immunization</td>
<td>cdc.gov/vaccines</td>
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<tr>
<td>ADHD</td>
<td>cdc.gov/ncbddd/adhd/</td>
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<tr>
<td>Smoking Cessation</td>
<td>surgeongeneral.gov/tobacco/treating_tobacco_use.pdf</td>
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<tr>
<td>Acute MI</td>
<td>acc.org/clinical/guidelines/stemi/Guideline1/index.htm</td>
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<tr>
<td>Sickle Cell</td>
<td>nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf</td>
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## Public Health Websites

<table>
<thead>
<tr>
<th>County Health Department</th>
<th>Phone Number</th>
<th>County LHD Website/CHA Report</th>
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<tbody>
<tr>
<td>Department</td>
<td>(518) 447-2089</td>
<td>Albany County Department of Health</td>
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<tr>
<td>Phone Number County LHD Website/CHA Report</td>
<td>(607) 777-2622</td>
<td>Broome County Health Department</td>
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<tr>
<td>Cayuga</td>
<td>(315) 253-1451</td>
<td>Cayuga County Health Department</td>
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<td>Chautauqua</td>
<td>(716) 753-4789</td>
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<td>Chemung</td>
<td>(607) 737-2068</td>
<td>Chemung County Health Department</td>
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<tr>
<td>Chenango</td>
<td>(607) 337-1650</td>
<td>Chenango County Department Health</td>
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<tr>
<td>Clinton</td>
<td>(518) 565-4840</td>
<td>Clinton County Health Department</td>
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<tr>
<td>Columbia</td>
<td>(518) 828-3358 ext. 1326</td>
<td>Columbia County Department of Health</td>
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<tr>
<td>Erie</td>
<td>(716) 858-7695</td>
<td>Erie County Department of Health</td>
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<tr>
<td>Essex</td>
<td>(518) 873-3518</td>
<td>Essex County Public Health Department</td>
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<td>Fulton</td>
<td>(518) 736-5720</td>
<td>Fulton County Public Health Department</td>
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<tr>
<td>Genesee</td>
<td>(585) 344-2580 ext. 5497</td>
<td>Genesee County Health Department</td>
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<tr>
<td>Herkimer</td>
<td>(315) 867-1176</td>
<td>Herkimer County Public Health Nursing</td>
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<tr>
<td>Jefferson</td>
<td>(315) 786-3710</td>
<td>Jefferson County Public Health Service</td>
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<td>Lewis</td>
<td>(315) 376-5453</td>
<td>Lewis County Public Health Agency</td>
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<td>Madison</td>
<td>(315) 366-2361</td>
<td>Madison County Department of Health</td>
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<tr>
<td>Monroe</td>
<td>(585) 753-5332</td>
<td>Monroe County Department of Public Health</td>
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<tr>
<td>Nassau</td>
<td>(516) 227-9408</td>
<td>Nassau County Department of Health</td>
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<tr>
<td>New York City</td>
<td>(347) 396-7964</td>
<td>New York City Department of Health and Mental Hygiene</td>
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<td>Niagara</td>
<td>(716) 439-7435</td>
<td>Niagara County Department of Health</td>
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<td>Oneida</td>
<td>(315) 798-5508</td>
<td>Oneida County Health Department</td>
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<td>Onondaga</td>
<td>(315) 435-3648</td>
<td>Onondaga County Health Department</td>
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<td>Ontario</td>
<td>(585) 396-4343</td>
<td>Ontario County Public Health</td>
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<td>Orange</td>
<td>(845) 291-2334</td>
<td>Orange County Department of Health</td>
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<td>Oswego</td>
<td>(315) 349-3587</td>
<td>Oswego County Health Department</td>
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<td>Rensselaer</td>
<td>(518) 270-2626</td>
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<td>Rockland</td>
<td>(845) 364-2956</td>
<td>Rockland County Department of Health</td>
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<td>Saint Lawrence</td>
<td>(315) 386-2325</td>
<td>St. Lawrence County Public Health Department</td>
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<td>Seneca</td>
<td>(315) 539-1925</td>
<td>Seneca County Health Department</td>
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<td>Suffolk</td>
<td>(631) 854-0088</td>
<td>Suffolk County Department of Health Services</td>
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<td>Tioga</td>
<td>(607) 687-8607</td>
<td>Tioga County Health Department</td>
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<td>Ulster</td>
<td>(845) 334-5527</td>
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<td>Warren</td>
<td>(518) 761-6580</td>
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<td>Wayne</td>
<td>(315) 946-5749</td>
<td>Wayne County Public Health Department</td>
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<tr>
<td>Westchester</td>
<td>(914) 955-7522</td>
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<tr>
<td>AIDS/HIV – Discusses testing, training for physicians, facts and resources, etc.</td>
<td>health.state.ny.us/diseases/aids/</td>
<td></td>
</tr>
<tr>
<td>Asthma – Provides asthma action plans, materials, etc.</td>
<td>health.state.ny.us/diseases/asthma/</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Disease – Discusses statewide programs and data and statistics</td>
<td>health.state.ny.us/nysdoh/heart/heart_disease.htm</td>
<td></td>
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<tr>
<td>Diabetes – Discusses prevention, statistics and professional education</td>
<td>health.state.ny.us/diseases/conditions/diabetes/</td>
<td></td>
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<tr>
<td>Early Intervention – discusses regulations and laws, training, etc.</td>
<td>health.ny.gov/community/infants_children/early_intervention/</td>
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<tr>
<td>Immunizations – discusses vaccine safety, supply and locating immunization records</td>
<td>health.state.ny.us/prevention/immunization/</td>
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<tr>
<td>Lead – Provides data and statistics as well as information for healthcare physicians</td>
<td>health.state.ny.us/environmental/lead/</td>
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<tr>
<td>Tobacco use – Provides NY state quitline, reports on tobaccos use, its effects on health and economics, etc.</td>
<td>health.state.ny.us/prevention/tobacco_control/</td>
<td></td>
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<tr>
<td>TB – Provides FAQs, data and statistics</td>
<td>health.ny.gov/diseases/communicable/tuberculosis/fact_sheet.htm</td>
<td></td>
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<tr>
<td>Health Insurance Programs – Discusses all of the health insurance programs for NY state</td>
<td>health.state.ny.us/health_care/</td>
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<thead>
<tr>
<th>Description</th>
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<tr>
<td>HIV/AIDS – CDC and NY State recommendations</td>
<td>cdc.gov/hiv/research/demonstration/echpp/sites/ny.html</td>
</tr>
<tr>
<td>Alcohol and Substance Abuse Services – Addiction, treatment services, screening, publications</td>
<td>oasas.ny.gov/</td>
</tr>
<tr>
<td>Asthma – provides resources, information for healthcare physicians and data</td>
<td>health.ny.gov/diseases/asthma/</td>
</tr>
<tr>
<td>Cardiovascular Disease - Discusses stroke, HTN prevention</td>
<td>www1.nyc.gov/site/doh/providers/resources/public-health-action-kits-cholesterol.page</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>health.ny.gov/professionals/diseases/reporting/communicable/</td>
</tr>
<tr>
<td>Depression</td>
<td>health.state.ny.us/prevention/tobacco_control/</td>
</tr>
<tr>
<td>Discusses numerous communicable diseases, their treatment and prevention</td>
<td>health.state.ny.us/health_care/</td>
</tr>
<tr>
<td>Crisis Intervention – Provides contacts and services</td>
<td>www1.nyc.gov/site/doh/health/topics/crisis-emergency-services.page</td>
</tr>
<tr>
<td>Discusses services and information for healthcare physicians</td>
<td>health.ny.gov/diseases/conditions/diabetes/</td>
</tr>
<tr>
<td>Early Intervention – Provides information on eligibility and services, physician directories, etc.</td>
<td>www1.nyc.gov/site/doh/health/topics/early-intervention-eligibility-and-services.page</td>
</tr>
<tr>
<td>HIV – provides reporting information</td>
<td>health.ny.gov/diseases/aids/providers/regulations/partner_services/</td>
</tr>
<tr>
<td>Hypertension – Discusses controlling HTN, provides publications and resources</td>
<td>www1.nyc.gov/site/doh/health/topics/heart-disease-blood-pressure.page</td>
</tr>
</tbody>
</table>
New York State Department of Health and Mental Hygiene

<table>
<thead>
<tr>
<th>Description</th>
<th>Web Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization – Discusses clinics, programs and services</td>
<td>health.ny.gov/prevention/immunization/</td>
</tr>
<tr>
<td>Lead – this is specific for healthcare physicians for information on lead</td>
<td>health.ny.gov/environmental/lead/health_care_providers/</td>
</tr>
<tr>
<td>Managed Medicaid Compendium</td>
<td>hca-nys.org/about/about-home-care</td>
</tr>
<tr>
<td>Physician Directory – for NYC DOHMH UnitedHealthcare Community Plan Families, Kids</td>
<td>UHCprovider.com → Menu → Find a Care Provider</td>
</tr>
<tr>
<td>Smoking Cessation/Tobacco Control – Discusses reporting violations, controlling the epidemic, etc.</td>
<td>health.ny.gov/prevention/tobacco_control/program_components.htm</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>www1.nyc.gov/site/doh/providers/health-topics/tuberculosis.page</td>
</tr>
</tbody>
</table>

**Custodial Nursing Home Benefit**

Effective Feb. 1, 2015, the Health Plan implemented the state-mandated custodial nursing home benefit carve in for Health Plan beneficiaries 21 years and older who are enrolled in Medicaid Managed Care (MMC) and require long term placement. This benefit is already available for any member enrolled in the Health Plan’s Managed Long Term Care (MLTC) Plan.

The state is phasing in this benefit into MMC by county on the following schedule (subject to change by the New York Department of Health):

### State Nursing Home Transition Phase-In Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb. 1, 2015</td>
<td>New York City – Bronx, Kings, New York, Queens, Richmond</td>
</tr>
<tr>
<td>April 1, 2015</td>
<td>Nassau, Suffolk and Westchester</td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>For the above counties (Phase 1 &amp; 2) - voluntary enrollment in MMC becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.</td>
</tr>
<tr>
<td>Oct. 1, 2015</td>
<td>All remaining counties – voluntary enrollment in MMC becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.</td>
</tr>
</tbody>
</table>
Existing MMC members will not be disenrolled if they require long-term stay custodial placement and no one will be required to change nursing homes resulting from this transition. Current custodial care beneficiaries in a nursing home prior to Feb. 1, 2015 remain in the FFS Medicaid program and are not be required to enroll in a plan. New placements are based on the members’ needs and the health plan’s contracts with its nursing home care providers. The Health Plan helps ensure that placement is in the most integrated, least restrictive setting available to meet the members’ needs.

The Local Department of Social Services (LDSS) makes the eligibility determinations using institutional rules, including a transfer of assets look-back period and notifies the plan, the member and the nursing home of the eligibility decision. The LDSS may authorize eligibility for custodial nursing home placement for up to 90 days from the date of admission pending a final eligibility determination. The LDSS also makes the recertification determinations.

In some cases the member may have some financial liability, called the Net Available Monthly Income (NAMI), which the plan collects from the member.

All custodial placements require prior authorization. The placement decision must be made by a physician or clinical peer based on medical necessity, functional criteria and the availability of services in the community. The transitioning decision should involve the member, his or her family, the health plan, the nursing home, hospital planner (where applicable) and LDSS.

For more information, please call Provider Services at 866-362-3368.
Chapter 2: Medical Management

Member Selection of a Primary Care Physician (PCP)

It is important that each health plan member selects a Primary Care Physician (PCP) to oversee his or her care. UnitedHealthcare Community Plan considers the following specialties to be PCPs:

• General Practice
• Internal Medicine
• Family Practice
• Pediatrics
• Geriatrics

Additionally, an enrollee diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, may select a specialist to serve as his or her PCP. If you are a specialty care provider and may be willing to providing all primary care services for a member who meets one of these conditions, please contact Provider Services and ask to speak to the Plan Chief Medical Officer (CMO). The CMO will provide guidance regarding the responsibilities of acting as a PCP. For a member to utilize a specialist for his or her PCP, the Plan must have agreement from the member, specialist, and the Plan CMO, along with an agreed-upon treatment plan. The Plan will also need a written request that states that you are willing to act as the member’s PCP. This letter can be mailed to:

Member Services Director
UnitedHealthcare Community Plan
77 Water Street, 14th Floor
New York, NY 10005

Utilization Management

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. A care provider may call UnitedHealthcare Community Plan Utilization Management at 866-604-3267 for questions about utilization management or denials. Someone is available to take your calls 24 hours a day, seven days a week.

Emergency Admissions

Prior authorization is not required for emergency services. Emergency care should be rendered at once, with notification of any admission to the Prior Authorization Department at 866-604-3267 or fax 866-950-4490 by 5 p.m. next business day. Nurses in the Health Services Department review emergency admissions within one working day of notification. UnitedHealthcare Community Plan uses Milliman (MCG) Care Guidelines for determinations of appropriateness of care.

Care in the Emergency Room

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

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

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

Determination of Medical Necessity

“Medically Necessary” means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap.
UnitedHealthcare Community Plan evaluates medical necessity according to the following standard:

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

Retrospective Review is a process of reviewing medical services after the service has been provided, not inclusive of an appeal review. The process includes review of records to determine medical necessity and appropriateness of care and setting.

When an adverse determination is rendered without your input, you have the right to reconsideration. The reconsideration will occur within one business day of receipt of the request and will be conducted by the member’s health care provider and the clinical peer reviewer making the initial determination.

All services that have not been appropriately authorized may be subject to retrospective review. Retrospective review decisions are rendered by the appropriate clinical staff and the authorization decision communicated to you within 30 days of receipt of necessary information. Notice will be mailed to both you and member on the date of any payment denial, in whole or in part. You may file a UR Appeal or a Retrospective Denial (See Standard Appeal information on page 36).

Once a service has been authorized by UnitedHealthcare Community Plan, a retrospective review will not reverse the original decision to allow the service unless the information provided for the prior authorization is materially different from the information presented during the pre-authorization review, and relevant medical information upon retrospective review existed at the time of the pre-authorization, but was withheld from or not made available to UnitedHealthcare Community Plan, UnitedHealthcare Community Plan was not aware of the information at the time of the pre-auth review; and had UnitedHealthcare Community Plan been aware of the information, the requested service would not have been authorized, based upon the same specific standards, criteria and procedures used during the original prior approval.

Treatments or procedures performed without an authorization in conjunction with an approved service are subject to review for benefit eligibility, appropriateness, and compliance with medical policy.

The services provided, as well as the type of physician and setting, must reflect the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the patient and not solely for the convenience of the patient or physician of service. In addition, the services must be in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Experimental services or services generally regarded by the medical profession as unacceptable treatment are considered not medically necessary. These specific cases are determined on a case-by-case basis.

The determination of medical necessity must be based on peer-reviewed publications, expert pediatric, psychiatric and medical opinion, and medical/pediatric community acceptance. In the case of pediatric members, the standard of medical necessity will include the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily covered services for other members, are:

- Appropriate for the age and health status of the individual; and
- Will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

For Medicaid, the plan mails the notice to the member. UnitedHealthcare Community Plan must send a notice of denial on the date review time frames expire.
Utilization Review Criteria and Guidelines

UnitedHealthcare Community Plan uses MCG Care Guidelines and Apollo guidelines for determinations of appropriateness of care. UnitedHealthcare Community Plan has written policies and procedures specifying responsibilities and qualifications of staff that authorize admissions, services, procedures, or extensions of stay. These policies can be found in the Participating Physician Responsibilities section in this manual. UnitedHealthcare Community Plan makes initial adverse determinations on a timely basis, as required by the exigencies of the situation. The Case Manager can authorize, but not deny, an admission, service, procedure, or extension of stay. If the Case Manager is unable to determine by chart documentation, documentation from the facility utilization review department, or discussion with the PCP or attending physician, the need for admission, surgical or diagnostic procedure, or continued stay, the case is referred to a Medical Director or a Physician Reviewer under the direction of a Medical Director or Physician Reviewer. If, after reviewing all documentation of clinical information, a medical director/physician advisor determines the admission, service, procedure, or extension of stay is medically necessary, a Medical Director/Physician Reviewer notifies the Case Manager, who notifies the facility’s utilization review department verbally and in writing. UnitedHealthcare Community Plan will not retroactively deny reimbursement for a covered service provided to a patient by a physician who relied upon the written or oral authorization of UnitedHealthcare Community Plan prior to providing the service to the member, except in cases where there was material misrepresentation or fraud. Utilization review will be conducted by a clinical peer reviewer where the review involves an adverse determination.

Notice of an adverse determination (denials) are made verbally and in writing and includes:

a. The reasons for the determination including the clinical rationale, if any;

b. Instructions on how to initiate standard and expedited appeals;

c. Notice of the availability, upon request of the member or the member’s designee, of the clinical review criteria relied upon to make such determination;

d. Will identify what additional necessary information must be provided to the UnitedHealthcare Community Plan to render a decision on the appeal;

e. Description of Action to be taken;

f. Statement that UnitedHealthcare Community Plan will not retaliate or take discriminatory action if appeal is filed;

g. Process and timeframe for filing/reviewing appeals, including the member’s right to request expedited review;

h. The member’s right to contact DOH, with 800 number, regarding their complaint;

i. Fair Hearing notice including aid to continue rights;

j. Statement that notice is available in other languages and formats for special needs and how to access these formats;

k. For Medicaid Advantage, offer of choice of Medicaid or Medicare appeal processes if service is determined by UnitedHealthcare Community Plan to be either Medicare or Medicaid, with notice that:

   • Medicare appeal must be filed 60 days from denial;

   • Filing Medicare appeal means the member cannot file for a State Fair Hearing; and

   • The member may still file for Medicare appeal after filing for Medicaid appeal, if within the 60 day period.

Such notice will also specify what, if any, additional necessary information must be provided to, or obtained by us to render a decision on an appeal. For UnitedHealthcare Community Plan for Families, the Plan must send notice of denial on the date review time frames expire.

If UnitedHealthcare Community Plan renders an adverse determination without attempting to discuss such matter with the member’s health care physician who specifically recommended the health care service, procedure or treatment under review, such health care physician will have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, the reconsideration will occur within one business day of receipt of the request and will be conducted by the member’s health care physician and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. If the adverse determination is upheld after reconsideration, UnitedHealthcare Community Plan will provide notice, and nothing will preclude the patient or his/her physician from initiating an appeal from an adverse determination.

Should UnitedHealthcare Community Plan fail to make a determination within the time period allowed, the decision will be deemed to be an adverse determination subject to appeal. Adverse determinations are always made by clinical peer reviewer.
Prior authorization for an inpatient stay does not mean authorization for continued inpatient stays. After giving prior authorization for an admission, service, or procedure, UnitedHealthcare Community Plan conducts concurrent review to determine whether the stay continues to meet MCG Care Guidelines for determinations of appropriateness of care. UnitedHealthcare Community Plan approves or denies continuation of the stay in accordance with the criteria and guidelines described in this section.

In the case of a denial of continued stay or any adverse determination, UnitedHealthcare Community Plan notifies the facility verbally and in writing within one working day, followed by formal written notification from the UnitedHealthcare Community Plan UM Denials and Appeals Department within one working day. The PCP, attending physician, or the facility may appeal any adverse decision, in accordance with the procedures outlined in the denial letter.

**Responsibility to Verify Prior Authorization**

All physicians, facilities, and agencies providing services that require prior authorization should call the Prior Authorization Department at 866-604-3267 or fax written requests to 866-950-4490 in advance of performing the procedure or providing service(s) to verify UnitedHealthcare Community Plan has issued an authorization number. Please note: A reference number is a tracking number and is an indication the physician has called to notify us and/or make a service request which is subject to a medical necessity determination prior to formal authorization.

Emergency services are not subject to prior authorization. Failure of UnitedHealthcare Community Plan to make a UM decision within the time periods is deemed to be an adverse determination subject to appeal.

Service Authorizations include both Prior Authorization and Concurrent Review Requests.

UnitedHealthcare Community Plan is required to provide notice by phone and in writing to the member and to the care provider of Service Authorization Determinations, whether adverse or not, within three business days. Notice to the care provider must contain the same information as the Notice of Action for the member.

**Authorization of Care for New Members**

UnitedHealthcare Community Plan will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member’s enrollment until the PCP evaluates the member and establishes a new plan of care.

**Service Continuation for New Members:** If a new member has an existing relationship with a health care physician who is not a member of the physician network, the member is permitted to continue an ongoing course of treatment by the nonparticipating physician during a transitional period of up to 60 days from the Effective Date of Enrollment, if,

1. The member has a life-threatening disease or condition or a degenerative and disabling disease or condition; or
2. The member has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period will include the provision of post-partum care directly related to the delivery up until 60 days post-partum. If the new member elects to continue to receive care from the non-participating physician, care will be authorized for the transitional period only if the physician agrees to:
   a. Accept reimbursement at rates established by the Plan as payment in full at no more than the level of reimbursement applicable to similar physicians within our network for such services;
   b. Adhere to our quality assurance requirements and agree to provide us with the necessary medical information related to the care; and
   c. Otherwise adhere to our policies and procedures including, but not limited to, procedures regarding referrals and obtaining prior authorization in a treatment plan approved by us. In no event will this requirement be construed to require us to provide coverage for benefits not otherwise covered.

**Continuing Care When a Member’s Health Care Provider Leaves the Network:** The patient is permitted to continue an ongoing course of treatment with their current health care physician during a transitional period, when their physician has left our network of physicians for reasons other than imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board that impairs the health professional’s ability to practice. The transitional period will begin on the date the contract is no longer effective and will continue up to 90 days from the date the physician’s contractual
obligation to provide member services to our plan’s member terminates; or, if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of post-partum care directly related to the delivery through post-partum care. If the member elects to continue to receive care from a non-participating physician, care will be authorized for the transitional period only if the physician agrees to:

a. Accept reimbursement at rates established by the Plan as payment in full at no more than the level of reimbursement applicable to similar physicians within our network for such services;

b. Adhere to our quality assurance requirements and agree to provide us with the necessary medical information related to the care; and

c. Otherwise adhere to our policies and procedures including, but not limited to, procedures regarding referrals and obtaining pre-authorization in a treatment plan approved by us. In no event will this requirement be construed to require us to provide coverage for benefits not otherwise covered.

Second Opinion:
Seek a second opinion in the UnitedHealthcare Community Plan network. UnitedHealthcare Community Plan can assist with arrangements for a second opinion outside of the network at no cost. This may be asked for when the member or guardian needs to know more about treatment or thinks the care provider is not giving requested care.
UnitedHealthcare Community Plan Services that Require Prior Notification/Prior Authorization New York
UnitedHealthcare Community Plan for Families/Kids Lines of Business
(Does not apply to Medicare HMO)

UnitedHealthcare Community Plan renders a decision and notifies member and care provider by phone and in writing within three business days of receipt of necessary information or for UnitedHealthcare Community Plan for Families, as fast as the member’s condition requires and:

1. Within three business days of receipt of an expedited authorization request; or
2. In all other cases, within three business days of receipt of necessary information but no more than 14 days of the request.

<table>
<thead>
<tr>
<th>Service Needed</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health-Ambulatory After 1st Visit</td>
<td>New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506</td>
</tr>
<tr>
<td>Cardiac Testing or Procedures</td>
<td>Call CareCore Cardiology 866-889-8054</td>
</tr>
<tr>
<td>Cosmetic and Reconstructive Surgery</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td></td>
<td>Beginning April 1, 2017, the following cosmetic and reconstructive procedure codes no longer require prior authorization: 15876, 21282, 67916, 21137, 21295, 67917, 21138, 21296, 67921, 21139, 36468, 67922, 21208, 67911, 67923, 21209, 67911, 67923, 21209, 67914, 67924, 21280, 67915. Although prior authorization requirements are being removed, post-service determinations may still be applicable based on criteria published in medical policies and/or local and national coverage determination criteria. For more information on covered CPT codes go to UHCprovider.com/priorauth</td>
</tr>
<tr>
<td>Durable Medical Equipment &gt; $500 Per Item</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>Prosthetics and Orthotics &gt; $500 Per Item</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>Gastric Bypass Evaluations and Surgery</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>• Medication or Infusion</td>
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<tr>
<td>• All Other</td>
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<tr>
<td>Hospice Services – Inpatient and Outpatient</td>
<td>For Medicaid, Effective October 1, 2013, the provision of Hospice services is the responsibility of UnitedHealthcare Community Plan. For more information please refer to the NYS DOH link: health/ny.gov/health_care/medicaid/redesign/docs/2013-2017-10-07_hospice_guidelines.pdf</td>
</tr>
<tr>
<td>Hospital Services – Inpatient</td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td>• Acute (Medical, Surgical, Level 2 through Level 4 Nursery, and Maternity)</td>
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<tr>
<td>• Subacute, Rehab and SNF</td>
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## Service Needed

<table>
<thead>
<tr>
<th>Service Needed</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td><strong>Hospital Services – Behavioral Health</strong></td>
<td>New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506. Exception SSI – certain services covered by Medicaid FFS</td>
</tr>
<tr>
<td><strong>Medical Injectables including, but not limited to:</strong></td>
<td></td>
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<tr>
<td>• Acthar HP</td>
<td>866-604-3267 or Fax 866-950-4490</td>
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<tr>
<td>• Botulinum Toxins</td>
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<td>• Immune globulins</td>
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<td>• Makena</td>
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<tr>
<td><strong>MRI, MRA and PET Scans, CT Scans (CAT), Nuclear Radiology and Nuclear Medicine Scans (Ambulatory and Non-Emergency)</strong></td>
<td>866-604-3267 or Fax 866-950-4490. MRI, MRA and PET Scans, CT Scans (CAT), Nuclear Radiology and Nuclear Medicine Scans get approval by calling Care Core Radiology at 866-889-8054 or Fax 866-889-8061</td>
</tr>
<tr>
<td><strong>Non-Contracted Physician Services (Hospital and Professional)</strong></td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td>New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506.</td>
</tr>
<tr>
<td><strong>Transplantation Evaluations</strong></td>
<td>866-604-3267 or Fax 866-950-4490</td>
</tr>
<tr>
<td><strong>Transportation – Non-Emergent</strong></td>
<td>Call 800-493-4647 to arrange for elective transportation services. Transportation does not require prior authorization, members must call in advance to request transportation. UnitedHealthcare Community Plan for Families and 19 and 20 year old members should call 800-493-4647 to arrange transportation for medical appointments. Transportation must be requested in advance. Car service and ambulette transportation in NYC requires medical necessity from a physician.</td>
</tr>
</tbody>
</table>

Prior notification is not required for emergency services but participating hospitals must provide notification to UnitedHealthcare Community Plan within 1 business day of inpatient admission.

Services for which members may self-refer: Ob/Gyn prenatal care, two routine visits per year and any follow-up care, acute gynecological condition.

**UnitedHealthcare Community Plan for Families members may also self-refer for:**

- a. One mental health visit and one substance abuse visit with a participating care provider per year for evaluation;
- b. Vision services with a participating care provider;
- c. Diagnosis and treatment of TB by public health agency facilities;
- d. Family planning and reproductive health from a participating care provider or Medicaid care provider.

### Other Important Phone Numbers

**Member Services:** Available 24 hours a day, seven days a week for UnitedHealthcare Community Plan for Families, Kids and Adults call: 800-493-4647 – For UnitedHealthcare Dual Complete call: 800-514-4912

**Specialized Services:** Provided through the below vendors:

- Behavioral Health – Optum
- Vision – March Vision Care
- Dental – Optum Dental Services
- Pharmacy PBM – Prescription Solutions

New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506

Call March Vision Care at 888-493-4070

Call UnitedHealthcare Dental Provider Services at 800-304-0634

Call the Prescription Solutions Help Desk at 800-866-0931
New to Therapy Short-Acting Opioid Supply and Daily Dose Limits

UnitedHealthcare Community Plan in New York will implement a short-acting opioid supply limit of three days and less than 50 Morphine Equivalent Dose (MED) per day for members 19 years and younger and new to opioid therapy. Opioid requests beyond these limits will 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.

Long-acting Opioids
There is a 90 morphine equivalent doses (MED) supply limit for the long-acting opioid class. Prior authorization criteria is being modified to coincide with the CDC’s recommendations for the treatment of chronic non-cancer pain. Prior authorization will apply to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at cdc.gov > More CDC Topics > Injury, Violence & Safety > Prescription Drug Overdose > CDC Guideline for Prescribing Opioids for Chronic Pain.

Please use these tools and resources to help manage your patients with chronic pain.

Resources:
- National Center for Biotechnology Information: ncbi.nlm.nih.gov > enter either “3218789” or “The Role of Psychological Interventions in the Management of Patients with Chronic Pain” in Search engine
- Opioid Use Disorder Diagnostic Criteria from the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, 2013.

Screening Tools:
- Pain Assessment Scale: painedu.org/nipc-resourcenter.asp > Pain Assessment Scales CAGE-AID (Adapted to Include Drugs): opioid risk > Type in “CAGE-AID” in the Search engine > Select CAGE – “Aid Screen Tool”

Patient Substance Use Treatment Helpline:
- Free, confidential service for UnitedHealthcare Community Plan members. Specialized licensed clinicians provide treatment advocate services 24 hours a day, seven days a week.
- Phone: 855-780-5955
- Website: liveandworkwell.com

If you have additional questions, please contact us at 888-362-3368.

Seek prior authorization/notify UnitedHealthcare Community Plan within the following time frames:

Emergency Facility Admission
Notify UnitedHealthcare Community Plan within one business day after an emergency or urgent admission.

Inpatient Admissions After Ambulatory Surgery
Notify UnitedHealthcare Community Plan within one business day after an inpatient admission that immediately followed ambulatory surgery.

Non-Emergency Admissions and/or Selected Out-Patient Services (Except Maternity)
Seek prior authorization at least five business days prior to non-emergent, non-urgent facility admissions and/or outpatient services; in cases in which the admission is scheduled less than
five business days in advance, notify at the time the admission is scheduled.

**Return calls from Case Managers/Medical Directors and provide complete health information as required within four hours if request is received before 1:00 p.m. local time, or by 12:00 p.m. the next business day if request is received after 1:00 p.m. local time.**

**Inpatient Admission-Facility Responsibility to Notify Member**

When the member is inpatient, verbal notice to the member is delegated to the hospital facility, as the member’s health care provider according to specified requirements of Public Health Law §4903. Notice to the care provider verbally and in writing will occur within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within 72 hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday and except, with respect to inpatient substance use disorder treatment, within 24 hours of receipt of the request for services when the request is submitted at least 24 hours prior to discharge from an inpatient admission.

**Maternity Care and Obstetrical Admissions**

**Maternity Care**

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan participating physicians only. Pregnant members may self-refer for pre-natal care, two routine visits per year and any follow-up care and/or gynecological care.

UnitedHealthcare Community Plan will consider exceptions to this policy if:

1. The woman was in her second trimester of pregnancy when she became an UnitedHealthcare Community Plan member, and
2. If she has an established relationship with a nonparticipating obstetrician. UnitedHealthcare Community Plan must approve all out-of-plan maternity care. Physicians should call Healthy First Steps, 800-599-5985, to obtain approval.

Physicians should notify UnitedHealthcare Community Plan immediately of a member’s confirmed pregnancy to ensure appropriate follow-up and coordination by the UnitedHealthcare Community Plan Maternal.

Care providers should call Healthy First Steps, 800-599-5985 or fax to 877-365-5960 to notify us of pregnancies. To notify us of deliveries call 800-599-5985 or fax to 877-353-6913.

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

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

**Pregnancy Notification**

Pregnant UnitedHealthcare Community Plan for Families and members should be informed to notify their local DSS office of New York City’s Human Resources Administration office of their pregnancy. By doing so, the UnitedHealthcare Community Plan for Families program will create a Medicaid CIN (Case Identification Number) for the unborn child. This CIN will become the child’s Medicaid ID number after the birth is reported to UnitedHealthcare Community Plan for Families. Members will need a letter from their OBGYN confirming their pregnancy and expected date of delivery as proof.

If a UnitedHealthcare Community Plan for Kids member becomes pregnant, please inform the member that they should complete an enrollment application for Medicaid for herself and unborn child. If the application is not completed, the newborn’s medical expenses are not covered under UnitedHealthcare Community Plan for Kids.
A UnitedHealthcare Community Plan member does not need a referral from her PCP for the following ob-gyn care: prenatal care, two routine visits per year and any follow-up care, acute gynecological condition, provided by participating obstetricians. An obstetrician does not need approval from the member’s PCP for prenatal testing or obstetrical procedures. Obstetricians may give the pregnant member a written prescription to present at any of the UnitedHealthcare Community Plan participating radiology and imaging facilities listed in the physician directory.

Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary. In addition, UnitedHealthcare Community Plan has community-based outreach and social service support programs specific to the needs of pregnant women. The UnitedHealthcare Community Plan Maternal Case Manager can assist obstetricians and PCPs with referrals to these services.

Members or physicians can call Healthy First Steps at 800-599-5985, to speak with a Maternal Case Manager.

**Obstetrical Admissions**

UnitedHealthcare Community Plan considers all full-term maternity admissions to be scheduled admissions and notification to the Prior Authorization Department of the admission is required. Obstetricians and PCPs are expected to notify UnitedHealthcare Community Plan as soon as the pregnancy is confirmed.

**Newborn Admissions**

The hospital must notify UnitedHealthcare Community Plan at Healthy First Steps, 800-599-5985, prior to or upon the mother’s discharge, if the baby stays in the hospital after the mother is discharged. The Health Services Department will conduct concurrent review of the newborn’s extended stay. The hospital should make available the following information:

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

**Enrollment of Newborns**

The hospital is now responsible to notify the city/state of all deliveries to UnitedHealthcare Community Plan members (provided they were admitted using their UnitedHealthcare Community Plan ID cards). A daily electronic file is then put on the Bulletin Board for the plan to pick up with the newborn information. The next roster will have all of the newborns listed as enrolled in UnitedHealthcare Community Plan from their month of birth. Enrollment may update their systems accordingly based on the information provided on these files. The plan is no longer able to submit information to the city/state requesting newborn enrollments as of 4/6/03.

There may be a case or two where the mother delivers out-of-state. This baby may not be identified to the city/state and thus not come onto UnitedHealthcare Community Plan in a timely manner. In this case, the Enrollment Department would have to contact the city/state once we receive the birth notification and request the baby be added to our Plan.

The hospital can give significant support to the enrollment process by following the new electronic process that has been set up to identify all newborns and have them added to the health plan as soon as possible.
Prior Authorization
Fax Request Form 877-353-6913

This FAX form has been developed to streamline the request process, and to give you a response as quickly as possible. Please complete all fields on the form, and refer to the listing of services below that require authorization; you only need to request authorization for services on that list.

Date: ____________________________
From: ____________________________ Contact Name:__________________________
Telephone #: ____________________________ Fax #: _______________________________

**Type of Service:**

- DME
- Hospice Services
- Prosthetic / Orthotics
- Inpatient Elective Surgery
- Transplantation Evaluation
- Cosmetic or Reconstructive Surgery
- PT / OT / ST
- MRI, MRA or PET Scan
- Gastric Bypass Evaluation & Surgery
- Home Health Care Services
- Skilled Nursing Facility
- Hysterectomy
- Other

**Physician Information:**

Date of Service: ____________ Physician ID: ____________
Attending Physician or Surgeon: __________________________ Phone #: __________________________
Address: ____________________________________________ Fax #: ______________________________
Facility: ____________________________________________ PAR or Non-PAR (please circle one)

**Member Information:**

Member Name: ____________________ Member ID #: ____________________ Date of Birth: ____________
Is request related to MVA or work-related injury? Yes [ ] No [ ] Does member have other insurance? Yes [ ] No [ ]
Other insurance name: __________________________________________________________________________

**Clinical Information:**

Diagnoses: _________________________________________________________________________________
ICD –10 Codes: _______________________________________________________________________________
Procedures: _________________________________________________________________________________
CPT Codes: _________________________________________________________________________________
Number of visits: ____________ Duration: ____________ Frequency: ____________

Note: Please submit any pertinent clinical data (i.e. progress notes, treatment rendered, tests, labs, radiology reports) to support request for services.

M41274 5/07 ©2007 United HealthCare Services, Inc.
Chapter 3: Prior Authorization/Notification


Contact Information
Ordering physicians or their office staff may obtain or verify a prior authorization number by contacting UnitedHealthcare Community Plan in the following ways:

- **UHCprovider.com/priorauth**
- **Phone:** 866-889-8054 (7 a.m. – 7 p.m., Monday through Friday, local time)
- **Fax:** 866-889-8061
  Fax forms are available at [UHCprovider.com](http://UHCprovider.com)

All calls received outside of normal business hours will be routed to an option that helps ensure a registered professional nurse or physician will be immediately available by phone seven days a week, 24 hours a day, to render utilization management determinations for care providers.

Prior Authorization is required for each of the following Advanced Outpatient Imaging Procedures

- CT/CTA scans
- MRI/MRA
- PET scans
- Nuclear medicine/cardiology

Place of Service Exclusions: Services performed at the following places of service DO NOT require prior authorization:

- Inpatient setting
- Emergency room
- Observation unit
- Urgent care centers

Retrospective Reviews
If an outpatient advanced imaging procedure is required on an urgent basis (note Place of Service Exclusions above), or prior authorization cannot be obtained because it is outside of UnitedHealthcare Community Plan’s normal business hours, the service may be performed and prior authorization requested retrospectively within two business days of the service.

Documentation must include an explanation regarding why the procedure was required on an urgent basis or could not be submitted for prior authorization during UnitedHealthcare Community Plan’s normal business hours.

Prior Authorization Verification
To determine if prior authorization is required for a specific service for UnitedHealthcare Community Plan members, call 877-842-3210.

In-Scope Products
Products in-scope for the Radiology Prior Authorization Program includes those products offered by UnitedHealthcare Community Plan.

Information Required for a Prior Authorization Number Request

Member Information:
- Member’s UnitedHealthcare® Community Plan ID number
- Member’s name
- Member’s date of birth
- Member’s telephone number and address (optional)

Ordering Physician/Provider Information:
- Ordering physician’s tax ID number
- Ordering physician’s last name
- Ordering physician’s telephone number (10-digit)
- Ordering physician’s fax number (10-digit)
- Contact person at the ordering physician’s office

Clinical Information:
- The examination(s) being requested, with the CPT code(s)
- The working diagnosis or “rule out” with the ICD-10 code(s)
- The patient’s symptoms, listed in detail, with severity and duration. Any treatments that have been tried, including dosage and duration for drugs, and dates for other therapies.
- Any other information that the physician believes will help in evaluating the request, including but not limited to prior diagnostic tests, consultation reports, etc.
- Dates of prior imaging studies performed.

To help ensure proper payment, the authorization number should be obtained and communicated by the ordering Physician to the rendering physician scheduled to perform the imaging procedures. Please note that the receipt of a prior authorization number does not guarantee or authorize payment. Payment of covered services is contingent upon the member being eligible for services on the date of service, the physician being eligible for payment, and any claim processing requirements.
Radiology Prior Authorization Phone Prompt Selections
Dial 866-889-8054 and follow the prompts outlined below.

<table>
<thead>
<tr>
<th>Request Prior Authorization</th>
<th></th>
<th>For UnitedHealthcare Community Plan members, Select Phone Prompt #3</th>
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<tr>
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<td>Please have the following Member information available:</td>
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<td>• Member’s ID Number (key numeric characters)</td>
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<td>• Member’s DOB (mm/dd/yyyy)</td>
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<td></td>
<td></td>
<td>• Member’s Phone Number</td>
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</tbody>
</table>

Select Phone Prompt #1
Please have the following Provider information available:
• Ordering Provider’s NPI
• Ordering Provider’s Phone Number
• Ordering Provider’s Fax Number

For Outpatient Diagnostic Imaging (including Nuclear Stress, MR, CT, PET), Select Phone Prompt #1
Please have the study type information available. If there are no additional requests, Press #1
• New Procedure: If there is another procedure request for this member, press #2
• New Patient: If you have additional member requests for this Provider, press #3
• New Provider: If you are requesting notification/prior authorization for additional Providers, press #4

<table>
<thead>
<tr>
<th>Verify or Check Notification/Prior Authorization status</th>
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<th>Select Phone Prompt #2</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>Please provide the 10-digit Case Number</td>
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<td>To return to previous menu, press #9</td>
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<tr>
<th>Initiate Peer-to-Peer Discussion</th>
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<th>Select Phone Prompt #3</th>
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<td>Please provide the 10-digit Case Number</td>
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<td>To return to previous menu, press #9</td>
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<tr>
<th>To Speak to a Customer Care Professional</th>
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<th>Select Phone Prompt #4</th>
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<tr>
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<td>Please provide the 10-digit Case Number</td>
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<td>If invalid Case Number, press #9 to return to previous menu</td>
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<tr>
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<td>For general questions regarding United Healthcare Commercial, Medicare Advantage, AARP, or Medicare Solutions Member, or the UnitedHealthcare Community Plans, press #2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For all other inquiries press #3</td>
</tr>
</tbody>
</table>
Study Type Fast Keys
CT-10
Nuclear Medicine-13
MRI/MRA-11
PET-15
Nuclear Stress Test-12

Phone Keys
ABC-2   GHI-4
MNO-6   TUV-8
DEF-3   JKL-5
PQRS-7  WXYZ-9

Helpful Hints
- Background noise may interfere with the application. Please attempt to reduce background noise while making a request (e.g., If using a speaker phone, please have the mute button on when using the telephone keypad).
- The application will always repeat the information you have entered. If you wish to bypass this function, simply enter the next required data element.
- If you make a typing error, you may press # to end that entry and try again.
- Organize information according to the guide before calling.
- Physician can initiate multiple requests per call for the same member.

Cardiology Prior Authorization Program – Quick Reference Guide

Contact Information
Ordering physicians or their office staff may request or verify a prior authorization number by contacting UnitedHealthcare Community Plan in the following ways:

UHCprovider.com/priorauth
866-889-8054 (7 a.m. – 7 p.m. local time, Monday – Friday)

Prior Authorization is Required for Each of the Following Cardiac Procedures:
- Cardiac catheterizations
- Electrophysiology implants
- Echocardiograms/Stress Echocardiograms

Place of service exclusions: Services performed at the following places of service DO NOT require prior authorization:
- Inpatient setting (with the exception of electrophysiology implants which require prior authorization in the inpatient setting)
- Emergency rooms
- Observation units
- Urgent care centers

Retrospective Reviews
If cardiac procedures are required on an urgent basis (note place of service exclusions) or authorization cannot be obtained because it is outside of UnitedHealthcare Community Plan’s normal business hours, the service may be performed and prior authorization requested retrospectively within the following timeframes:
- Two business days for Echocardiography/Stress Echocardiography
- Fifteen calendar days for Cardiac Catheterizations and Electrophysiology Implants

Documentation must include an explanation regarding why the procedure was required on an urgent basis or could not be submitted for prior authorization during normal business hours.

Prior Authorization Verification
To determine if prior authorization is required for a specific service for UnitedHealthcare Community Plan members, please call 877-842-3210.

In-Scope Programs
Products in-scope for the Cardiology Prior Authorization program includes those products offered by UnitedHealthcare Community Plan.

Information Required for a Prior Authorization Number Request

1. Member Information:
   - Member’s UnitedHealthcare Community Plan ID number
   - Member’s name
   - Member’s date of birth

2. Ordering Physician/Provider Information:
   - Ordering provider’s NPI number
   - Ordering provider’s tax ID number
   - Ordering providers last name
   - Ordering provider’s telephone number
• Ordering provider’s fax number
• Contact person at the ordering provider’s office

3. Clinical Information:
• The examination(s) being requested, with the CPT code(s)
• The working diagnosis or “rule out” with the ICD-10 code(s)
• The patient’s symptoms, listed in detail, with severity and duration. Any treatments that have been received, including dosage and duration for drugs,
• Any other information that the physician believes will help in evaluating the request, including but not limited to prior diagnostic tests, consultation reports, etc.
• Dates of prior cardiac procedures studies performed.

To help ensure proper payment, the authorization number should be obtained and communicated by the ordering care provider to the rendering care provider scheduled to perform the cardiac procedures. Please note that the receipt of a prior authorization number does not guarantee or authorize payment. Payment of covered services is contingent upon the member being eligible for services on the date of service, the physician being eligible for payment, and any claim processing requirements.

Helpful Hints
• Background noise may interfere with the application. Please attempt to reduce background noise while making a request. If using a speaker phone, please have the mute button on when using the telephone keypad.
• The application will always repeat the information you have entered. If you wish to bypass this function, simply enter the next required data element.
• If you make a typing error, you may press # to end that entry and try again.
• Organize information according to the guide before calling.
• Care provider may initiate multiple requests per call for the same member.

Cardiology Prior Authorization Phone Prompt Selections
Dial 866-889-8054 and select the appropriate option for Medicaid members. Then, follow the prompts outlined in the chart below.

| Request Prior Authorization | Select Phone Prompt #1  
Please have the following Provider information available:  
• Ordering Provider’s NPI  
• Ordering Provider’s Phone Number  
• Ordering Provider’s Fax Number | For UnitedHealthcare Community Plan members,  
Select Phone Prompt #3  
Please have the following Member information available:  
• Member’s ID Number (key numeric characters)  
• Member’s DOB (mm/dd/yyyy)  
• Member’s Phone Number |

| For Cardiac Procedures Including echo/echo stress, catheterizations and implantables.  
Select Phone Prompt #2  
Please have the study type information available. If there are no additional requests, Press #1 |  
• New Procedure: If there is another procedure request for this member, press #2  
• New Patient: If you have additional member requests for this Provider, press #3  
• New Provider: If you are requesting notification/prior authorization for additional Providers, press #4 |
Outpatient Injectable Chemotherapy Drugs

UnitedHealthcare Community Plan members in New York will require prior authorization through eviCore for outpatient injectable chemotherapy drugs for a cancer diagnosis.

iExchange

iExchange is a system that allows physicians to enter requests for prior authorization through the UnitedHealthcare Community Plan Physician Portal. Physicians who currently use iExchange for other MCOs can easily adapt to using it for UnitedHealthcare Community Plan.

Physicians will experience:
- 24 hours a day, seven days a week service.
- No call hold time.
- No lost faxes or incorrectly entered data from fax sheets.
- Auto-adjudicated authorization requests interactively.
- Immediate confirmation of receipt and authorization tracking number.
- Real-time authorization status communication.

The Physician also receives an authorization tracking number and a response that the request is:
- Automatically approved, or;
- The request is routed to the appropriate area where they are reviewed. Turn around time is usually one business day;
- The physician can go back into iExchange at any time to view the request to see if there is a status change.

Concurrent Review

UnitedHealthcare Community Plan performs concurrent review on all hospitalizations for the duration of the stay based on contractual arrangements with the hospital. UnitedHealthcare Community Plan performs the reviews over the phone or on-site at the facility. UnitedHealthcare Community Plan uses MCG Care Guidelines and Apollo guidelines for determinations of appropriateness of care.

The Case Manager may certify extension of the length of stay, but may not deny any portion of the stay. Only a medical director or physician advisor, can deny an extension of the length of stay. UnitedHealthcare Community Plan notifies the facility when the Case Manager refers a hospital stay for review by a medical director or physician advisor. If a medical director or physician advisor determines that the extended stay is not justified, UnitedHealthcare Community Plan notifies the facility within one working day, and notifies the member by phone and mail to the member’s home. For UnitedHealthcare Community Plan for Families, as fast as the member’s condition requires and:

1. Within one business day of receipt of necessary information but no more than three business days of an expedited authorization request; or

2. In all other cases, within one business days of receipt of necessary information but no more than 14 days of the request.

The PCP, attending physician, or the facility may appeal any adverse decision, according to the procedures in the Utilization Management Appeals Section.

- Expedited and standard review timeframes for pre-authorization and concurrent review may be extended by an additional 14 days if:
  1. The member, designee or care provider requests an extension; or
  2. The MCO demonstrates there is a need for more information and the extension is in the member’s interest. Notice of extension to the member is required.

Expediting review must be conducted when MCO or care provider indicates delay would seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum functions. Members have the right to request expedited review, but the MCO may deny and notice will process under standard timeframes.

Inpatient Concurrent Review: Clinical Information

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, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

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

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must
provide all requested and complete clinical information and/ or documents as required within four hours of receipt of our request if it is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day).

UnitedHealthcare Community Plan uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

**Discharge Planning and Continuing Care**

The Case Manager contacts the PCP, the attending physician, the member, and member’s family to assess needs and develop a plan for continuing care beyond discharge, if medically necessary.

UnitedHealthcare Community Plan Case Managers facilitate coordination of care across multiple sites of care. The Case Managers work with the member, family members, physicians, hospital discharge planners, rehabilitation facilities, and home care agencies. They evaluate the appropriate use of benefits, oversee the transition of patients between levels of care, and refer to community based services as needed.

When a member is admitted to the hospital, the Plan will notify the patient’s PCP, so that he/she can begin to coordinate care.

**Restricted Recipient Program (RRP)**

The restriction program previously managed by the Office of the Medicaid Inspector General (OMIG) is now administered by UnitedHealthcare Community Plan for our Plan members who are restricted. These members were auto-assigned to us by the Department of Health. The OMIG program was designed to restrict certain members to particular primary care providers, pharmacies or hospitals based on a history of aberrant utilization patterns or referrals and are recommended to local districts for restriction based on medical review which indicates over/mis-utilization and/or abusive practices as defined in the regulations. UnitedHealthcare Community Plan and other Medicaid Managed Care plans are also tasked with developing an internal process that identifies such members. There will be procedures in place to monitor them on an ongoing basis and a monthly reporting mechanism.

The recommendation as to the type of restriction is based on the type of over/mis-utilization or abusive practice.

Types of restrictions - may be a single restriction type or any combination:

- **Primary Medical Provider;** this can be a physician, physician group or clinic.
- **Primary Pharmacy;** an additional pharmacy may be added if there is a need for a specialty item that only that pharmacy can provide.
- **Primary Hospital Provider.**
- **Primary Dental Provider;** may be a dental clinic or dentist.
- **Primary DME Dealer.**
- **Primary Podiatrist;** this is rarely used.

After the member is identified a complete profile of both claims and encounters is reviewed. The review would include an examination of the member’s utilization patterns resulting in a determination about whether there is overutilization of services and how it relates to the necessity for such utilization. The billing care providers may be contacted to get a more complete picture of the member’s health care needs vs. what they are receiving.

UnitedHealthcare Community Plan is required to notify members when we have placed them under restriction and provide a detailed packet of information outlining the reasons for their restrictions. Ongoing review will be done and these members will be placed into case management.

If members are restricted to the type of service that you provide and you are not the care provider to whom they are restricted or do not have the proper authorization, your services will not be paid. This is why it is important to always verify eligibility for the member each time they visit your office. Call for eligibility at 800-493-4647, or verify through our secure web portal at portaladmin.americhoice.com/portal_admin/login/index.jsp.

If you are the care provider to whom the member is restricted, please notify the plan when the member requires a different provider by calling the Authorizations Department at 866-604-3267 to provide the proper referral/authorization for outside care.

UnitedHealthcare Community Plan has developed specific RRP groups and the members will be placed into these groups for easy identification. These groups are:

- **90800-UnitedHealthcare Community Plan for Families (Medicaid)**
These members will also have ID cards that will be easy to identify. Examples are:

![ID Card Image](image)

Please call UnitedHealthcare Community Plan Provider Services at 866-362-3368 if you have additional questions about our Restricted Recipients Program.

Utilization Management Appeals

Overview of Utilization Management

UnitedHealthcare Community Plan operates an internal appeals process to review appeals by members (or a member’s designee) who are dissatisfied with UnitedHealthcare Community Plan utilization management decisions. In New York State, UnitedHealthcare Community Plan members also have the right to an external appeal once the internal appeal process has been exhausted.

Types of Internal Utilization Management Appeals

There are two types of internal Utilization Management (UM) appeals:

1. Clinical Appeals: a request for a review of a medical necessity/experimental/investigational initial adverse determination. The appeal decision must be made by a UnitedHealthcare Community Plan Medical Director or physician advisor. Clinical appeals may be standard or expedited.

2. Administrative Appeals: These are appeals of administrative denials. Examples of these appeals include, but are not limited to, late notification of an admission, other insurance primary, not a covered benefit, out of network care provider. A standard UM Appeal may be filed by a member or member’s designee. A care provider may file a UM appeal for a retrospective denial.

Appeals of claims regarding any other denial reason or alleged inappropriate type or level of payment are addressed in the Claims Administrative Appeals Section.

This section covers the following UM appeals in three sections:

- Appeals for decisions related to UnitedHealthcare Community Plan for Families/Kids
- Appeals of pharmacy decisions

Standard UM Appeal for UnitedHealthcare Community Plan for Families/Kids

Any member, a member’s designee, or a care provider who is dissatisfied with any aspect of UnitedHealthcare Community Plan utilization management decisions has a right to file a UM appeal. A care provider may also file a standard appeal for a retrospective denial.

MCO must make a standard appeal determination within 60 days after receipt of necessary information.

PHL 4904.3
MMC Contract Appendix F.2(4)(a)(i) and (iii)

The time frame for appeal determination begins upon the Plan’s receipt of necessary information. For UnitedHealthcare Community Plan for Families, the review time frame begins upon first receipt of appeal, whether filed orally or in writing. An internal appeal can be initiated as follows:

- A call from the member (or member’s designee) or the health care physician to the UM Appeals Department (888-456-0218). For UnitedHealthcare Community Plan for Families, oral appeals must be followed up by a written signed appeal, which you can fax to 866-950-4490.
- A written request or fax for appeal from the member (or member’s designee) or health care physician on behalf of the member.
For UM appeals, the following would apply: the member may file a written action appeal or an oral action appeal and it must be received by UnitedHealthcare Community Plan no later than 90 calendar days from the date that we notified the member or physician of the initial adverse determination. The appeal should contain the following information:

- Member name and UnitedHealthcare Community Plan member ID number.
- Physician name and UnitedHealthcare Community Plan provider number.
- Physician’s address and phone number.
- Requested procedure or service.
- Date of denial (if known).
- Diagnosis and medical justification for the procedure or service.
- A copy of the original denial letter.

Mail the appeal to:
UnitedHealthcare Community Plan
Attention: UM Appeals Coordinator
P.O. Box 31364
Salt Lake City, UT 84131-0364

UnitedHealthcare Community Plan provides written acknowledgment of all appeals filed to the appealing party within 15 days of such filing. Upon receipt of an appeal, UnitedHealthcare Community Plan will notify the member and the member’s health care physician, in writing, within 15 days of receipt of the appeal and request the necessary information identified.

If only a portion of the identified necessary information is received, UnitedHealthcare Community Plan will request the missing information, in writing, within five business days of receipt of the partial information.

For UnitedHealthcare Community Plan for Families members, before and during appeal review period, the member or designee may see their case file. The member may present evidence to support their appeal in person or in writing. The period of time for UnitedHealthcare Community Plan to make an appeal determination (under section 4904 of the Public Health Law and Part 98-2.9[b]) begins upon our receipt of necessary information.

The UnitedHealthcare Community Plan Medical Director or Physician Reviewer determining the appeal will be a clinical peer reviewer but will not be the same physician who rendered the initial denial, as required by law. The Medical Director or Physician Reviewer rendering an appeal decision will respond in writing either to reinstate some or all of the denied days or to approve the denial.

UnitedHealthcare Community Plan resolves appeals as fast as the member’s condition requires and no later than 30 days from the date of the receipt of the appeal. This time may be extended for up to 14 days upon member or care provider request, or if UnitedHealthcare Community Plan demonstrates more information is needed and delay is in the best interest of the member and so notifies member. The plan must send written notice to the member, his or her designee and the care provider where appropriate within two business days of the appeal decision.

Should UnitedHealthcare Community Plan fail to make a determination within the applicable time periods, the determination is deemed to be a reversal of the adverse determination.

If the denial is upheld, this is called the Final Adverse Determination. UnitedHealthcare Community Plan’s notice of a final adverse determination of a utilization review appeal will be transmitted to the member within two business days of rendering the determination. For UnitedHealthcare Community Plan for Families, we make reasonable efforts to provide oral notice to enrollee and physician at the time the determination is made. Written dated notice is provided and includes the following:

1. A clear statement describing the basis and clinical rationale for the denial as applicable to the member;
2. A clear statement that the notice constitutes the “final adverse determination”;
3. Plan contact information and telephone number;
4. Member’s coverage type;
5. Contact information including full address and telephone number and contact person of our utilization review agent;
6. A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
7. A statement that the member may be eligible for an external appeal and the time frames for requesting an appeal;
8. A statement that notice is available in other languages and formats for special needs and how to access these formats;
9. Standard description of external appeals process;
10. That member has four months from the final adverse determination letter to request an external appeal and
choosing second level of standard appeal may cause time to file external appeal to expire;

11. Summary of appeal and date filed;

12. Date appeal process was completed;

13. Description of member’s fair hearing rights, if not included in initial adverse determination;

14. Right of member to complain to Department of Health at 800-206-8125;

15. Statement that notice available in other languages and formats for special needs and how to access these formats.

If the member and UnitedHealthcare Community Plan have jointly agreed to waive the internal appeal process, the above information will be provided to the enrollee simultaneously with a letter agreeing to such waiver. The letter agreeing to the waiver and the information listed above will be provided to the member within 24 hours of the agreement to waive UnitedHealthcare Community Plan’s internal appeal process.

**Expedited Appeal for UnitedHealthcare Community Plan for Families/Kids**

The appeal is to be expedited if a delay would significantly increase the risk to a member’s health. Such circumstances include:

- Continued or extended health care services, procedures or treatments;
- Additional services for a member undergoing a course of continued treatment; and
- A denial in which the health care physician believes an immediate appeal is warranted;

A call from the member (or member’s designee) or the health care physician to the UM Appeals Department at 888-456-0218. For UnitedHealthcare Community Plan for Families/Kids, oral appeals must be followed up by a written signed appeal.

UnitedHealthcare Community Plan will make its physician reviewer available within one business day of receiving a request for an expedited appeal.

Expedited appeals will be conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination.

UnitedHealthcare Community Plan will render a decision on the expedited appeal within two business days of receipt of necessary information and for UnitedHealthcare Community Plan for Families, as fast as the member’s condition requires and within two business days of receipt of all information necessary and no more than three business days of the date of receipt of the appeal. This time may be extended for up to 14 days upon member or physician request; or if UnitedHealthcare Community Plan demonstrates more information is needed and delay is in the best interest of the member and so notices member. UnitedHealthcare Community Plan will provide a written notification at the same time to all appealing parties.

To facilitate the expedited resolution of an appeal, UnitedHealthcare Community Plan will encourage the health care physician to work collaboratively, including, but not limited to, sharing information by telephone or facsimile.

In the case of expedited appeals, UnitedHealthcare Community Plan will immediately notify the member and the member’s health care physician by telephone or facsimile to identify and request the necessary information, followed by written notification within two days. If UnitedHealthcare Community Plan denies member request for expedited, UnitedHealthcare Community Plan will notify by phone immediately followed by written notice in two days.

An example of the Medicaid Contract indicates the following:

**Timeframes for Resolution of Action Appeals**

a) The Contractor’s Action Appeals process will indicate the following specific timeframes regarding Action Appeal resolution:

i) The Contractor will resolve expedited Action Appeals as fast as the member’s condition requires, within two (2) business days of receipt of necessary information and no later than three (3) business days of the date of the receipt of the Action Appeal. Days if:

ii) The Contractor will make a reasonable effort to provide oral notice to the member, his or her designee, and the provider where appropriate, for expedited Action Appeals at the time the Action Appeal determination is made.

iii) The Contractor must send written notice to the member, his or her designee, and he provider where appropriate, within two (2) business days of the Action Appeal determination.

Expedited appeals that do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process or through the external appeal process pursuant to Section 4914 of the Public Health Law (effective July 1, 1999).
For UnitedHealthcare Community Plan for Families, UnitedHealthcare Community Plan will make reasonable effort to provide oral notice to the member and care provider at the time the determination is made.

**External Appeals Process for Health Care Physicians**

In connection with retrospective adverse determinations, an enrollee’s health care physician has the right to request an external appeal pursuant to section 4910.2 of the Public Health Law.

The “New York State External Appeal Application For Health Care Physicians” is available by contacting the New York State Department of Financial Services by calling 800-400-8882 or by visiting their website at [dfs.ny.gov](http://dfs.ny.gov).

**External Appeal Process for UnitedHealthcare Community Plan for Families/Kids**

UnitedHealthcare Community Plan members have the right to an external appeal when we have denied a service on the basis that:

- such service is not medically necessary, or is considered experimental or investigational a clinical trial, a rare disease treatment or, in certain cases, out-of-network,
- when the member has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health care service is not medically necessary, and UnitedHealthcare Community Plan has rendered a final adverse determination with respect to such health care service, or both UnitedHealthcare Community Plan and the member have jointly agreed to waive any internal appeal. External appeals can only be initiated if there is a denial of a health care service or treatment recommended by the member’s health care physician that would otherwise be covered by UnitedHealthcare Community Plan except for UnitedHealthcare Community Plan determination that such health care service or treatment is not medically necessary or is experimental or investigational.

An external appeal can be requested once UnitedHealthcare Community Plan has made a Final Adverse Determination, i.e., upheld the appealed denial. An independent external appeal agent certified by the state of New York conducts the external appeal.

Members can obtain more information and the form for filing an appeal by contacting:

- **New York State Department of Financial Services**
  800-400-8882  
  [dfs.ny.gov](http://dfs.ny.gov)

**External Appeal Process for Retrospective Adverse Determinations**

Retrospective Adverse Determination means a determination for which Utilization Review was initiated after the health care service or treatment has been provided. Retrospective Adverse Determination does not mean an initial determination involving continued or extended health care service or treatment, or additional service or treatment for a member undergoing a course of continued treatment prescribed by a health care physician.

A member, the member’s designee, and in connection with Retrospective Adverse Determinations, a member’s health care physician has the right to request an external appeal.

**External Appeal Process**

A member, the member’s designee and, in connection with concurrent and retrospective adverse determinations — a member’s physician, will have the right to request an external appeal. In the case of an experimental or investigational service request, the member’s attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the member’s condition or disease. That physician must certify the member has a life threatening or disabling condition or disease for which any of the following apply:

- The member has had coverage denied for a health care service because the service is considered experimental or investigational, and such denial has been upheld on the appeal, or both the health care plan and the member
have jointly agreed to waive any internal appeal, or the member is deemed to have exhausted or is not required to complete any internal appeal; and,

• The member’s attending physician has confirmed that the member has a condition or disease under the following:
  – One by which standard health services or procedures are considered ineffective or would be medically inappropriate, or
  – One where there is no other beneficial standard health service or procedure covered by the health care plan, or
  – One which is under clinical trial or rare disease treatment, and

• The member’s current doctor, who must be a licensed, board-certified or board-eligible doctor qualified to practice in the area of practice appropriate to treat the member’s condition or disease, must have recommended either:
  – A health service or procedure (including a pharmaceutical product) based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any standard health care service covered by UnitedHealthcare Community Plan; or
    • There is a clinical trial for which the member is eligible.

A member has four months and a care provider appealing on his own behalf has 45 days from the receipt of the Final Adverse Determination to request in writing an external appeal.

Additional information can be supplied to the external appeal agent. If the additional documentation should represent a material change from the documentation upon which UnitedHealthcare Community Plan relied to make the Final Adverse Determination, UnitedHealthcare Community Plan will have three days to consider such documentation and amend or confirm the Final Adverse Determination.

The External Appeal Agent will make a determination within 30 days. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. The External Appeal Agent will notify the member and UnitedHealthcare Community Plan within two business days of its determination.

If the member’s attending physician certifies the delay in providing the service would pose an imminent or serious threat to the member’s health, the external appeal must be completed within three days. The external appeals agent will notify the member and UnitedHealthcare Community Plan of their determination immediately by telephone or facsimile, followed by formal notification in writing to the member.

The External Appeal Agent’s decision is binding on both the member and UnitedHealthcare Community Plan.

If an External Appeal Agent approves coverage of an experimental or investigation treatment that is part of a clinical trial, UnitedHealthcare Community Plan will cover only the costs of services required to provide treatment to the member according to the design of the trial. UnitedHealthcare Community Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or the costs that would not be covered for non-experimental or non-investigational treatments.

Please Note: pursuant to New York State Public Health and Insurance Laws, a fair hearing determination prevails over an external appeal determination; therefore, any appeal for which a determination has been made pursuant to the fair hearing process will not be considered by the New York State Department of Financial Services for external appeal.
Additionally in January 2010, there has been a change of New York State Public Health Law about care providers requesting external appeals. You can now ask for external appeals yourself under certain circumstances. You can also still ask for external appeals for members. If your external appeal is denied because the external appeal agent says the care is not medically necessary, you may not ask the member to pay for the care. The member is only responsible for any applicable copays. This is called begin "held harmless."

**Fair Hearing Rights for New York State**
**UnitedHealthcare Community Plan for Families and Members Only**
*(Fair Hearing Rights are never applicable to UnitedHealthcare Community Plan for Kids (CHP))*

A New York State Fair Hearing process is available to UnitedHealthcare Community Plan for Families members. A Fair Hearing can be granted regarding medical care and utilization management medical decisions, if a member:

- Is not happy with a decision UnitedHealthcare Community Plan made about the member’s medical care. The member feels that UnitedHealthcare Community Plan decision limits his/her benefits and/or the decision was not made within the regulated timeframes;
- Is not happy about a decision UnitedHealthcare Community Plan made that denied medical care the member wanted. The member feels UnitedHealthcare Community Plan decision limits his/her benefits; or
- Is not happy with the decision that the doctor will not conduct medical services the member wanted. The member feels the doctor’s decision limits his/her benefits.

The member must file a complaint and an appeal with UnitedHealthcare Community Plan first.

- If UnitedHealthcare Community Plan agrees with the doctor, the member is within his/her rights to ask for a State Fair Hearing.
- The member has the right to continue his/her treatment during the Fair Hearing Process.
- The decision from the Fair Hearing is binding on all parties.
- Member has the right to have a designee file on their behalf.

To file a complaint orally,

- Call the office of Administrative Hearings at 800-342-3334
- Complete the Fair Hearing request and mail to: New York State Office of Temporary and Disability Assistance Office of Administrative Hearings P.O. Box 22023 Albany, NY 12201-2023

The form can be completed on the web at: [otda.state.ny.us/oah/FHREQ.pdf](otda.state.ny.us/oah/FHREQ.pdf) or can be faxed to:

518-473-6735
Attn: Office of Temporary and Disability Assistance Office of Administrative Hearings

A request for a Fair Hearing may also be made in person at the following locations:

**New York City:**
Office of Temporary and Disability Assistance Office of Administrative Hearings
14 Boerum Place, 1st floor
Brooklyn, NY 11201

**Albany:**
Office of Administrative Hearings
99 Washington Ave, 12th floor
Albany, NY 12260

**Member Access to Fair Hearing Process**
Members may access the Fair Hearing Process in accordance with applicable federal and state laws and regulations. Health plans must abide by and participate in New York State’s Fair Hearing Process and comply with determinations made by a Fair Hearing officer.

**Member Rights to a Fair Hearing**
Members may request a fair hearing regarding adverse LDSS determinations concerning enrollment, disenrollment and eligibility, and regarding the denial, termination, suspension or reduction of a clinical treatment or other Benefit Package services by the Health plan. For issues related to disputed services, members must have received an adverse determination from the Health plan or its approved utilization review agent either overriding a recommendation to provide services by a Participating Physician or confirming the decision of a Participating Physician to deny those services. A member may also seek a fair hearing for a failure by the Health plan to act with reasonable promptness with respect to such services. Reasonable promptness will mean compliance with the timeframes established for review of grievances and
utilization review in Sections 44 and 49 of the Public Health Law, the grievance system requirements of 42 CFR Part 438.

Notification of Action and Grievance System Procedures
We will provide written notice of the following Complaint, Complaint Appeal, Action Appeal and fair hearing procedures to all Participating doctors and subcontractor’s to whom the Health Plan has delegated utilization review and Service Authorization Determination Procedures, at the time they enter into an agreement with us:

• The Member’s right to a fair hearing, how to obtain a fair hearing, and representation rules at a hearing;
• The Member’s right to file Complaints, Complaint Appeals and Action Appeals and the process and timeframes for filing;
• The Member’s right to designate a representative to file Complaints, Complaint Appeals and Action Appeals on his/her behalf;
• The availability of assistance from the Health Plan for filing Complaints, Complaint Appeals and Action Appeals;
• The toll-free numbers to file oral Complaints, Complaint Appeals and Action Appeals;
• The member’s right to request continuation of benefits while an Action Appeal or state fair hearing is pending, and that if the Health Plan’s Action is upheld in a hearing, the member may be liable for the cost of any continued benefits;
• The right of the provider to reconsideration of an Adverse Determination pursuant to Section 4903(6) of the PHL; and
• The right of the provider to appeal a retrospective Adverse Determination pursuant to Section 4904(1) of the PHL.

Health Plan Notice to Members
a. Health Plan must issue a written notice of Action and Right to Fair Hearing within applicable timeframes to any member when making an adverse Action and when making an Appeal determination.
b. Health plan agrees to serve notice of affected members by mail, oral and must maintain documentation of such.

Aid Continuing
a. Health plan will be required to continue the provision of the Benefit Package services that are the subject of the fair hearing to a member (hereafter referred to as “aid continuing”) if so ordered by the NYS Office of Administrative Hearings (OAH) under the following circumstances:

1. Health plan has or is seeking to reduce, suspend or terminate a treatment or Benefit Package service currently being provided;
2. Member has filed a timely request for a fair hearing with OAH; and
3. There is a valid order for the treatment or service from a Participating Physician.

b. Health plan will provide aid continuing until the matter has been resolved to the member’s satisfaction or until the administrative process is completed and there is a determination from OAH that the member is not entitled to receive the service; the member withdraws the request for aid continuing and/or the fair hearing in writing; or the treatment or service originally ordered by the physician has been completed, whichever occurs first.

c. If the services and/or benefits in dispute have been terminated, suspended or reduced and the member timely requests a fair hearing, Health plan will, at the direction of either SDOH or LDSS, restore the disputed services and/or benefits consistent with the provisions of Section 25.4 (b).

Appeals of Pharmacy Denials
Any member, a member’s designee or physician on behalf of a member (with the member’s consent) who is dissatisfied with any aspect of UnitedHealthcare Community Plan pharmaceutical decisions or operations has a right to file a UM Appeal.

You should call Member Services for pharmacy appeals at 800-493-4647 and identify that you are calling on behalf of the member.

Written correspondence should be sent to UnitedHealthcare Community Plan New York:

 Appeals
P.O. Box 31364
Salt Lake City, MO 64131-0364

A pharmaceutical appeal should include the following information:
• Patient name and UnitedHealthcare Community Plan member ID number.
• Physician name and UnitedHealthcare Community Plan provider number.
Chapter 3: Prior Authorization/Notification

- DEA number and license number.
- Address and phone number.
- Requested prescription.
- Date of denial (if known).
- Diagnosis and medical justification for the prescription.
- A copy of the original denial letter.

A member’s physician is generally contacted when a member initiates a pharmaceutical medical appeal.

The Medicaid Appeal processes described above will be followed in the event of a pharmaceutical appeal.

Assistance
UnitedHealthcare Community Plan is available to assist members in filing complaints, complaint appeals and action appeals. Members may call Member Services at 800-493-4647.

Disease Management
UnitedHealthcare Community Plan Disease Management (DM) programs are part of our innovative Care Management Program. Our Disease Management (DM) program is guided by the principles of the UnitedHealthcare Community Plan Personal Care Model™.

We developed the Personal Care Model to address the needs of medically underserved and low-income populations. The Personal Care Model places emphasis on the individual as a whole, to include the environment, background and culture.

Identifications and Stratification
The Health Risk Assessment (HRA) and our predictive modeling and stratification system are the primary tools for identifying Members for disease management programs. As a care provider you are also able to refer Members for inclusion in the Disease Management program. Please call your provider services number to make the referral.

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

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

Stratification
Our multi-dimensional, episode-based predictive modeling tool compiles information from multiple sources, including claims, laboratory and pharmacy data, and uses it to predict future risk for intensive care services. On a monthly basis, the system uses algorithms to identify Members for disease management and stratify them into risk levels by severity of disease and associated co-morbidities. The algorithm takes into consideration inpatient and emergency room (ER) use. An “Overall Future Risk Score” is assigned to each Member and represents the degree to which the DM program has the opportunity to affect Members’ health status and clinical outcomes. This assists Care Managers in identifying Members who are most likely to benefit from interventions.

Outreach and other Identification Processes
While HRAs and retrospective data are the first line of identification of new Members in the UnitedHealthcare Community Plan DM programs, we have developed an extensive outreach program that supports real-time identification and referral for our DM services. Through community partnerships and relationships, our staff encourages and educates care providers, ER staff and hospital discharge planners to refer program Members for a greater intensity and frequency of DM interventions when the situation requires it.

We supplement the HRA and the stratification tool identification process through several other methods. One of these approaches is an extensive outreach program that supports real-time identification and referral for our DM services. We also rely on partnering programs and agencies to identify those Members most at need. Our DM staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners, and fiduciary entities to identify Members. Finally, in addition to claims and pharmacy data, we integrate authorization and pre-certification information into the DM software system. This data provides real-time identification of Members experiencing health care barriers and self-care deficits.
DM Interventions

After a Member has been identified with one of the five core conditions (asthma, diabetes, COPD, CAD or CHF), they are mailed health education materials related to the identified condition. The accompanying letter informs the Member’s parent or caregiver on how the Member became eligible to participate in the program, how to use the DM services, and how to opt out if they do not wish to participate. Those Members who are viewed to be more complex utilizing various stratification methodologies are eligible for Care Management interventions. The Care Manager contacts the Member’s parent or caregiver by telephone and sends additional program and health education materials targeted to the Member’s specific care opportunities.

Because our DM program provides benefits and quality-of-life improvements that ultimately affect the overall costs in care, our Welcome call staff make every attempt to enroll Members in the DM program. We employ a number of strategies to locate and contact the Member’s parents or caregivers, including after-hours calls, searching for updated Member information by contacting the PCP/specialist office, reviewing prior authorization information, and sending written correspondence. We document and track contacts to help ensure that all options have been exhausted prior to reporting failure to contact. Once a Member agrees to enroll in the DM program, the Care Manager performs a comprehensive health risk and needs assessment that identifies additional risk factors, current and past medical history, personal behaviors, family history, social history, and environmental risk factors. This information is used to augment and validate the risk stratification of Members. We also institute disease specific assessments to augment the HRA when the caretaker is contacted.

We have developed evidence-based interventions for our DM program. The following general interventions have been structured to improve members’ health status:

- Health risk assessment.
- Health review phone calls.
- Provide assigned Care Manager’s phone number to the Member/family.
- Ongoing monitoring of claims and other tools to re-assess risk and needs.
- Access to program website.
- Episodic educational interventions, as needed.
- Post hospitalization and emergency room assessment.
- Educational materials are sent to member.
- Letter is sent to the care provider identifying the member’s involvement, intervention and point of contact for the DM program.
- Additional and/or specific interventions are also conducted to individualize the plan of care.

Plan of Care

All of our DM programs are part of the Personal Care Model, our overall care management program, in which we pioneered a Member-centric approach to the development of the Plan of Care for program participants. Our unique Personal Care Model features direct Member, parent and caregiver contact by clinical staff who work to build a support network for high risk chronically and acutely ill Members involving family, care providers, and community-based organizations. The goal is to employ practical solutions to improve Members’ health and keep them in their communities with the resources they need to maintain the highest possible functional status. The goals of the Plan of Care implementation are two-fold:

1. Care Manager interventions support self-management/self-efficacy and patient education.

2. Care Manager interventions are defined to help ensure appropriate medical care referrals and assure appointments are kept, immunizations are received, and the member is connected with available and appropriate community support groups, for example, nutrition programs or caregiver support services.

When the Plan of Care is implemented, our goals are:

- To assure the member is leveraging personal, family, and community strengths when able.
- To help ensure that we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities.
- To modify our approach or services based on the feedback from the member, family, and other health care team Members.
- To document services and outcomes in a way that can be captured and modified to continually improve.
- To communicate effectively with the primary care provider/ specialist and other care providers involved in the member’s care.
- To monitor member satisfaction with services, adjusting as needed.
The Care Manager develops and implements an individualized plan of care for members requiring services, reviews the member’s progress and adjusts the plan of care, as necessary, to help ensure that the member continues to receive an appropriate level of care. The Care Manager involves the care provider caring for our member in the plan of care development process and assists them in directing the course of treatment in accordance with the evidence-based clinical guidelines that support our DM Program. The plan of care addresses the following areas of care:

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

### Coordination of Care with Care Providers

Each member is encouraged to select a medical home for community-based health and preventive services. Care providers caring for our members receive reports regarding the health status of members participating in specific DM programs. As this link is established, we involve the care provider in the plan of Care development process and assist them in directing the course of treatment in accordance with evidence-based clinical guidelines. The Care Manager collaborates with the member’s care provider on an ongoing basis to help ensure integration of physical and behavioral health issues. In addition, the Care Manager will help ensure the Plan of Care supports the member’s/caregiver’s preferences for psychosocial, educational, therapeutic and other non-medical services. The Care Manager helps ensure the Plan of Care supports care providers’ clinical treatment goals and builds the Plan of Care to reflect personal, family and community strengths. The Care Manager and member will review the member’s compliance with the treatment during each assessment cycle. Treatment, including medication compliance, is established as a health care goal with interventions and progress towards that goal documented in each assessment session. At any point that the Care Manager recognizes that the member is non-compliant with part or all of the treatment plan, the Care Manager will:

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

As the member’s medical home, the care provider caring for our member is continuously updated on the member’s participation in the DM program(s), the member’s compliance with the Plan of Care and any unscheduled hospital admissions and emergency room visits. The provider receives notifications of when members are enrolled and disenrolled from the DM programs, the assigned Care Manager for the DM program, and how to contact the Care Manager. In addition, the care provider receives notification of members who have generated care opportunities related to specific DM programs. These evidence-based medical guidelines are generated from our multi-dimensional, episode based predictive modeling tool. We also distribute clinical practice guidelines upon the care provider’s request and provide training for providers and their staff on how best to integrate practice guidelines into everyday physician practice. When a care provider demonstrates a pattern of noncompliance with clinical practice guidelines, the medical director may contact the care provider by phone or in person to review the guideline and identify any barriers that can be resolved.

### Case Management

We use retrospective and prospective methods to help ensure potential high-risk members are identified as early as possible. To identify members who meet criteria for disease and care management, we continuously forecast risk through predictive modeling of our claims data. To supplement our retrospective, claims-based approach, we perform an automated, mini health risk assessment. We also review authorization requests, hospital and ER use, Rx data, and referrals from care providers, members and their family/caregivers as well as UnitedHealthcare Community Plan clinical staff. Individuals identified for possible care management go through a more in-depth, scored comprehensive assessment and are routed to the appropriate DM or CM program based on the outcome of that scoring.

#### Prospective Identification—UnitedHealthcare Community Plan

The UnitedHealthcare Community Plan uses numerous data sources to identify Members with a diagnosis for which we have a DM program as well as those whose utilization reflects high-risk and/or complex conditions (Level 3). These data sources include but are not limited to:
• Short health risk assessments conducted during new Member welcome calls.
• Member reported health needs in calls made to our Member Service Department.
• Pharmacy and lab data indicating the incidence of a specific condition (for example, insulin or inhalers).
• Emergency room utilization reports, hospital inpatient census reports, authorization requests and transitional care coordination requests.
• Physician referrals.
• Referrals from health departments, rural health clinics and FQHCs.
• UnitedHealthcare Community Plan clinical staff referrals.

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

Clinical Practice Guidelines

UnitedHealthcare Community Plan uses nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including MCG Care Guidelines and CMS policy guidelines. MCG Care Guidelines is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best practice care templates, and key milestones for the best possible treatment and recovery. These guidelines are integrated into our clinical system. For specific state benefits or services not covered under national guidelines, we develop criteria through the review of current medical literature and peer reviewed publications, Medical Technology Assessment Reviews and consultation with specialists. The clinical practice guidelines are reviewed and revised annually. The UnitedHealthcare Community Plan Executive Medical Policy Committee (EMPC) reviews and approves nationally recognized clinical practice guidelines. The guidelines are then distributed to the National Quality Management Oversight Committee (NQMOC) and the Health Plan Quality Management Committee.

Medical policies and coverage determination guidelines can be found at UHCprovider.com > Menu > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

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

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

Medical policies and coverage determination guidelines can be found at UHCprovider.com > Menu > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.
Chapter 4: Healthy First Steps

UnitedHealthcare Community Plan has developed a Maternal/Prenatal program for all of its members. Healthy First Steps (HFS) is a voluntary program provided to all pregnant members, who are encouraged to participate.

A pregnant member may self-refer and/or be referred by their physician for HFS. A member is usually identified for HFS when the prenatal information is submitted by the physician or through pharmacy data. Once a pregnant member is identified, a referral is made to our HFS team. The team attempts to reach the member by telephone. Several attempts are made to reach the member at various times of the day and evening. If contacted, an assessment is completed and the member is enrolled in one of three levels of case management. The member’s physician is also contacted and advised of the member’s participation in HFS and offered the ability to participate in the member’s HFS care plan.

Members receive educational mailings when enrolled in HFS. The mailings include the following:

- Healthy First Steps brochure – available in English and Spanish.
- Text 4babies brochure – available in English and Spanish.
- You Can Quit Smoking – available in English and Spanish.
- Hi Mom (prenatal care) – available in English and Spanish.
- Post Partum Depression – available in English and Spanish.

After the assessment is complete, the member is stratified into one of three levels of case management.

If the member meets high-risk criteria they are placed in Level 3 Case Management and managed by an experienced obstetrical Registered nurse.

If a member has moderate risks (other co morbidities, smoking etc.) they are placed in Level 2 case Management with our Level 2 health coach for additional education and outreach services.

In addition, under the HFS program the RN case manager or health coach is responsible for coordinating a member’s care from the onset of pregnancy, through delivery, and their postpartum checkup. This integrated system is efficient and comprehensive for both members and physicians. From the onset of pregnancy, physicians contact one individual within the team who can assist with all their needs. This approach enables the team to capture high-risk pregnancies early on and immediately refer to the case manager.

Further, members who are hospitalized during their pregnancy will work with their obstetrical case manager therefore ensuring a continuity of care after discharge. The utilization case manager is involved in initial and concurrent hospital reviews as well as case management activities.

Additionally, the Optum Health case manager will be following NICU cases after delivery, ensuring continuity of care, discharge planning, and referrals as needed to the pediatric case manager.

The structure of the obstetrical program also allows for effective and efficient referrals into prenatal care, our Healthy First Steps program, and reporting of new births. The ultimate goal is to help ensure the highest quality of care for our pregnant members and to facilitate a proactive approach to promoting healthy pregnancies.

NYC Hospital Requirement to Report Births

Hospitals and birthing facilities are required to report births for women who receive Medicaid within five business days of the birth to the New York State Department of Health or to the New York City Department of Health and Mental Hygiene for births occurring in NYC. This took effect on July 1, 2000. Hospitals and birthing facilities must report the birth using the State Perinatal Data System (SPDS). Failure to fulfill the reporting requirements or submitting an incorrect Medicaid Client Identification Number (CIN) for the birth mother may result in the hospital or birthing facilities receiving a Notice of Deficiency and/or a $3500 fine per occurrence if the hospital or birthing facility is found to be non-compliant. The mother’s CIN associates the newborn with the birth mother. If the mother’s CIN is unknown, the field should be left blank. If you are unsure of the SSN, it is preferable to leave the area blank to help ensure a system automated match. You should not use a sequence such as 123456789 if the CIN is unknown. Please contact the Bureau of Medicaid at 518-474-8887 with any questions.

NOTE: Newborns of mothers enrolled in a Medicaid managed care plan are automatically enrolled in the mother’s health plan unless the newborn appears to meet the criteria for SSI eligibility.

Effective December 1, 2010 you will receive an incentive payment of $25 for each completed Obstetrical Health Risk Assessment form faxed to us at 877-353-6913, within 5 days of
Chapter 4: Healthy First Steps

the initial visit. The incentive check along with a list of members for whom we have received a completed Obstetrical Risk Assessment Form will be sent to you. Payment will only be issued for risk assessment forms that are legible and contain the following information:

• Physician name and plan provider ID number.
• Current pregnancy information e.g. gestational diabetes, pre-term labor, PROM, etc.
• Prior medical and obstetrical history e.g., hypertension, Diabetes Mellitus, Pre-term delivery, infant birth weight of less than 4 pounds, Cerclage, etc.
• Current Medical conditions e.g., HIV+, Sickle Cell Disease, bleeding or clotting abnormalities, any other medical condition.
• Hospitalizations related to pregnancy complications.

Questions and additional information related to Healthy First Steps may be directed to HFS at 800-599-5985.
## Chapter 4: Healthy First Steps

### Intake Form

**PX Codes:** W5950 or 59425

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Current Member Phone#</th>
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<tbody>
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<table>
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<tr>
<th>Member Id:</th>
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</table>

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>HMO Provider ID Number</th>
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</table>

<table>
<thead>
<tr>
<th>Provider Site</th>
<th>Date of visit</th>
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</table>

**Is this a missed appointment?**

---

### Past Pregnancy History

1. **Gravida:**
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - >9

2. **Para:**
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - >9

3. **Preterm:**
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - >9

4. **Abortions & Ectopics:**
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - >9

5. **Living:**
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - >9

6. **Number of prior babies born with birth weight <2500g (9lbs. 8 oz.):**
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - >9

7. **Prior C-section**
   - Yes
   - No
   - NA

8. **Prior infant (<12 months) death?**
   - Yes
   - No
   - NA

9. **Prior pregnancy complications?**
   - Diabetes
     - Yes
     - No
     - NA
   - Asthma
     - Yes
     - No
     - NA
   - HTN
     - Yes
     - No
     - NA
   - Pre-eclampsia/eclampsia
     - Yes
     - No
     - NA
   - IUFD
     - Yes
     - No
     - NA
   - Other
     - Yes
     - No
     - NA

### Current Pregnancy

10. **LNMP**
    - / / 

11. **EDC/EDD (due date by current best estimate)**
    - / / 

12. **Is this pregnancy a multiple gestation**
    - Yes
    - No
    - Twins
    - Triplets

13. **Did mother received influenza vaccine during this pregnancy?**
    - Yes
    - No

14. **Was mother offered HIV screening**
    - Yes, accepted
    - Yes, declined
    - No

(continued)
Social

15. Is the mother homeless or without permanent housing  □ Yes  □ No  □ Unknown

16. Tobacco:
   a) Did mother ever smoke before this pregnancy?  □ Yes  □ No  if yes, how many cigarettes per day? __________
   b) When did mother start? __________
   c) Is mother smoking during this pregnancy?  □ Yes  □ No  if yes, how many cigarettes per day? __________
   d) When did mother last smoke a cigarette __________
   e) Was counseling done this visit regarding the effects of smoking on the baby?  □ Yes  □ No
   f) Is mother currently enrolled in a smoking cessation program?  □ Yes  □ No  If no referral made?  □ Yes  □ No
   g) Is mother exposed to second hand smoke?  □ Yes  □ No  if yes
   h) Was counseling done this visit?  □ Yes  □ No  If no referral made?  □ Yes  □ No

17. Alcohol: has mother used alcohol during this pregnancy?  □ Yes  □ No

18. Drugs: has mother used marijuana during this pregnancy?  □ Yes  □ No

19. Drugs: has mother used cocaine, heroin or amphetamines during this pregnancy?  □ Yes  □ No

20. Past Present/Domestic Violence?  □ Yes  □ No

Medical History

21. Maternal history of mental, physical or sexual abuse?  □ Current  □ Past  □ None

22. Maternal history of mental illness  □ Yes  □ No

23. History of other maternal medical conditions?  □ Cardiac  □ HTN  □ Diabetes  □ Asthma  □ HIV/AIDS
   □ other medical complications (eg appendicitis) __________

24. Is the mother currently taking any prescription medications other than prenatal vitamins?  □ Yes  □ No

Gynecological History

25. Date of last Pap smear (month/year) __________/______/______ this is the first Pap smear  □ Unknown

26. History of STD?  □ Yes  □ No

Referrals

27. Was WIC Referral issued  □ Yes  □ No

Please return form by fax to UnitedHealthcare Community Plan Healthy First Steps at 877-353-6913
Chapter 5: Quality Management

Physician Participation in Quality Management

UnitedHealthcare Community Plan has a Quality Management Committee (QMC) through which participating physicians give UnitedHealthcare Community Plan advice and expert counsel in medical policy, quality management, and quality improvement. The Chief Executive Officer chairs the QMC, which meets quarterly and has oversight responsibility for issues affecting health services delivery. The QMC is composed of participating physicians and UnitedHealthcare Community Plan management staff and reports its recommendations and actions to the UnitedHealthcare Community Plan Board of Directors. The Quality Management Committee has three standing committees:

- **Provider Affairs Committee** reviews and recommends action on topics concerning credentialing and recredentialing of physicians and facilities, peer review activities, and performance of all participating physicians.
- **Health Care Quality Utilization Management Subcommittee** reviews statistics on utilization, provides feedback on Utilization Management and Case Management policies and procedures, and makes recommendations on clinical standards and protocols for medical care.
- **Service Quality Improvement Subcommittee** reviews timely tracking, trending and resolution of member administrative complaints and grievances. This subcommittee oversees member and practitioner intervention for quality improvement activities as needed.

Quality Improvement Program

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

- Quality Improvement measures and studies.
- Clinical practice guidelines.
- Health promotion activities.
- Service measures and monitoring.
- Ongoing monitoring of key indicators (e.g., over and underutilization, continuity of care).
- Health plan performance information analysis and auditing (e.g., HEDIS/QARR).
- Care Coordination℠.
- Educating members and physicians.
- Risk management.
- Compliance with all external regulatory agencies.

Your participation is an integral component of UnitedHealthcare Community Plan’s Quality Improvement Program. All care providers and practitioners are required to participate in and cooperate with the UnitedHealthcare Community Plan Quality Improvement program. The UnitedHealthcare Community Plan Quality Improvement program is allowed to use practitioner and care provider performance data to conduct quality activities.

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

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

Medical Recredentialing Requirements

Medical record requirements include:

- Separate medical record for each member.
- The record verifies that PCP coordinates and manages care.
c. Medical record retention period of six years after date of service rendered to members and for a minor, three years after majority or six years after the date of the service, whichever is later.

d. (Prenatal care only): centralized medical record for the provision of prenatal care and all other services Medical records must be accessible to:
   a. UnitedHealthcare Community Plan and/or IPA for UR and QA
   b. NYS DOH by CMS and LDSS (Medicaid only)

### Credentialing and Recredentialing

UnitedHealthcare Community Plan is required to credential each health care professional, prior to the professional providing services to UnitedHealthcare Community Plan members.

#### Physician Responsibilities

Physicians will immediately notify UnitedHealthcare Community Plan in writing if their ability to practice medicine is restricted or impaired in any way, if any adverse action is taken, or an investigation is initiated by any authorized City, State or Federal agency, or of any new or pending malpractice actions, or of any reduction, restriction or denial of clinical privileges at any affiliated hospital.

#### Physician Rights:

- To review information submitted to support your credentialing application.
- To correct erroneous information.
- To receive the status of your credentialing or recredentialing application upon request.

### Credentialing Recredentialing Process

UnitedHealthcare Community Plan’s credentialing process uses standards set forth by the New York State Department of Health, including primary verification of training/experience, etc. Each physician will be re-credentialed at least every 3 years. UnitedHealthcare Community Plan and Affiliates National Credentialing Committee reviews credentialing information and recommends appointment to the panel. It is the applicant’s responsibility to supply all requested documentation in a form that is satisfactory to the Credentialing Committee. Applications that are lacking supporting documentation will not be considered by the committee. UnitedHealthcare Community Plan will process the initial application and present for committee review (within 90 days) upon receipt of a “completed” application and contract. The contract effective date will be the date the initial application is considered received by that National Credentialing Center (NCC). During processing of the initial application, if additional time is necessary to make a determination due to failure of a third party to provide necessary documentation, National Credentialing and its vendors will make every effort to obtain such information as soon as possible. National Credentialing and its vendors notify the practitioner of the missing information, through written correspondence or phone call. Notification to the care provider includes whether or not the care provider has been credentialed, and if not, whether the plan is not in need of additional care providers. If additional information is required, the care provider is notified as quickly as possible, but not more than 90 days from receipt of care provider’s application.

#### Confidentiality

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

### Resolving Disputes

#### Contract Concern or Complaint

If you have a concern or complaint about your agreement with us, send a letter containing the details to Network Management, 2 Penn Plaza, 7th Floor, New York, NY 10121. A representative will look into your complaint and try to resolve it through informal discussions.

#### Arbitration

Any arbitration proceeding under your agreement will be conducted in New York under the auspices of the American Arbitration Association, as further described in our agreement. For more information on the American Arbitration Association guidelines, visit their website at [adr.org](http://adr.org).

If a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the member’s benefit contract or handbook.
Chapter 5: Quality Management

HIPAA Compliance

Physician Responsibilities

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

1. Transactions and Code Sets
These provisions were originally added because of the need for national standardization of formats and codes for electronic health care claims to facilitate electronic data interchange (EDI). From the many hundreds of formats in use prior to the regulation, nine standard formats were adopted in the final Transactions and Code sets Rule. All physicians who conduct business electronically are required to do so utilizing the standard formats adopted under HIPAA or to utilize a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare Community Plan.

2. Unique Identifiers
HIPAA also requires the development of unique identifiers for employers, health care physicians, health plans and individuals for use in standard transactions.

Physicians
The National Provider Identifier (NPI) is the standard unique identifier for health care physicians. The NPI is a 10 digit number with no embedded intelligence which covered entities must accept and use in standard transactions. While the HIPAA regulation only requires that the NPI be used in electronic transactions, many state agencies require the identifier on fee for service claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan will require the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) and should be shared by the physician with all affected trading partners such as physicians to whom you refer patients, billing companies, and health plans.

Individuals
The development of the individual identifier remains on hold.

3. Privacy of Individually Identifiable Health Information
The privacy regulations help ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients’ personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information and to improve the efficiency and effectiveness of healthcare delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.

4. Security
The Security Regulations require covered entities meet basic security objectives:

1. Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates, receives, maintains and transmits;
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Regulations; and
4. Help ensure compliance with the Security Regulations by the covered entity’s workforce.

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

Member Rights and Responsibilities

Privacy Regulations
HIPAA Privacy Regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The Privacy Regulations also create certain individual patient rights.
• **Access to Protected Health Information**
UnitedHealthcare Community Plan members have the right to access information in a designated record set held at the physician's office or at the health plan. Members may make this request to UnitedHealthcare Community Plan for claims and data used to make medical treatment decisions. They may also make a request of the physician of service to obtain copies of their medical records.

• **Amendment of PHI**
UnitedHealthcare Community Plan members have the right to request information held by the physician or health plan be amended if they believe the information to be inaccurate or incomplete. Any request for amendment of PHI must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member.

• **Accounting of Disclosures**
UnitedHealthcare Community Plan members have the right to request an Accounting of Disclosures of his or her PHI made by the physician or the health plan. This accounting must include disclosures by business associates.

• **Right to Request Restrictions**
Members have the right to request restrictions to the physician or health plan's uses and disclosures of the individual's PHI. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented.

• **Right to Request Confidential Communications**
Members have the right to request that communications from the physician or the health plan be received at an alternative location or by alternative means. A physician must accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A health plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

• Mandated for use in ALL standard electronic transactions across the industry (claims, enrollment, remittance, claim status request and response, auth request and response, NCPDP, etc.).

• CMS contracted with Fox Systems to develop the National Plan and Provider Enumeration System (NPPES) on authority delegated by the Secretary of HHS.

• The NPPES assists physicians with their application, processes the application and returns the NPI to the physician.

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

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

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

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

**How to get an NPI:**
Health care providers can apply for NPIs in one of three ways:

• For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan & Provider Enumeration System - Home Page and apply on line.

• Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.

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**National Provider Identifier**

**What is NPI?**

• A 10 character number with no imbedded intelligence.

• A standard of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
• Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator.

Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:

800-465-3203 or TTY: 711

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

How to share your NPI with us:
Once you have NPI, it is imperative that it be communicated to UnitedHealthcare Community Plan by calling the Provider Services Helpline at 866-362-3368 and the state Medicaid agency.

For more information on NPI, please call the Provider Services Helpline at 866-362-3368.

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

Examples of fraud and abuse include:

Misrepresenting Services Provided
• Billing for services or supplies not rendered.
• Misrepresentation of services/supplies.
• Billing for higher level of service than performed.

Falsifying Claims/Encounters
• Alteration of a claim.
• Incorrect coding.
• Double billing.
• False data submitted.

Administrative or Financial
• Kickbacks.
• Falsifying credentials.
• Fraudulent enrollment practices.
• Fraudulent third party liability reporting.

Member Fraud or Abuse Issues
• Fraudulent/Altered prescriptions.
• Card loaning/selling.
• Eligibility fraud.
• Failure to report third party liability/other insurance.

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

Go to UHCprovider.com and select “Contact Us” to report information relating to suspected fraud or abuse.

Call the UnitedHealthcare Special Investigations Unit Fraud Hotline at 877-401-9430.

Mail the information listed below to:
UnitedHealthcare
Special Investigations Unit
Four Gateway Center
100 Mulberry Street – 4th Floor
Newark, NJ 07102
For care provider related matters (e.g. doctor, dentist, hospital, etc.) please furnish the following:

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

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

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

Ethics and Integrity

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

Compliance Program
As a business segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity Program. The UnitedHealthcare Community Plan Corporate Compliance Program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity. The UnitedHealth Group Ethics and Integrity Program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity Program,
- Development and implementation of ethical standards and business conduct policies,
- Creating awareness of the standards and policies by education of employees,
- Assessing compliance by monitoring and auditing,
- Responding to allegations or information regarding violations,
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty,
- Reporting mechanisms for employees, managers and others to alert management and/or the Ethics and Integrity Program staff to violations of law, regulations, policies and procedures, or contractual obligations. UnitedHealthcare Community Plan has Compliance Officers located in each health plan or business unit. In addition, each health plan has an active Compliance Committee, consisting of senior managers from key organizational functions. The Committee provides direction and oversight of the program with the health plan.

Reporting and Auditing
Any unethical, unlawful or otherwise inappropriate activity by an UnitedHealthcare Community Plan employee which comes to the attention of a physician should be reported to an UnitedHealthcare Community Plan senior manager in the health plan or directly to the Corporate Compliance Department at e-mail address: UnitedhealthcareCompliance@uhc.com.

UnitedHealthcare’s Special Investigations Unit (SIU) is an important component of the Corporate Compliance Program. The SIU focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by physicians and plan members. This department is responsible for the conduct and/or coordination of anti-fraud activities in all UnitedHealthcare business units. A toll-free Fraud and Abuse Hotline (877-401-9430) has been set up to facilitate the reporting process of any questionable incidents involving plan members or physicians. Please refer to the Fraud and Abuse section of this administrative guide for additional details about the UnitedHealthcare Fraud and Abuse Program.

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

If a care provider becomes the subject of a governmental inquiry or investigation, or a government agency requests or subpoena documents relating to the care provider’s operations (other than a routine request for documentation from a regulatory agency), the care provider must advise UnitedHealthcare Community Plan of the details of this and of the factual situation which gave rise to the inquiry. The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are estimated to reduce program spending by $11 billion over five years. These provisions are aimed at reducing Medicaid fraud.

Under Section 6032 of The DRA, every entity that receives at least five million dollars in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any health plan or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a contracted physician with UnitedHealthcare Community Plan, you and your staff are subject to this provision. The UnitedHealth Group policy, titled “Integrity of Claims, Reports and Representations to Government Entities” can be found at UHCprovider.com. This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.

**Care Provider Evaluation**

When evaluating the performance of a participating care provider, UnitedHealthcare Dual Complete will review at a minimum the following areas:

- **Quality of Care** – measured by clinical data related to the appropriateness of member care and member outcomes.
- **Efficiency of Care** – measured by clinical and financial data related to a member’s health care costs.
- **Member Satisfaction** – measured by the members’ reports regarding accessibility, quality of health care, Member- Participating Provider relations, and the comfort of the practice setting.
- **Administrative Requirements** – measured by the participating care provider’s methods and systems for keeping records and transmitting information.
- **Participation in Clinical Standards** – measured by the participating care provider’s involvement with panels used to monitor quality of care standards.

UnitedHealthcare Community Plan will make available on a periodic basis and upon request of the care provider the information, profiling data and analysis used to evaluate the care provider’s performance. Each care provider is given the opportunity to discuss the unique nature of the care provider’s professional patient population which may have bearing on the care provider’s profile and to work in partnership with UnitedHealthcare Community Plan to improve performance.

**Physician Termination**

It is the policy of UnitedHealthcare Community Plan to provide due process to physicians who are terminated by UnitedHealthcare Community Plan for Quality of Care reasons. If UnitedHealthcare Community Plan decides to terminate the participation agreement for cause and quality of care reasons, you have the right to appeal the determination based on the following protocols:

- **Quality Concerns** – Concerns regarding the healthcare professional’s competence or professional conduct which could adversely affect, or could adversely affect the health or welfare of a UnitedHealthcare Community Plan member or any other patient of a healthcare professional.
- **Clinical Privileges** – The ability to furnish medical care to persons enrolled in UnitedHealthcare Community Plan.

The hearing procedure is not available in any other circumstances, included but not limited to the following:

- When UnitedHealthcare Community Plan has suspended or restricted healthcare professional’s privileges for a period of time of no longer than 14 days, during which time an investigation is being conducted to determine the need for action.
- When UnitedHealthcare Community Plan decides not to renew a healthcare contract.
UnitedHealthcare Community Plan will not terminate or refuse to renew a contract solely because a healthcare professional has:

- Advocated on behalf of a member;
- Filed a complaint against UnitedHealthcare Community Plan;
- Appealed a decision of UnitedHealthcare Community Plan;
- Made a report to an appropriate governmental body regarding the policies or practices of UnitedHealthcare Community Plan that the healthcare professional believes may negatively impact upon the quality of, or access to, patient care or
- Requested a hearing or review.

**Procedure**

UnitedHealthcare Community Plan reserves the right to terminate the participation status of any participating physician without cause upon 90 days prior written notice delivered to the physician, or as otherwise required under the terms of the provider contract.

UnitedHealthcare Community Plan is legally obligated to report to the appropriate professional disciplinary agency within 30 days of the occurrence of any of the following:

1. Termination of a health care physician for reasons relating to alleged mental or physical impairment, misconduct or impairment of member safety or welfare.
2. Voluntary or involuntary termination of a contract or employment, or other affiliation to avoid the imposition of disciplinary measures.
3. Termination of a health care provider contract, in the case of a determination of fraud or in a case of imminent harm to a member’s health.

UnitedHealthcare Community Plan may terminate a physician’s participation in the network for failure to comply with certain contractual obligations or Quality Management requirements. UnitedHealthcare Community Plan may not suspend or terminate a physician solely because the physician:

- Advocated on behalf of a member.
- Filed a complaint.
- Appealed an UnitedHealthcare Community Plan decision.
- Provided information to an appropriate agency.
- Requested a hearing or review.

**Immediate Termination**

UnitedHealthcare Community Plan will immediately remove any care provider from the network who is unable to provide health care services due to a final disciplinary action. UnitedHealthcare Community Plan may immediately terminate a physician’s participation in the network if one of the following events occurs:

- The physician fails to maintain any of the licenses, certifications or accreditations required by the care provider’s agreement with UnitedHealthcare Community Plan or by state government programs.
- UnitedHealthcare Community Plan determines that immediate termination is in the best medical interest of the members pursuant to the terms of your agreement and applicable NY state law.
- A state licensing board or other agency has made a determination that limits, impairs, or otherwise encumbers the physician’s ability to practice his/her profession.
- The Centers for Medicare and Medicaid Services determine that the physician has not satisfactorily performed his/her obligations under the physician’s agreement with UnitedHealthcare Community Plan.
- There has been a determination of fraud against the physician.
- The physician is terminated or suspended by the State of New York Medicaid Program or the federal Medicare Program. In case of immediate termination, UnitedHealthcare Community Plan will notify the physician in the most expeditious manner and by certified letter.
- Care providers who are sanctioned by the DOH’s Medicaid Program will be excluded from participation in UnitedHealthcare Community Plan’s Medicaid panel.

**Termination for Failure to Comply With Quality Management Requirements**

The Quality Management Committee, based upon recommendations made by the Provider Affairs Subcommittee, may suspend or terminate any health care physician’s participation in the network. UnitedHealthcare Community Plan may initiate termination proceedings regarding a physician’s network participation for several reasons, including failure to implement and comply with his/her corrective action plan, refusal to make medical records available for examination, failure to submit recredentialing information, or failure to comply with and participate in the quality management program. In the case of termination for failure to comply with Quality Management requirements, a Medical Director or Physician Reviewer will send the physician a certified letter notifying him/her of the intent to terminate his/her network participation privileges.
Notice of Proposed Action
The Plan will not terminate a contract with a health care professional unless the Plan provides the health care professional a written explanation for reasons for the proposed contract termination and an opportunity for a review or hearing, at the care provider’s discretion, before a panel appointed by the Plan, as described below.

The notice of proposed action will contain the following information:

• Notification that a professional review action has been recommended against the physician.
• The reasons for the proposed action and any supplemental materials.
• Notification that the physician may request a hearing within 30 days from receipt of the notice; failure to request the hearing will make the termination notice final.

Notice of Hearing
• After receipt of a physician’s request for hearing, a notice of hearing together with any supplemental materials will be served upon the physician.
• If a physician requests a hearing within 30 days, UnitedHealthcare Community Plan will notify the physician of the place, time and date of the hearing. The date of the hearing will be no later than 30 days after the request for a hearing, unless otherwise agreed to by the physician and UnitedHealthcare Community Plan.
• UnitedHealthcare Community Plan will include a list of the witnesses (if any) expected to testify at the hearing on behalf of the Quality Management Committee.

Time of Filing a Response
• At least five business days prior to the hearing, the physician must file a written response to the Termination Notice.
• The Physician’s Response must be filed with UnitedHealthcare Community Plan to the person and address identified in the Termination Notice, and a copy served upon each attorney of record and upon each party not represented by an attorney.
• The Physician’s Response must be in writing, the original being signed by the physician or their representative. The Physician’s Response must contain the physician’s address, telephone number and, if made by an attorney or if the physician will make use of an attorney, the name and post office address and telephone number of the attorney.
• The Physician’s Response must contain a separate and specific response to each and every particular of the Termination Notice or a denial of any knowledge or information thereof sufficient to form a belief.
• Any allegation in the Termination Notice which is not denied, will be deemed admitted.
• If the Physician fails to respond to the Termination Notice, the Termination Notice will be deemed final.

Hearings

Appearances
• All parties to the proceeding may be present and must be allowed to present testimony in person or by counsel and question witnesses.
• If a respondent fails to appear at the duly noted time and place of the hearing and the hearing is not adjourned, irrespective of whether a response to the Termination Notice has been filed, the hearing must proceed on the evidence in support of the Termination Notice. Upon application, the hearing panel for good cause shown may reopen the proceeding, upon equitable terms and conditions.
• Prior to an order after hearing, a default entered upon a physician’s failure to appear may be reopened, for good cause shown, upon written application to the hearing panel.

Conducting Hearing
The hearing panel will be comprised of three persons appointed by the MCO. At least one person on the panel in the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.

Form and Content of Proof
The hearing panel, in conducting the hearing, should use any procedures consonant with fairness to elicit evidence concerning the issues before the panel. The following guidelines must govern:

• This is not an adversarial proceeding, but rather one of inquiry and clarification protected by the peer review privilege and thus confidential.
• All witnesses will be sworn in at the commencement of the proceeding.
• With the permission of the hearing panel, parties will be allowed to ask clarifying questions throughout the testimony of any particular witness, thus saving hearing time and avoiding confusion on a particular subject of testimony.
• Hearsay evidence is fully admissible.
• The Physician will present its evidence, testimonial and documentary first, followed by the evidence, testimonial and documentary, of UnitedHealthcare Community Plan.
• UnitedHealthcare Community Plan’s representative will prepare a binder of evidentiary exhibits to be shared with the hearing panel at the time of the hearing; a copy of the binder will be sent to the physician or his/her representative prior to the hearing.
• Documentary evidence may be admitted without testamentary foundation, where reasonable.
• Witness information need not be introduced in the form of question and answer testimony.
• Information from witnesses may be introduced in the form of affidavits.
• The parties have the right to call and question witnesses.
• A stenographic record will be taken of the proceedings.
• Written stipulations may be introduced in evidence if signed by the person sought to be bound thereby or by that person’s attorney-at-law. Oral stipulations may be made on the record.
• Where reasonable and convenient, the hearing panel may permit the testimony of a witness to be taken by telephone, subject to the following conditions:
  1. A person within the hearing room can testify that the voice of the witness is recognized, or identity can otherwise be established;
  2. The hearing panel, reporter and respective attorneys can hear the questions and answers;
  3. The witness is placed under oath and testifies that he or she is not being coached by any other person.

Powers of the Hearing Panel
The hearing panel will render a decision in a timely manner. The hearing panel has the following powers to control the presentation of the evidence and the conduct of the hearing:
• To fully control the procedure of the hearing, subject to these rules, and to rule upon all motions and objections, and to issue a final determination affirming, modifying or reversing the Notice of Termination in whole or in part including but not limited to:
  • Uphold the suspension or termination
  • Reinstate the physician subject to conditions set forth by UnitedHealthcare Community Plan, which may include a corrective action plan;
  • to refuse to consider objections which unnecessarily prolong the presentation of the evidence;
  • to foreclose the presentation of evidence that is cumulative, argumentative, or beyond the scope of the case;
  • to place evidence in the record without an offer by a party;
  • to call and to question witnesses;
  • to have oaths administered by a notary public or stenographic reporter who is also a notary; to exclude non-party witnesses who have not yet testified from the hearing room;
  • to direct the production of documents and other evidentiary matter;
  • to propose stipulations of fact for the parties’ consideration;
  • to issue interim or tentative findings of fact at any point during the hearing process;
  • to issue questions delimiting the issues for hearing;
  • to direct further hearing sessions for the taking of additional evidence or for other purposes, upon the hearing panel’s own finding that the record is incomplete or fails to provide the basis for an informed decision;
  • to amend the Termination Notice to conform to the proof.

Decisions of the panel will include one of the following and will be provided in writing to the health care professional: reinstatement; provisional reinstatement with conditions set forth by the Plan, or termination.

Hearing Record
The record of the hearing may be taken by shorthand reporting, tape recording, or other reasonable method. The method chosen must be within the discretion and direction of UnitedHealthcare Community Plan.
Hearings
Hearings will be confidential in support of the peer review privilege which governs this proceeding. The hearing panel may exclude from the hearing room or from further participation in the proceeding any person who engages in improper conduct at the hearing. The hearing must be conducted with dignity and respect.

Settlements
Where the parties agree to a settlement during the course of the hearing, they will so stipulate on the record and the hearing will be closed on that basis.

Oral Arguments and Briefs
The hearing panel may permit the parties or their attorneys, to argue orally within such time limits as the panel may determine. The parties are free to file pre-hearing or post-hearing letter briefs or memorandum. Any such letter brief or memorandum must be filed in triplicate for distribution to the hearing panel members, with proof of service upon all counsel in the proceeding and parties appearing without counsel. The hearing panel will render a decision in a timely manner. Decisions will include one of the following and will be provided in writing to the health care professional: reinstatement, provisional reinstatement with conditions set forth by UnitedHealthcare Community Plan, or termination.

Continuations, Adjournments and Substitutions of Hearing Panel Members
UnitedHealthcare Community Plan may postpone a scheduled hearing, or continue a hearing from day to day or adjourn it to a later date or to a different place, by announcement thereof at the hearing or by appropriate notice to all parties.

Timeframes for Hearing Panel Order
The hearing panel will render a decision on the proposed action in a timely manner. Such decision will include reinstatement of the physician by UnitedHealthcare Community Plan, provisional reinstatement subject to conditions set forth by UnitedHealthcare Community Plan or termination of the physician. Such decision will be provided in writing to the physician. A decision by the hearing panel to terminate a physician will be effective not less than 30 days after the receipt by the physician of the hearing panel’s decision. Notwithstanding the termination of a physician for cause or pursuant to a hearing, the physician will continue to participate in the plan on an on-going course of treatment for a transition period of up to 90 days, and post-partum care, subject to provider agreement. In no event will termination be effective earlier than 60 days from the receipt of the notice of termination.

Reinstatement in the UnitedHealthcare Community Plan Care Provider Network
If a physician has been suspended or terminated because of quality of care issues, the physician will not be eligible for reinstatement in the UnitedHealthcare Community Plan network until he/she has developed and implemented an improvement action plan acceptable to UnitedHealthcare Community Plan. If a physician has been suspended or terminated because he/she has been suspended or terminated from a government sponsored health care program, the physician will not be eligible for reinstatement in the UnitedHealthcare Community Plan network until he/she is eligible for participation in the government-sponsored health care program from which he/she was suspended or terminated. Expired contracts are not terminations. Non-renewals for lapsed contracts also do not constitute terminations. For contracts without expiration dates, non-renewal on January 1st after the contract has been in effect for a year or more will not constitute a termination.

Continuity of Care for Primary Care Physicians
Should a Primary Care Physician terminate the provider agreement, the physician will provide services to members assigned to the physician through the end of the month in which termination becomes effective. In the event of UnitedHealthcare Community Plan’s insolvency or other cessation of operations, the physician will continue to provide benefits to members through the period for which the premium has been paid, including benefits to members in an inpatient facility. Despite the above provisions, if UnitedHealthcare Community Plan terminates the provider agreement for cause, UnitedHealthcare Community Plan will not be responsible for health care services provided to members following the effective date of termination.

Continuity of Care During a Pregnancy
In the case of a member in the second or third trimester of pregnancy at the time of notice of the termination, the transitional period will extend through post-partum care related to delivery and 60 days after delivery. Any health service provided during the transitional period will be covered by UnitedHealthcare Community Plan under the same terms and conditions as applicable to participating physicians.
Continuity of Care When Physician Leaves Network

Upon termination of the provider agreement, UnitedHealthcare Community Plan will use its best efforts to persuade members assigned to the physician to choose an alternative participating physician. However, the physician will continue to furnish covered services to any member under the physician’s care who, at the time of termination of the provider agreement, is an inpatient or other institution until the member’s discharge.

Upon termination of the provider agreement, a member may continue an ongoing course of treatment with the physician, at the member’s option, for a transitional period of up to 60 days from the date the member was notified by UnitedHealthcare Community Plan of the termination of the provider agreement. UnitedHealthcare Community Plan, in consultation with the physician and member, may extend the transitional period if clinically appropriate. Continued care will be provided under the same terms and conditions.

Member Notification of Physician Departure From the UnitedHealthcare Community Plan Participating Physician Network

• When you leave a participating network Medical Group, your Medical Group is required to notify UnitedHealthcare Community Plan of your departure as described in your Medical Groups’ participation agreement.

• You are required to notify UnitedHealthcare Community Plan when you terminate from our network as described in your Physician Contract.

• At least 30 days prior to the effective date of your termination or your groups’ termination from the network, UnitedHealthcare Community Plan will send, by regular mail, notification to our affected members/your patients. If an applicable state statute requires earlier notification, the state statute will prevail, assuming UnitedHealthcare Community Plan has been provided timely notice from you or your Medical Group practice.

• Your affected patients/our members will include those UnitedHealthcare Community Plan members for whom a claim was filed on your behalf or on behalf of your Medical Group within the six months prior to the effective date of termination or departure, or the state statutory look back period, whichever is greater.
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We know that you want to be paid promptly for the services you provide. Here’s what you can do to help promote prompt payment:

Register for UnitedHealthcare Online® Service, our free service for network physicians, health care professionals and facilities.

At UnitedHealthcare Online, you can check the following and submit claims electronically, for faster claims payment:

- Verify Member eligibility including secondary coverage.
- Review benefits and coverage limits.
- Submit claims.
- Check claim status.
- Access capitation rosters.
- View your panel roster.
- Access remittance advice and review recoveries.
- Review your HEDIS physician profile report.
- Submit demographic profile changes.

UnitedHealthcare Online is also your source for important updates, UnitedHealthcare policies, product and process information and news bulletins.

Once you’ve registered, review the member’s eligibility at UHCprovider.com/eligibility.

Alternately, to check member eligibility by phone, call 866-362-3368.

Prepare a complete and accurate claim form. Submit the claim online at UHCprovider.com/claims or use another electronic option:

- If you currently use a vendor to submit claims electronically, be sure to use our electronic payer (ID 87726) to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit by phone at 800-210-8315 option 1 or by email at ac_edi_ops@uhc.com. Please see the EDI Support Services page on UHCprovider.com/EDI for more information regarding electronic claims and remits.

Electronic Funds Transfer (EFT)

UnitedHealthcare Community Plan has implemented Electronic Funds Transfer (EFT) for claims payments.

With EFT, you can expect payment within 24-48 hours after your claims have been processed and approved for payment, rather than waiting up to a week for a check to arrive in the mail.

To sign up for this free service, go to UHCprovider.com/EPS and log into the Secure Online Services section.

Once you have logged into your account, download the Electronic Payment Authorization/Maintenance Form. This form includes instructions for completion and an address and fax number to send it once completed.

If you haven’t yet registered for access to our Secure Online Services portal, there are other reasons for signing up:

- File claims.
- Check claim status.
- Review remit advice.
- Check member eligibility.
- View PCP panel roster.

For those claims that UnitedHealthcare Community Plan cannot accept electronically, mail paper claims to the claims address on the member’s ID card.

If you are a physician, practitioner, or medical group, you must only bill for services that you or your staff perform.

For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our members for any laboratory services for which you lack the applicable CLIA certification.

Payment of a claim is subject to our payment policies (reimbursement policies), which are available to you online or upon request. You must not bill our member for amounts unpaid due to application of a payment policy.

UnitedHealthcare Community Plan will adjudicate claims submitted per New York State Department of Financial Services Prompt Pay Law.
NPI Compliance

HIPAA mandates the adoption and use of NPI in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and auth request/response) for all healthcare physicians who conduct business electronically.

Complete Claims

Whether you use an electronic or a paper form, complete a CMS 1500 (formerly HCFA 1500) or UB-04 form. A complete claim includes the following information (additional information may be required by us for particular types of services or based on particular circumstances or state requirements).

A clean claim has no defect or impropriety and meets the following criteria:

- The claim is an eligible claim for a health service provided by an eligible health care physician to an UnitedHealthcare Community Plan member under the agreement.
- The claim does not lack any of the required substantiating documentation.
- The claims contains correct coding of diagnosis, procedure, or other required information.
- There is no dispute regarding the amount claimed.
- UnitedHealthcare Community Plan has no reason to believe the claim has been submitted fraudulently.
- The claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the agreement.

The following data elements are required for correct claims payment. The bolded information is critical for correct claim payment:

CMS 1500

- **Member ID number.**
  - Patient’s name, sex, date of birth and relationship to subscriber.
  - Information about other insurance coverage, including job-related, auto or accident information.
  - Referring physician’s name (if applicable).
  - Current ICD-10 diagnostic codes by specific service code to the highest level of specificity.

- **Date of service(s), place of service(s) and number of services (units) rendered, current CPT-4 and HCPCS procedure codes with modifiers where appropriate.**

- **Physician’s or care provider’s NPI and federal tax ID number.**

- **Charges per service and total charges.**

- **Name and signature.**

- **Name, address and phone number of physician or care provider performing the service, as in your contract document.**

All physicians are required to supply their assigned care provider ID on all claims in the PIN field.

UB-04

- **Date and hour of admission and discharge as well as patient status-at-discharge code.**

- **Type of bill code, type of admission (e.g., emergency, urgent, elective, newborn).**

- **Birth weight of a newborn.**

- **Current revenue code and description.**

- **Current principal diagnosis code at highest level of specificity. Current other diagnosis codes, if applicable, at highest level of specificity.**

- **Attending physician ID.**

- **Bill all outpatient surgeries with the appropriate revenue and CPT/HCPCS code.**

- **Provide specific CPT and appropriate revenue code (e.g., laboratory, radiology, diagnostic or therapeutic) for services reimbursed based on a contractual fee maximum.**
• Attach an itemized list of services or complete Box 45 for physical, occupational or speech therapy services (revenue code 420-449) submitted on a UB-04.

• Attach an itemized statement if submitting a claim that will reach the contracted stop loss.

• Submit claims according to any special billing instructions that may be indicated in your agreement or letter of agreement.

• Care provider ID.

The use of care provider ID is mandatory, as the adjudication system verifies the care provider ID prior to loading the claim for payment. If the care provider ID is not found or is incorrect, the claim is rejected for processing and must be resubmitted with the correct care provider ID.

**Submission of CMS 1500 Claims With Unlisted Codes and Experimental or Reconstructive Services**

**Submission of Medical or Surgical Codes**
Attach a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or “other” revenue codes as well as experimental or reconstructive services.

**Submission of CMS 1500 Unlisted Drug Codes**
Attach the current NDC (National Drug Code) number for claims submitted with unlisted drug codes (e.g. J3490, J3590, etc.). The NDC number must be entered in 24D field of the CMS1500 paper form or the LiNo3 field of the HIPAA 837 electronic form. Second submissions, tracers, claim status requests should be submitted electronically no sooner than 45 days after original submission.

**Other Billing Guidelines**
UnitedHealthcare Community Plan contracted physicians are generally prohibited by the terms of their contract and by New York State Medicaid Law from billing members for any costs related to services they provide, other than any applicable copayment amount. For covered services, payment by UnitedHealthcare Community Plan is considered payment in full.

Please be aware that physicians must not balance bill members for any of the following reasons:

• If there is a difference between the charge amount and the UnitedHealthcare Community Plan fee schedule.

• If a claim has been denied for late submission.

• Unauthorized service, or as not medically necessary.

• When claims are pending review by UnitedHealthcare Community Plan.

Please remember to obtain the member copay as indicated on the member’s identification card at the time of service. If you wish to bill the member for non-covered services, you must discuss this with the member prior to rendering the services and obtain signed waiver of liability from that member, that specifies the service in question.

If you have questions about submitting claims to us, please contact Member Care at the phone number listed on the member’s ID card.

**Claim Administrative Appeals**

Claims administrative appeals are appeals of any payment decision that DOES NOT involve UnitedHealthcare Community Plan’s determination of medical necessity or obtaining from the physician information pertinent to a determination of medical necessity. Please see the section addressing the Types of Internal UM Appeals for a definition of payment decisions involving UM appeals.

Claims administrative appeals may be made for claims that are:

• Denied in entirety.

• Denied in part.

• Paid at a rate asserted to be inconsistent with contracted rates.

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

• Failure to obtain required prior authorization.

• Untimely submission.

• Reimbursement disputes.

All claims administrative appeals must be filed within 60 days of the date of the UnitedHealthcare Community Plan provider remittance. To file a claims administrative appeal, the physician should send a written appeal by regular mail to:

**UnitedHealthcare Community Plan**
Attention: Claims Administrative Appeals
PO Box 31364
Salt Lake City, UT 84131-03641
The cover letter should state that a claims administrative appeal is being made. Several claims with the same reasons for appeal may be combined in a single appeal letter, with an attached list of claims. State the specific reason for denial as stated on the remittance. UnitedHealthcare Community Plan does not accept appeals that fail to address the reason for the denial as stated on the remittance.

For appeals of payment rates, state the basis for the dispute and enclose all relevant documentation, including but not limited to contract rate sheets and fee schedules.

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

**Electronic claims** – include confirmation that UnitedHealthcare Community Plan or one of its affiliates received and accepted your claim.

**Paper claims** – include a copy of a screen print from your accounting software to show the date you submitted the claim. If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed.

**Claims Adjustment Request**

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

You may also call Provider Services at 866-362-3368 and select the correct prompts, including opting out to speak with a Provider Phone Representative (PPR). The PPR is trained to address your inquiry and handle initial claim related calls. During the call, if the PPR is unable to resolve the issue, they will put the physician in contact with a Rapid Resolution Expert (RRE). The RRE is trained to manage more complex and escalated claim service issues. The Rapid Resolution Program is designed to make more highly skilled claims resolution experts readily accessible and to improve the overall call center experience for physicians.

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

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination (see Claim Administrative Appeals).

**Overpayments**

If you identify a claim where you were overpaid or if we identify an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days from the date of your identification of the overpayment or our request. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our agreement and applicable law.

All overpayments received from us or credit balances existing on your records should be sent to:

**Receivable Strategies, LLC,**
**P.O. Box 260**
**Parsippany, NJ 007054**

Please include appropriate documentation that outlines the overpayment including patient ID and number, date of service and amount paid.

If you disagree with an overpayment refund request, send a letter of appeal to the address noted on the refund request letter.

Your appeal must be received within 30 days of the refund request letter to allow sufficient time for processing the appeal and avoid possible offset of the overpayment against future claim payments to you. When submitting the appeal, please attach a copy of the refund request letter and a detailed explanation of why you believe the refund.

**Coordination of Benefits**

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

**COB** – Coordination of benefits is administered according to the member’s benefit contract and in accordance with applicable statutes and regulations.

Please update patient’s insurance information at each visit to avoid confusion and inaccurate COB.
Claim Editing

Physical Claim Editing – iCES Clearinghouse From Ingenix:
UnitedHealthcare Community Plan utilizes iCES (INGENIX Claim Edit System clearinghouse), which is owned and maintained by Ingenix. iCES is a clinical edit system application that analyzes physician healthcare claims based on business rules designed to automate UnitedHealthcare reimbursement policy and industry standard coding practices.

iCES is interfaced with the Diamond claims application and claims are analyzed prior to payment to validate billings in order to minimize inaccurate claim payments.

The UnitedHealthcare Provider Portal (UHCprovider.com) outlines the reimbursement policies, which are applied in iCES as clinical edits. In addition iCES applies the following edits:

1. Basic field validity screens for patient demographic and clinical data elements on each claim.
2. Effective-dated ICD-10-CM, CPT-4 and HCPCS Level II code validation, based on service dates and patient clinical data.

Facility Claim Editing – Facility Editor From Ingenix:
UnitedHealthcare Community Plan utilizes the INGENIX Facility Editor® for claims for outpatient services provided to Medicaid beneficiaries. The Facility Editor is a rules-based software application that evaluates outpatient claims data for validity and reasonableness. These reasonableness tests incorporate the Outpatient Code Edits (OCE) developed by the Centers for Medicare and Medicaid Services (CMS) for hospital outpatient claims. The Facility Editor will be used to examine outpatient facility-based claims prior to payment to validate billings to minimize inaccurate claim payments.

The UnitedHealthcare Provider Portal outlines the reimbursement policies which are applied in Facility Editor as clinical edits. The CMS OCE edits that will be applied by the Facility Editor include:

1. Basic field validity screens for patient demographic and clinical data elements on each claim.
2. Effective-dated ICD-10-CM, CPT-4 and HCPCS Level II code validation, based on service dates and patient clinical data.
3. Facility-specific National Correct Coding Initiative edits. The NCCI edits identify pairs of codes that are not separately payable, except under certain circumstances. NCCI edits were developed for use by all health care providers; the Facility Editor incorporates those NCCI edits that are applicable to facility claims. The NCCI edits in the Facility Editor are applied to services billed by the same hospital for the same beneficiary on the same date of service. There are two categories of NCCI edits:
   a. Comprehensive code edits, which identify individual codes, known as component codes, which are considered part of another code and which are designed to prevent unbundling; and
   b. Mutually exclusive code edits, which identify procedures or services that could not reasonably be performed at the same session by the same care provider on the same beneficiary.
4. Other OCE edits for inappropriate coding, including incorrect coding of bilateral services, evaluation and management services, incorrect use of certain modifiers, and inadequate coding of services in specific revenue centers are also included in the Facility Editor.

Other Claim Edits – Diamond Claim Processing System From Perot Systems

Generic Claim Edits:
- Member active in system on date of service.
- Physician active in system on date of service, for contract to be paid upon.
- Timely filing checks by type of care provider or line of business.
- Check for authorization, if required for service on claim.
- Diagnosis, procedure, HCPCS, revenue code or modifier valid in system.
- Paperwork missing when required for claim processing (e.g. EOB for coordination of benefits).
- Duplicate payment.
- Dates of services validity.
- Facility-Specific Claim Edits
- Incomplete or invalid patient status, admission date, admission type, or discharge information.
- Date of service precedes date of death.

DRG Validation Process

Process to help ensure coding provided on select claims is substantiated by services documented in medical record.

UnitedHealthcare Community Plan notifies you that New York County Health Services Review Organization (NYCHSRO)/MedReview is assisting UnitedHealthcare Community Plan in its DRG validation process with claims
Chapter 6: Our Claims Process

for services provided to UnitedHealthcare Community Plan for Families, UnitedHealthcare Community Plan for Kids, and UnitedHealthcare Dual Complete members. NYCHSRO/MedReview directly interfaces with physicians to request chart documentation necessary to conduct coding validation reviews and readmission reviews.

Documentation Request
NYCHSRO/MedReview notifies you, by certified mail, of cases selected for review. Case identification information: Patient names, medical record number, admit/discharge date, member’s ID, and date of birth are supplied to assist the care provider in chart retrieval. You will be requested to send a photo copy of the medical chart documentation within 45 business days to:

NYCHSRO/MedReview
199 Water Street, 27th Floor
New York, NY 10038

Initial Review Process
Upon receipt of the complete medical chart, NYCHSRO/MedReview will complete its initial review within 30 business days for post pay review and 15 business days for prepay review. If not approved as billed, you are notified, in writing, of the initial review results and afforded the opportunity to submit additional information in rebuttal of the findings, within 45 business days. If no response is received within the specified timeframe, the case is considered closed and payment is made in accordance with the initial review findings.

For non-receipt of medical chart within timeframes requested, MedReview provides notice to pay at the assumption code rate. You may submit medical records utilizing the appeal process to have the claim reconsidered.

Appeal Process
Care providers that file an appeal within the designated timeframes will receive notification of the appeal determination within 30 business days of receipt of the appeal. The appeal information submitted is reviewed by a coder and/or Physician Advisor not involved in the original decision. The review determination correspondence will indicate whether the initial review determination has been upheld, modified, or reversed in addition to a rationale determination. The case is considered closed and UnitedHealthcare Community Plan will process payment based on the final appeal determination.

Physician Reimbursement Policy

Reimbursement policies are set for all markets, unless prohibited by state regulations.

Cost Outlier Review Process
Claims are reviewed according to the DRG Validation process described above. An inliers and day outlier payment is made according to the determination made at the time of review. You must follow the claim administrative appeal process as noted on the remittance advice and send an appeal for payment of the cost outlier to the claims administrative appeal address indicated on the remittance advice.

Appeals are received and reviewed for timeliness of submission and if compliant, is then forwarded with your submitted documentation to NYCHSRO/MedReview for review of the cost outlier.

Documentation Request
NYCHSRO/MedReview notifies you, by certified mail, of the intent to review the cost outlier appeal and requests the documents necessary to complete the review. You are requested to send the documentation, within 30 business days, to the following address:

NYCHSRO/MedReview
199 Water Street
New York, NY 10038
Attention: Cost Outlier Unit

If you fail to submit the requested documentation within the designated timeframe, missing information notification is submitted to you, by certified mail, requesting the documents necessary to complete the review. You are requested to send the documentation, within 30 business days, to the following address:

NYCHSRO/MedReview
199 Water Street
New York, NY 10038
Attention: Cost Outlier Unit

Should you fail to submit the requested documentation within the designated timeframe, UnitedHealthcare Community Plan will be unable to address the request for cost outlier consideration and will uphold the initial payment due to failure to submit requested documentation.
Initial Review Process
Upon receipt of the complete medical chart, NYCHSRO/MedReview will complete its initial cost outlier review within 30 business days. You are notified in writing of the initial review results and afforded the opportunity to submit additional information in rebuttal of the findings, within 45 business days. If no response is received within the specified timeframe, the case will be considered closed and payment will be made in accordance with the initial review findings.

Appeal Process
Care providers that file an appeal within the designated timeframes will receive notification of the appeal determination within 30 business days of receipt of the appeal. The appeal information submitted is reviewed by a Coder, Nurse Auditor and/or Physician Advisor not involved in the original decision. The review determination correspondence will indicate whether the initial review determination has been upheld, modified, or reversed in addition to a detailed line item determination. The case is considered closed and UnitedHealthcare Community Plan will process payment based on the final appeal determination.

Integrity of Claims, Reports and Representation to Government Entities
A number of federal and state regulations govern information provided to the government, including the Federal False Claims Act, State False Claims Acts, and other regulations and protections. UnitedHealth Group’s Integrity of Claims, Reports and Representations to Government Entities Policy provides information about these regulations. Physicians, health plans and agents who contract with the Medicaid businesses of UnitedHealth Group or submit claims to government agencies should review this policy.

A “health plan” or “agent” includes any health plan, subcontractor, agent or other person which or who, on behalf of UnitedHealth Group, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

Balance Billing Reminder
UnitedHealthcare Community Plan contracted care providers are generally prohibited by the terms of their contract and federal regulations from billing our members for any costs related to services they provide, other than any applicable deductible or copayment amount. For covered services, payment by the Plan is considered payment in full.

Please be aware that you must not balance bill members for any of the following reasons:

- If there is a difference between the charged amount and the UnitedHealthcare Community Plan fee schedule.
- If a claim has been denied for late submission, unauthorized service or as not medically necessary.
- When claims are pending review by UnitedHealthcare Community Plan.
- For Medicare members, fee-for service Medicaid is secondary—not the health plan.

As a reminder, to obtain the member’s copay if indicated on the member’s identification card at the time of service. If you wish to bill the member for non-covered services, you must discuss this with the member prior to rendering the services and obtain a signed waiver of liability from the member that specifies the service in question. If you have any questions, please contact UnitedHealthcare Community Plan by UnitedHealthcare Customer Service at 866-362-3368.
Chapter 6: Our Claims Process

Member Identification Cards

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

Be sure to check the member’s ID card at each visit and to copy both sides of the card for your files.

Sample Member ID Cards
Chapter 6: Our Claims Process

Encounter Data
You are required to submit encounter data to UnitedHealthcare Community Plan. Submit member encounter data to UnitedHealthcare Community Plan through claims submissions using the approved Encounter Form (CMS 1500). The encounter data enables us to:

- Track utilization.
- Analyze patient care patterns.
- Adhere to state and federal HMO reporting requirements.
- Provide a source for quality assurance studies.

Encounter Forms
Submit the approved form to UnitedHealthcare Community Plan at least monthly. Complete the following information:

- Member name, birth date, sex, address and Member number found on the Member’s ID card.
- Physician name and participating physician or other health care professional number.
- Date of service.
- Diagnosis in a written description and the appropriate ICD diagnosis code, procedure in a written description and the appropriate CPT code, or the HCPCS procedure codes as established by the federal government, and type of visit.

Member Encounters
When you see one of our members, document the visit by noting:

- Member’s complaint or reason for the visit.
- Physical assessment.
- Unresolved problems from previous visit(s).
- Diagnosis and treatment plans consistent with your findings.
- BMI charts for pediatric members.
- Developmental assessment for pediatric members.
- Member education, counseling or coordination of care with other physicians.
- Date of return visit or other follow-up care.
- Review by the primary care physician (initialed) on consultation, lab, imaging, special studies, outpatient and inpatient records.

- Consultation and abnormal studies including follow-up plans.
- Reasons for referrals documented.

Patient Hospitalization
When a patient is hospitalized, your records should include:

- History and physical.
- Consultation notes.
- Operative notes.
- Discharge summary.
- Other appropriate clinical information.

Clinical Decision and Safety Support Tools
in place to help ensure evidence-based care is provided. Examples include:

- Immunization tracking sheet.
- Flow sheet for chronic diseases (e.g. diabetes, asthma).
- Member reminder system.
- Electronic medical records.
- E-prescribing/epocrates.

Patient Information
Participating care providers acting within the lawful scope of practice are encouraged to advise patients who are members of UnitedHealthcare Community Plan about:

1. The patient’s health status including diagnosis, medical care, or treatment options (including any alternative treatments that may be self-administered), and prognosis. This should include the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options in language the member can be expected to understand. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member’s behalf.

2. The risks, benefits, and consequences of treatment or non-treatment.

3. The opportunity for the individual to refuse treatment to the extent permitted by law, and to express preferences about future treatment decisions and the medical consequences of those decisions.

4. The information necessary to give informed consent prior to the start of any procedure or treatment.
Member Rights and Responsibilities

Members’ Rights
Members of UnitedHealthcare Community Plan have a right to:

- Be cared for with respect, dignity and right to privacy, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from UnitedHealthcare Community Plan.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you and to participate with practitioners in making decisions about your health care.
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- Refuse care and be told what you may risk if you do.
- Get information about UnitedHealthcare Community Plan, its services, its practitioners and care providers and member rights and responsibilities.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- The member’s right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- Use the UnitedHealthcare Community Plan complaint system to settle any complaints, or you can complain to the NY State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- Make recommendations regarding the organization’s member rights and responsibilities policy.

Member Responsibilities
Members of UnitedHealthcare Community Plan have a responsibility to:

- Work with their Primary Care Physician to guard and improve their health including following plans and instructions for care that you have agreed upon.
- Work to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Supply information that the organization and its practitioners and care providers need to provide care.
- Find out how their health care system works.
- Listen to their Primary Care Physician’s advice and ask questions when they are in doubt.
- Call or go back to their Primary Care Physician if they do not get better, or ask for a second opinion.
- Treat health care staff with the respect they’d expect themselves.
- Tell us if they have problems with any health care staff. Call Member Services.
- Keep their appointments. If they must cancel, call as soon as they can.
- Use the emergency room only for real emergencies.
- Call their Primary Care Physician when they need medical care, even if it is after-hours.
Chapter 7: Physician Standards and Policies

Role of the Primary Care Physician

The primary care physician supervises and coordinates medically necessary health care of our members.

The Primary Care Physician plays a vital role as a physician case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas—access, coordination, continuity, and prevention. The Primary Care Physician may see members who are not on their roster; and responsible for the provision of initial and primary care to members, who have selected the Primary Care Physician, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The Primary Care Physician must provide 24 hours/7 days coverage and backup coverage when he or she is not available. The Primary Care Physician is the point of entry into the delivery system, except for services allowing self-referral (such as OBGYN, Vision, etc.), emergencies, and out-of-area urgent care. UnitedHealthcare Community Plan expects Primary Care Physicians to communicate with specialists the reason for the necessity of specialty services by way of a prescription or note on their letterhead. UnitedHealthcare Community Plan also expects Primary Care Physicians to note the reason for the recommendation in the patient’s medical record. UnitedHealthcare Community Plan expects a specialist to communicate to the Primary Care Physician significant findings and recommendations for continuing care.

Non-Par Referrals

If you need to recommend a member to a specialist for medically necessary services, and UnitedHealthcare Community Plan network does not include an available care provider with the appropriate training and experience to meet the needs of the member, or, should the member feel that an in network specialist does not meet their needs; you must first receive approval from UnitedHealthcare Community Plan to recommend an out-of-network specialist by calling 866-604-3267. Emergency services never require prior authorization. Approval may be obtained pursuant to an approved treatment plan agreed upon by UnitedHealthcare Community Plan, the Primary Care Physician, and the Non-Par Specialist.

Specialists as a primary care physician and/or referral to a specialty care center is an option if a member has a life-threatening or degenerative and disabling condition or disease that requires prolonged specialized care, the member’s specialist may also serve as the Primary Care Physician. In these cases, a medical director must approve a treatment plan, in consultation with the Primary Care Physician, the specialist, and the member (or the member’s designee). UnitedHealthcare Community Plan will approve only specialists who are participating in UnitedHealthcare Community Plan’s network, unless no qualified specialist can be identified in the UnitedHealthcare Community Plan network.

Women can choose any of our OB/GYN or midwives to deal with women’s health issues. They never need a referral for family planning, well-women care, or care during pregnancy. Women can have routine check ups (twice a year), follow-up care if there is a problem, and regular care during pregnancy.

Members may self refer for OB/GYN prenatal care, two routine visits per year and any follow-up care, acute genealogical condition.

For UnitedHealthcare Community Plan for Families

In addition to the above:

- One mental health visit and one substance abuse visit with a participating care provider per year for evaluation
- Vision services with participating care provider
- Diagnosis and treatment of TB by public health agency facilities
- Family planning and reproductive health from a participating care provider or Medicaid provider

UnitedHealthcare Community Plan works with members and physicians to help ensure that all participants understand, support, and benefit from the primary care case management system.

Responsibilities of the Primary Care Physician

In addition to the requirements applicable to all physicians, the responsibilities of the Primary Care Physician include the following standards of care which are reflective of professional and generally accepted standards of medical practice:

- Offer access to office visits on a timely basis, in conformance with the standards outlined in the Timeliness Standards for Appointment Scheduling section of this administrative guide.
- Providing hours of operation that do not discriminate any Medicaid members relative to other members.
Chapter 7: Physician Standards and Policies

- Conduct a baseline examination during the member’s first appointment. This should occur within 90 days of a new member’s enrollment in UnitedHealthcare Community Plan, UnitedHealthcare Community Plan for Kids. The Primary Care Physician should attempt to schedule this appointment if the new member fails to do so.

- Treat general health care needs of members listed on the Primary Care Physician’s panel roster. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced on the UHCprovider.com website.

- UnitedHealthcare Community Plan does not prohibit or discourage a health professional from advocating on behalf of a member for appropriate medical treatment options. We do not prohibit a health professional from discussing healthcare treatments and services, regardless of coverage limitations, and quality assurance programs with a member. We do not prohibit a health professional from discussing financial arrangements between the provider and UnitedHealthcare Community Plan with a member.

- Make use of any member lists supplied by the health plan indicating which members appear to be due preventive health procedures or testing.

- Be sure to timely submit all accurately coded claims or encounters to help ensure member preventive health lists or the Primary Care Physician personal physician profile reports are as accurate as possible.

- Understand Primary Care Physician Profiling reports and use them to help determine what areas of practice may need to be strengthened as compared to peers. Profiles are already risk adjusted for the age, sex and patient health.

- For questions related to profiles, member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc., call the Provider Services line at 866-362-3368.

- Provide all EPSDT services to UnitedHealthcare Community Plan for Families/Kids members up to 21 years.

- In treating pregnant women, members may chose self-referral for vision services with a participating care provider. Members may self refer to a mental health professional. One mental health visit and one substance abuse visit with a participating provider per year for evaluation. Members may also receive diagnosis and treatment of TB by public health.

- Based on the results of the screening, refer member to appropriate specialist to manage behavioral health needs.

- Make recommendations to participating specialists for health problems not managed by the Primary Care Physician for each instance when such services are determined to be necessary for the member. The Primary Care Physician completes a prescription or a note on letterhead indicating the reason for the recommendation and assists the member in making an appointment. No formal referral form is required. The prescription note will suffice.

- Document the reason for a specialist recommendation and collaborate to help ensure that the outcome of the specialist intervention is documented in the members medical record.

- Coordinate each member’s overall course of care.

- Be available personally to accept UnitedHealthcare Community Plan members at each office location at least 16-hours-a-week.

- Be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating Primary Care Physician or an answering machine directing the member to a live voice.

- Respond to after-hour patient calls within 30 – 45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations.

- Educate members about appropriate use of emergency services.

- Discuss available treatment options and alternative courses of care with members.

- When discussing available options and alternative courses of care, you must provide members with enough information as necessary to assist the member in making an informed decision prior to any procedure or treatment.

- Refer services requiring prior authorization to the Prior Authorization Department, Behavioral Health Unit, or Pharmacy as appropriate.

- Inform UnitedHealthcare Community Plan Case Management at 866-219-5159 of any member showing signs of End Stage Renal Disease.
Chapter 7: Physician Standards and Policies

- Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized.

- UnitedHealthcare Community Plan for Families requires C/THP screening for children and adolescents and UnitedHealthcare Community Plan for Families behavioral health screening by PCP for all members, as appropriate.

- Respect the Advance Directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.

- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan.

- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments.

- Transfer medical records upon request. Copies of members' medical records must be provided to members upon request at no charge.

- Allow timely access to UnitedHealthcare Community Plan member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.

- Medical record requirements include
  a. Separate medical record for each member.
  b. The record verifies that PCP coordinates and manages care.
  c. Medical record retention period of 6 years after date of service rendered to members and for a minor, 3 years after majority or 6 years after the date of the service, whichever is later.
  d. (Prenatal care only): centralized medical record for the provision of prenatal care and all other services.
  e. Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital.
  f. Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
  g. For non-covered services inform members prior to initializing service, that the service is not covered by the Plan, and state the cost of the service.

- UnitedHealthcare Community Plan does not require standing referrals to specialists. A note on a prescription pad will suffice.

Panel Roster

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

Assignment to PCP Panel Roster

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

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.

Care Provider Privileges
To help our members get access to appropriate care and to help minimize out-of-pocket costs, you must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services. This includes but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Responsibilities of Specialist Physicians
In addition to the requirements applicable to all physicians, the responsibilities of specialist physicians include:

- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by the member’s Primary Care Physician or who self-refer.
- Provide the Primary Care Physician copies of all medical information, reports, and discharge summaries resulting from the specialist’s care.
- Communicate in writing to the Primary Care Physician all findings and recommendations for continuing patient care and note them in the patient’s medical record.
- Make no recommendations to patients to other specialists without the approval of the Primary Care Physician.
- Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.
- For non-covered services, inform members prior to initialing service, that the service is not covered by the Plan, and state the cost of the service.

Specialist Referrals
Referrals to specialists are not required, except for out of network requests, which are handled on a case by case basis.

Specialists as Primary Care Physicians and/or Referral to a Specialty Care Center
If a member has a life-threatening or degenerative and disabling condition or disease that requires prolonged specialized care, the member’s specialist may also serve as the Primary Care Physician. In these cases, a medical director must approve a treatment plan, in consultation with the Primary Care Physician, the specialist, and the member (or the member’s designee). UnitedHealthcare Community Plan will approve only specialists who are participating in UnitedHealthcare Community Plan’s network, unless no qualified specialist can be identified in the UnitedHealthcare Community Plan network.

Medical Residents in Specialty Practice
Specialists may use medical residents in specialty care in all settings supervised by fully credentialed UnitedHealthcare Community Plan specialty attending physicians.

24 Hours, Seven Days a Week Coverage
Primary Care Physicians and obstetricians must be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating Primary Care Physician or obstetrician. If a care provider uses an answering machine, the message must direct the member to a live voice. A Medical Director or Physician Reviewer must approve coverage arrangements that vary from this requirement. Primary Care Physicians and obstetricians are expected to respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations. UnitedHealthcare Community Plan tracks and follows up on all instances of Primary Care Physician or obstetrician unavailability.

UnitedHealthcare Community Plan also conducts periodic access surveys to help ensure that all access and availability standards are met. Primary Care Physicians and obstetricians are required to participate in all activities related to these surveys.

Timeliness Standards for Appointment Scheduling
Physicians shall comply with the following appointment availability standards:

Emergency Care
Immediately upon the member’s presentation at a service delivery site.
Primary Care
Primary Care Physicians and care providers of primary care should arrange appointments for:

- Urgent care within 24 hours of request.
- Non-urgent “sick” visit within 48–72 hours of request, as clinically indicated.
- Routine, preventive care within four to six weeks of request.
- Initial office visit for newborns within two weeks of hospital discharge.
- Well child care within four weeks of request.
- Initial family planning visits within two weeks of request.
- Adult (>21 years) baseline and routine physicals within 12 weeks.

Walk-in Appointment Standards
UnitedHealthcare Community Plan monitors Primary Care Physician offices that operate by “walk-in” or “first come, first served” appointments for access and waiting times. The physician should identify the applicable hours and days for walk-in appointments.

Specialty Care
Specialists and specialty clinics should arrange appointments for:

- Urgent care within 24 hours of request.
- Non-urgent “sick” visit within 48–72 hours of request, as clinically indicated.
- Non-urgent care within four to six weeks of request.

Behavioral Health (Mental Health and Chemical Dependence)
Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others) immediately upon presentation.
- Urgent problems within 24 hours of member’s request.
- Non-urgent problems within two weeks of member’s request.
- Following an emergency room visit or hospitalization within five days, or as medically necessary.
- Assessments for the purpose of making recommendations regarding a recipient’s services (LDSS) within 10 days of member’s request.

Dental Care
Dental is covered for UnitedHealthcare Community Plan for Families/Kids in the five boroughs plus Suffolk and Nassau. Dental is also UnitedHealthcare Community Plan for Kids in Cayuga, Herkimer, Madison, Oneida, Onondaga and Oswego.

Dental care providers should arrange appointments for:

- Urgent care within 24 hours of request
- Elective or routine care within 28 days of request

Prenatal Care
Care providers of prenatal care should arrange appointments for the initial prenatal visit:

- First trimester – within three weeks of the member’s request
- Second trimester – within two weeks of the member’s request
- Third trimester – within one week of the member’s request

Presumptive Eligibility
Presumptive eligibility (PE) is a means of immediately providing Medicaid coverage for prenatal care services pending a full Medicaid eligibility determination. A trained Article 28 prenatal care provider (or other prenatal care provider approved by the State Department of Health) performs a preliminary assessment of the pregnant woman’s and spouse’s income, if she is married. Then, based upon guidelines established by the Department, the care provider determines if the woman is presumptively eligible for all ambulatory Medicaid services or a limited array of medical services. A pregnant woman does not need to provide documentation of income for the presumptive eligibility determination.

Once the PE screening checklist has been completed by the care provider, it must be sent to the local department of social services to authorize PE coverage. Medicaid pays care providers during the presumptive eligibility period for care provided to pregnant women.

If the pregnant woman and her spouse, if any, have combined income no greater than 100% of the federal poverty level, she is eligible for coverage of all ambulatory Medicaid services. When the income is above 100% but less than or equal to 200% of the federal poverty level, the pregnant woman is eligible for coverage of ambulatory prenatal care Medicaid services only. For the pregnant woman to continue her coverage past the period of presumptive eligibility, she must complete the Medicaid application.
process, submit required documentation and meet the eligibility requirements for ongoing Medicaid. The prenatal care provider organization will develop a relationship with the local department of social services and submit the pregnant woman’s PE screening checklist and Medicaid application within five business days.

Presumptive Medicaid eligibility begins on the date the prenatal care provider determines presumptive eligibility. This is usually the date of the pregnant woman’s first visit or the date services were first rendered to her. This is also the date of application for on-going Medicaid. Current care provider organizations designated to perform PE may continue to do so.

**Mandated Training for Presumptive Eligibility (PE) Care Providers**

Licensed Article 28 care providers of prenatal care services are mandated by the new law to make presumptive eligibility determinations for pregnant women. PE care providers will also provide full Medicaid application assistance and assist pregnant women in choosing a Medicaid managed care health plan. To perform PE determinations, the PE screener must complete online training, at the Center for Development of Human Services (CDHS) e-learning portal, which is available at bsc-cdhs.org. To help ensure compliance with the new law, the trainees must register for training at the e-learning portal. Upon completion of the PE training modules, the individual will be given a certificate of training completion. This certificate must be retained to show proof of meeting the training requirement to screen for PE. The department will monitor the extent to which Article 28 prenatal care providers have completed on line presumptive eligibility training. The Department encourages prenatal care providers who have not recently performed presumptive eligibility determinations for pregnant women to repeat the training modules.

*The law permits an Article 28 facility that provides prenatal care to pregnant women to apply to the Commissioner of Health for an exemption from this requirement on the basis of undue hardship.*

**Timeliness Standards for Notifying Members of Test Results**

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

**Allowable Office Waiting Times**

Members with appointments should not routinely be made to wait longer than one hour.

**Physician Office Standards**

UnitedHealthcare Community Plan requires a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
Medical Record Charting Standards

All participating UnitedHealthcare Community Plan physicians are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care and which includes a record that verifies that the PCP coordinates and manages care. As part of this process physicians are required to participate in UnitedHealthcare Community Plan’s annual quality review of medical records and meet the following requirements for medical record keeping. Medical records must be retained for six years after date of service rendered to member and for a minor, three years after majority or six years after the date of service, which ever is later.

Prenatal care only: Centralized medical record for the provision of prenatal care and all other services, medical records must be accessible to UnitedHealthcare Community Plan for UM and QA, and to NYSDOH, CMS and LDSS (UnitedHealthcare Community Plan for Families only).

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<th>Confidentiality</th>
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<td>• The office has a policy and procedure in place that addresses the confidentiality of the patient medical record.</td>
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<td>• Office staff receive initial and periodic training in maintaining the confidentiality of patient records.</td>
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<td>• Medical records are released only to the patient and/or entities as designated in accordance with HIPAA regulations.</td>
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<tr>
<td>• Medical records are stored in a manner that helps ensure patient confidentiality. Records are kept in a secure area which is only accessible to authorized personnel.</td>
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<tr>
<th>Organization</th>
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</thead>
<tbody>
<tr>
<td>• Medical records are filed in a manner in which they are easily retrievable.</td>
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<tr>
<td>• Medical records are readily available to the treating physician whenever the patient is seen at the site where they generally receive care.</td>
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<tr>
<td>• Medical records are sent promptly to specialty physicians upon patient request. For urgent issues, records are made available within 48 hours.</td>
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<tr>
<td>• There is a policy for medical record retention.</td>
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<tr>
<td>• The contents of medical records must be organized in such a manner that reports, problem lists, immunization records, etc. are easily retrievable and are located in the same area in each record.</td>
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</tr>
<tr>
<td>• There is one medical record per patient.</td>
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<tr>
<td>• Pages in the medical record are secure.</td>
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</tbody>
</table>
### Medical Record Documentation Standards

- The chart is legible.
- The chart contains at a minimum the following patient identifiers: name, sex, address, phone number and DOB.
- The patient name/ID number is located on each page of the medical record.
- Each entry is dated and signed by the treating practitioner(s).
- An initial history and physical is present.
- Documentation of the presence or absence of allergies or adverse reactions is clearly noted.
- Screenings for high risk behaviors such as drug, alcohol and tobacco use are present.
- Screening for behavioral health issues including depression.
- Documentation of the presence or absence of an executed Advanced Directive.
- An updated problem list includes medical and psychological conditions.
- A medication list includes current and past meds.
- Progress notes from each visit that document the reason for the visit, the physical findings, the diagnosis, and treatment plan.
- Documentation of need for follow-up visits.
- Documentation of member input and/or understanding of the treatment plan.
- Documentation that reflects compliance with EPSDT standards for all pediatric patients.
- Maintenance of a current immunization record for all pediatric patients.
- Tracking and referral for age appropriate preventive health screenings such as mammography, pap smears, colorectal screen and flu shots are noted.
- Appropriate use of lab testing (HBA1c, LDL, lead screen).
- Results of lab, X-ray, and other tests as ordered by the practitioner including indication of physician review.
- Notation of treating specialists (including behavioral health) as well as copies of consultant reports ordered by the practitioner.
- Continuity of care demonstrated by evidence of copies of Home Health Nursing reports, Hospital Discharge summaries, Emergency Room visits, and physical or other therapies as ordered by the practitioner.
- Use of Clinical Practice Guidelines or flowsheets for the management of chronic conditions (diabetes, asthma, etc.).
- Mechanism for tracking and management of no shows.
Screening and Documentation Tools

Medical record inserts and screening tools are in the Forms and Guidelines section and online at UHCprovider.com. Most of these tools were developed by UnitedHealthcare Community Plan with assistance from the Medical Advisory Committee to help you comply with regulatory requirements and practice in accordance with accepted standards.

Ambulatory Medical

Record Review
On an annual basis, UnitedHealthcare Community Plan will conduct a review of the medical records you maintain for our members. Medical records should include:

- Initial health assessment, including a baseline comprehensive medical history, should be completed in less than two visits, is to be documented and ongoing physical assessments documented on each subsequent visit.

Problem list, includes the following documented data:

- Biographical data, including family history.
- Past and present medical and surgical intervention.
- Significant illnesses and medical conditions with dates of onset and resolution.
- Documentation of education/counseling regarding HIV pre- and post-test, including results.
- Entries dated and the author identified.
- Legible entries.
- Medication allergies and adverse reactions are prominently noted. Also note if no known allergies or adverse reactions.
- Past medical history is easily identified and includes serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years or younger), past history relates to prenatal care, birth, operations and childhood illnesses.
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record.
- Document tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of Advance Directive, or other document as allowed by state law, or a notation that patient does not want one.
- History of physical examination (including subjective and objective findings).
- Unresolved problems from previous visit(s) addressed in subsequent visits.
- Diagnosis and treatment plans consistent with findings.
- Lab and other studies as appropriate.
- Patient education, counseling and/or coordination of care with other physicians or health care professionals.
- Notation regarding the date of return visit or other needed follow-up care for each encounter.
- Consultations, lab, imaging and special studies initialed by primary physician to indicate review.
- Consultation and abnormal studies including follow-up plans.

Patient hospitalization records should include, as appropriate:

- History and physical,
- Consultation notes,
- Operative notes,
- Discharge summary,
- Other appropriate clinical information,
- Documentation of appropriate preventive screening and services,
- Documentation of mental health assessment (CAGE, TWEAK).
## Medical Record Documentation Standards Audit Tool

**Provider Name:**

**Provider ID#:**

**Provider Specialty:**

**Reviewer Name:**

**Review Date:**

**Score:**

**Member Name/Initials:**

**Member ID#:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the office have a policy regarding medical record confidentiality?</td>
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<tr>
<td>2. Has staff been trained in medical record confidentiality?</td>
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<td>3. Is there a Release of Information form in use requiring patient signature?</td>
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<td>4. Is there a policy for medical record retention?</td>
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<td>5. Are medical records stored in an organized fashion for easy retrieval?</td>
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<td>6. Is there a policy in place for timely transfer of medical records to other locations/physicians?</td>
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<td>7. Are records stored in a secure location only accessible by authorized personnel?</td>
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<td>8. Is there a policy for monitoring and addressing missed appointments?</td>
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<td>9. Is there one medical record per patient?</td>
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<td>10. Is the chart legible?</td>
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<tr>
<td>11. Is the medical record kept in an organized fashion?</td>
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<td>12. Are pages secure in the record?</td>
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<td>13. Is there patient biographical/demographic information in the chart?</td>
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<td>14. Do all pages of the record contain the patient name or ID#?</td>
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<td>15. Are all entries dated?</td>
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<td>16. Are all practitioner entries signed?</td>
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<td>17. Is there an H&amp;P in the chart?</td>
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<td>18. Are the presence/absence of allergies or adverse reactions clearly displayed?</td>
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<td>19. Is there screening of high risk behaviors-drug, alcohol and tobacco use?</td>
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<td>20. Is there screening for behavioral health issues including depression?</td>
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<td>21. Is there documentation of presence/absence of an Advanced Directive?</td>
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<td>22. Is there an updated Problem List?</td>
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<td>23. Is there an updated Medication List?</td>
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<td>24. Do notes document patient complaint, physical findings, diagnosis and Rx plan?</td>
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<td>25. Is there a time for a return visit or follow-up plan noted?</td>
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<td>26. Are there clinical tools or flow sheets for patients with chronic conditions?</td>
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<td>27. Do pediatric charts reflect compliance with EPSDT standards?</td>
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<td>28. Is there an updated immunization record in all pediatric charts?</td>
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<td>29. Is there documentation of preventive services-paps, mams, CR screens, flu shots?</td>
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<td>30. Are labs ordered as appropriate?</td>
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<td>31. Do lab and other reports reflect physician review?</td>
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<td>32. Is there evidence of continuity of care between Primary Care Physician, behavioral health and specialty physicians?</td>
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<td>33. Is continuity of care shown through hospital/ER D/C summaries, home health reports, PT reports, etc.?</td>
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</tbody>
</table>

If a physician scores less than 85%, review an additional 5 charts. Only review those elements that the physician 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 will be recalculated as all Yes in the initial scoring. If upon secondary review, a data element scores below 85% the original calculation of that element will remain.
Please answer the following questions.

1. Have you ever felt you should cut down on your drinking or drug use?
   _____ Yes   _____ No

2. Have people annoyed you by criticizing your drinking or drug use?
   _____ Yes   _____ No

3. Have you ever felt bad or guilty about your drinking or drug use?
   _____ Yes   _____ No

4. **Eye opener:** Have you ever had a drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover?
   _____ Yes   _____ No

*(Two positive responses are considered a positive test and indicate further assessment is warranted).*
# Depression Appraisal

The following appraisal asks questions about symptoms of depression. You can use this appraisal to decide if it would be helpful to discuss your mood with a behavioral health professional or with your doctor.

This appraisal is not intended to provide you with a diagnosis. A diagnosis for this condition may be made only after being evaluated by a behavioral health provider. Consider contacting a behavioral health provider if your answers to the appraisal indicate the possibility that you have a problem with depression, or if you have questions or concerns related to depression.

<table>
<thead>
<tr>
<th>Over the last two weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all (0 pts)</th>
<th>Several of the days (1 pt)</th>
<th>More than half the days (2 pt)</th>
<th>Nearly every day (3 pt)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things.</td>
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<tr>
<td>Feeling down, depressed or hopeless.</td>
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<tr>
<td>Trouble falling or staying asleep, or sleeping too much.</td>
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<tr>
<td>Feeling tired or having little energy.</td>
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<tr>
<td>Poor appetite or overeating.</td>
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<tr>
<td>Feeling bad about yourself – or that you are a failure or have let yourself or your family down.</td>
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<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television.</td>
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<tr>
<td>Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.</td>
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<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way.</td>
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<tr>
<td>If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</td>
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</tbody>
</table>
Score your appraisal as follows:

<table>
<thead>
<tr>
<th>For every question that you answered...</th>
<th>Add to your total score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Not at all” or “Not at all difficult”</td>
<td>0 points</td>
</tr>
<tr>
<td>“Several of the days” or “Somewhat difficult”</td>
<td>1 point</td>
</tr>
<tr>
<td>“More than half the days” or “Very difficult”</td>
<td>2 points</td>
</tr>
<tr>
<td>“Nearly every day” or “Extremely difficult”</td>
<td>3 points</td>
</tr>
</tbody>
</table>

Total Score | Results
---|---
0 | It appears from your score that you don’t think you have a problem with depression. If you begin to feel you might have depression, take this appraisal again.
1-4 | Minimal Depression – Your responses indicate a possibility that you have minimal depression and should consider getting an evaluation.
5-9 | Mild Depression – Your responses indicate a possibility that you have mild depression and should consider getting an evaluation.
10-14 | Moderate Depression – Your responses indicate a possibility that you have moderate depression and should consider getting an evaluation.
15-19 | Moderately Severe Depression – Your responses indicate a possibility that you have moderately severe depression and should consider getting an evaluation.
20+ | Severe Depression – Your responses indicate a possibility that you have severe depression and should consider getting an evaluation.

This appraisal is not a substitute for a professional evaluation – and is not intended to be a self-diagnosis. Only a professional can make a diagnosis. If you have concerns about your mood after answering these questions please talk to your doctor or contact Optum and we can arrange for a professional consultation.

How to Get Help

We’re available 24 hours a day, 7 days a week to help you arrange for a behavioral health consultation with one of our network clinicians. Please call 800-801-9627 and we will be happy to assist you.

When you contact us we will ask you a few questions that allow us to verify your insurance coverage. If you are experiencing an urgent problem, you will be immediately connected with one of our professional care advocates who will help you get to the care you need.

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

You may also call us if you have any questions about our prevention program or our services. Again, simply call 800-801-9627 and we will be happy to answer your questions or arrange for you to see a clinician.
ADHD Appraisal

All children have problems paying attention and controlling their behavior, but for some children, these problems negatively affect some areas of their life, like their performance at school or interaction with friends. A child with ADHD may have problems in either one or both of these areas.

- Paying attention
- Controlling either hyperactive or impulsive behavior

Use the questions in this appraisal to help you decide if your child needs further evaluation.

<table>
<thead>
<tr>
<th>Attention Problems</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>My Child Oftens...</td>
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<td></td>
</tr>
<tr>
<td>1. …makes careless mistakes on his schoolwork</td>
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<tr>
<td>2. …has trouble paying attention to instructions and/or concentrating on daily activities</td>
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<td>3. …does not seem to listen</td>
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<td>4. …does not finish tasks such as chores and homework</td>
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<tr>
<td>5. …has difficulty organizing activities</td>
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<td>6. …avoids tasks that require focused and sustained attention such as homework</td>
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<td>7. …loses things such as school supplies</td>
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<tr>
<td>8. …is distracted by noises and forgetful</td>
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</table>

<table>
<thead>
<tr>
<th>Problems With Behavior – Hyperactivity and Impulsivity</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>My Child Oftens...</td>
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<tr>
<td>1. …has problems sitting still – he/she seems to be constantly fidgeting and squirming</td>
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<td>2. …leaves their seat in school when he/she is not supposed to</td>
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<tr>
<td>3. …runs around and climbs on things</td>
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<tr>
<td>4. …has trouble playing quietly</td>
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<td>5. …seems to be “on the go”</td>
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<td>6. …talks too much for a given situation or blurts out answers when not called on</td>
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<tr>
<td>7. …has difficulty waiting for his or her turn in games</td>
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<tr>
<td>8. …interrupts others in conversations</td>
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If you would like us to arrange for a behavioral health consultation with one of our network clinicians please call the 800 number on your health insurance card that is listed for mental health and substance abuse benefits and we will be happy to help you.

When you contact us you will be asked a few questions that allow us to verify your insurance coverage. If you are experiencing an urgent problem you will be immediately connected with one of our professional care managers who will help you get to the care you need.

You may also call us if you have any questions about our prevention program or our services. Again, simply call the number on your card and we will be happy to answer your questions or arrange for you to see a clinician.
Alcohol Abuse and Dependence Self-Appraisal

The following appraisal asks questions about your use of alcohol. You can use this appraisal to decide if it would be helpful to discuss your alcohol use with a behavioral health professional or with your doctor. If you answer “yes” to even one of these questions it might be helpful for you to talk to a professional about your use of alcohol.

This self-appraisal is not a substitute for a professional evaluation – and is not intended to be a self-diagnosis. Only a professional can make a diagnosis. If you have concerns about your drinking after answering these questions please talk to your doctor or contact Optum and we can arrange for a professional consultation.

### Attention Problems

<table>
<thead>
<tr>
<th>My Child Often…</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Have you ever felt you should cut down on your drinking?</td>
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<tr>
<td>2. Have people annoyed you by criticizing your drinking?</td>
<td></td>
<td></td>
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<tr>
<td>3. Have you ever felt bad or guilty about your drinking?</td>
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<tr>
<td>4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?</td>
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</table>

If you would like us to arrange for a behavioral health consultant with one of our network clinicians please call the 800 number on your health insurance card that is listed for mental health and substance abuse benefits and we will be happy to help you.

When you contact us you will be asked a few questions that allow us to verify your insurance coverage. If you are experiencing an urgent problem you will be immediately connected with one of our professional care managers who will help you get to the care you need.

You may also call us if you have any questions about our prevention program or our services. Again, simply call the number on your card and we will be happy to answer your questions or arrange for you to see a clinician.
Chapter 7: Physician Standards and Policies

Advance Directives

The member has the right to make health care decisions and to execute advance directives. An Advance Directive is a formal document, written by the member in advance of an incapacitating illness or injury.

Depending on state law, there may be several types of advance directives available to a member. If completed, the member (or member’s designee) keeps the original. The physician should be aware of and maintain in the patient’s medical record a copy of the member’s completed directive or health care proxy. The physician should not send a copy to UnitedHealthcare Community Plan. Members are not required to initiate an Advance Directive or proxy and cannot be denied care if they do not have an Advance Directive. If a member believes that a physician has not complied with an Advance Directive, he or she may file a complaint with the UnitedHealthcare Community Plan Medical Director or Physician Reviewer.

Protect Confidentiality of Member Data

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

Member Services

Enrollment

Our team of marketing representatives coordinate with community-based organizations and care providers to educate potential members about UnitedHealthcare Community Plan. You are welcome to contribute to this process, but you must comply with the marketing rules set forth by the counties with which UnitedHealthcare Community Plan contracts. These rules include, but are not limited to: no cold-call telephoning, no door-to-door solicitation, mailings sent only at the request of the potential member, all materials and incentives must be pre-approved, and physicians or other health care professionals must tell their patients about all the managed care organizations with which they contract and must help individuals choose a plan best suited for them based on their individual needs.

Once a month, primary care physicians will receive a roster of UnitedHealthcare Community Plan for Families/Kids members who are under their care. UnitedHealthcare Community Plan for Families members if they participate for Medicare. Their UnitedHealthcare Community Plan for Kids enrollment will not exceed the member-to-physician ratios prescribed by the New York State Department of Health. If you need assistance in tracking your UnitedHealthcare Community Plan for Kids and member list(s), contact the Medical Professional Line.

Disenrollment

New York State supports a 12-month lock-in policy for UnitedHealthcare Community Plan for Families and members. These members can disenroll from UnitedHealthcare Community Plan for any reason in the first 90 days of enrollment. For the remainder of the year, they can only disenroll for good cause. A member wishing to disenroll should call the Member Services number at 800-493-4647 for information about who to contact to terminate his or her coverage.

(This information can also be found in the Member Handbook.)
Chapter 8: UnitedHealthcare Dual Advantage (Medicaid)

Program Description

UnitedHealthcare Dual Advantage offers an opportunity for Medicaid and Medicare dual eligibles, meeting eligibility criteria, on a voluntary basis, to enroll in UnitedHealthcare for most of their Medicare and Medicaid benefits. Through this plan, UnitedHealthcare provides dually eligible persons a uniform Medicare Advantage Product (UnitedHealthcare Dual Complete) and a supplemental Medicaid Advantage Product (UnitedHealthcare Dual Advantage). The UnitedHealthcare Community Plan for Families Product will cover benefits not covered by Medicare and beneficiary cost sharing (copays/deductibles, and premiums, if any) associated with the uniform UnitedHealthcare Community Plan for Families Benefit product. Some Medicaid services will continue to be available to UnitedHealthcare Dual Advantage members on a fee-for-service basis.

Program Effective Date: October 1, 2010

1. Who is eligible to enroll in UnitedHealthcare Dual Advantage?
   • Must have full Medicaid coverage.
   • Must have evidence of Medicare Part A and Part B coverage.
   • Must reside in the service area.
   • Must be enrolled in UnitedHealthcare Dual Complete.

2. What are the covered service areas for the UnitedHealthcare Dual Advantage Plan?

This plan is available for members who meet the above eligibility criteria and reside in one of the following counties: Bronx, Kings, Queens, New York, Richmond and Nassau.

3. How do I know who is eligible for the Medicaid Advantage Plan?

You should always check eligibility before providing services. Participants who are enrolled in UnitedHealthcare Dual Advantage will have an NYSDOH Medicaid identification card and UnitedHealthcare Dual Advantage identification card with a Group Number of 90150. Please remember that the card itself is not a guarantee of eligibility.

Below is a rendering of the UnitedHealthcare Dual Complete Identification Card.
You can request Medicaid eligibility and benefit plan information for participants using existing eligibility verification processes. To inquire about a patient’s eligibility to contact the Physician Hotline at 866-362-3368, 8:00 a.m. – 5:00 p.m. CST, or use the UnitedHealthcare Online Provider Portal at UHCprovider.com/eligibility.

Care providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare for Medicare and Medicaid benefits, will be able to take advantage of single-claim submission. Claims submitted to UnitedHealthcare for dual-enrolled members will process first against Medicare benefits under UnitedHealthcare Dual Complete, and then will automatically process against Medicaid benefits under the appropriate Medicaid benefits.

For electronic submission of claims, please access UnitedHealthcare Provider Portal at UHCprovider.com/claims and sign up for electronic claims submission. If you have questions about gaining access to UnitedHealthcare Provider Portal, choose the Provider Portal tab and follow the instructions to gain access.

Please mail your paper claims to:

UnitedHealthcare of New York
P.O. Box 5240
Kingston, NY 12402-5240

Services covered under the UnitedHealthcare Dual Advantage Plan are shown in the following table. You should file claims with UnitedHealthcare for rendering the services as described (e.g., those services which have an “X” in the UnitedHealthcare Dual Advantage box are to be billed to UnitedHealthcare).

The benefits outlined in this table, and found online at UHCprovider.com/eligibility, are available through the health plan.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Inpatient Hospital Care</td>
<td>Up to 365 days per year (366 days for leap year).</td>
</tr>
<tr>
<td>Inpatient Hospital Including Substance Abuse</td>
<td>Medically necessary care, including days in excess of the Medicare 190-day lifetime maximum.</td>
</tr>
<tr>
<td>and Rehabilitation Services</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Medicare covered care provided in a skilled nursing facility. Covered for 100 days each benefit period. No prior hospital stay required.</td>
</tr>
<tr>
<td>Home Health</td>
<td>Medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. Also includes non-Medicare covered home health services (e.g., home health aide services with nursing supervision to medically unstable individuals).</td>
</tr>
<tr>
<td>PCP Office Visits</td>
<td>Primary care doctor office visits.</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>Specialist office visits.</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Manual manipulation of the spine to correct subluxation provided by chiropractors or other qualified care providers.</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>Individual and group therapy visits. Member may self-refer for one assessment from a network care provider in a 12 month period.</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>Individual and group visits. Member may self-refer for one assessment from a network care provider in a 12 month period.</td>
</tr>
</tbody>
</table>
### Benefit Package for UnitedHealthcare Dual Advantage

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>Medically necessary visits to an ambulatory surgery center or outpatient hospital facility.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Transportation provided by an ambulance service, including air ambulance. Emergency transportation if for the purpose of obtaining hospital services for a member who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency services while the member is being transported. Includes transportation to a hospital emergency room generated by a “Dial 911”.</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Care provided in an emergency room subject to prudent layperson standard.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Care provided in an emergency room subject to prudent layperson standard.</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation (OT, PT, Speech)</strong></td>
<td>Occupational therapy, physical therapy and speech and language therapy.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>Medicare and Medicaid covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual’s use. Must be ordered by a qualified practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g. tub stool; grab bars).</td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td>Medicare and Medicaid covered prosthetics, orthotics and orthopedic footwear. No diabetic prerequisite for orthotics.</td>
</tr>
<tr>
<td><strong>Diabetes Monitoring</strong></td>
<td>Diabetes self-monitoring, management training and supplies, including coverage for glucose monitors, test strips, and lancets. OTC diabetic supplies such as 2x2 gauze pads, alcohol swabs/ pads, insulin syringes and needles are covered by Part D.</td>
</tr>
<tr>
<td><strong>Diagnostic Testing</strong></td>
<td>Diagnostic tests, X-rays, lab services and radiation therapy.</td>
</tr>
<tr>
<td><strong>Bone Mass Measurement</strong></td>
<td>Bone mass measurement for people at risk.</td>
</tr>
<tr>
<td><strong>Colorectal Screening</strong></td>
<td>Colorectal screening for people, age 50 and older.</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>Flu, Hepatitis B vaccine for people who are at risk, pneumonia vaccine.</td>
</tr>
<tr>
<td><strong>Mammograms</strong></td>
<td>Annual screening for women age 40 and older. No referral necessary.</td>
</tr>
<tr>
<td><strong>Pap Smear and Pelvic Exams</strong></td>
<td>Pap smears and pelvic exams for women.</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Depending on income and institutional status, member pays the following: For Part D generic drugs (including brand drugs treated as generic) either:</td>
</tr>
<tr>
<td></td>
<td>• A $0 copay</td>
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<td></td>
<td>• A $1.10 copay or</td>
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<td></td>
<td>• A $2.50 copay</td>
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<td></td>
<td>For all other Part D drugs, either:</td>
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<tr>
<td></td>
<td>• A $0 copay</td>
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<td></td>
<td>• A 3.30 copay, or</td>
</tr>
<tr>
<td></td>
<td>• A 6.30 copay</td>
</tr>
<tr>
<td><strong>Prostate Cancer Screening</strong></td>
<td>Prostate Cancer Screening exams for men age 50 and older.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Drugs</td>
<td>All Medicare Part B covered prescription drugs and other drugs obtained by a care provider and administered in a physician office or clinic setting covered by Medicaid.</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Medicare and Medicaid hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.</td>
</tr>
<tr>
<td>Vision Care Services</td>
<td>Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two years unless medically necessary or unless the glasses are lost, damaged or destroyed.</td>
</tr>
<tr>
<td>Routine Physical Exam 1/year</td>
<td>Up to one routine physical per year.</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Medically necessary private duty nursing services in accordance with the ordering physician, registered physician assistant or certified nurse practitioner’s written treatment plan.</td>
</tr>
<tr>
<td>Medicare Part D Prescription Drug Benefit as Approved by CMS</td>
<td>Member responsible for copays.</td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>Dual Advantage members receive 24 one way car service trips per year through the Medicare portion of their plan. After the 24 visits have been exceeded, the transportation benefit is provided through the Medicaid portion of their plan. New York City members receive round trip MetroCards for their visits. Car service and ambulette service is based on medical necessity and will require the completion of a Patient Transportation Restriction (PTR) Form by their physician. Nassau County members. Members request transportation by calling 800-514-4912.</td>
</tr>
<tr>
<td>Dental</td>
<td>Medicaid covered dental services including necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.</td>
</tr>
</tbody>
</table>

5. Are there any services covered by NYSDOH Medicaid on a Fee-for-Service basis?

Yes, patients will obtain some services from NYSDOH Medicaid.

It is the expectation that a care provider will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any UnitedHealthcare Dual Advantage member who is eligible for both Medicare and Medicaid, or his or her representative, or the UnitedHealthcare Dual Advantage organization for Medicare Part A and B cost sharing (e.g., copays, deductibles, coinsurance) when the state is responsible for paying such amounts.

The care provider will either: (a) accept payment made by or on behalf of the UnitedHealthcare Dual Advantage organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

Medicaid covered services shown on the table below should be billed directly to Medicaid (e.g., services for which there is an “X” in the NYSDOH Medicaid box should be billed to NYS Medicaid).
Chapter 8: UnitedHealthcare Dual Advantage (Medicaid)

<table>
<thead>
<tr>
<th>Services Covered by Medicaid Fee-for-Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network Family Planning services provided under the direct access provisions of the waiver</td>
<td>Out-of-network family planning services provided by qualified Medicaid care providers to plan members will be directly reimbursed by Medicaid fee-for-service at the Medicaid fee schedule. “Family Planning and Reproductive Health Services” means those health services which enable members, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancy. These include: diagnosis and all medically necessary treatment, sterilization, screening and treatment for sexually transmissible diseases and screening for disease and pregnancy. Also included are HIV counseling and testing when provided as part of a family planning visit. Additionally, reproductive health care includes coverage of all medically necessary abortions. Elective induced abortions must be covered for New York City recipients. Fertility services are not covered.</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) days not covered by Medicare</td>
<td>Skilled nursing facility days for Medicaid Advantage members in excess of the first one hundred (100) days in the benefit period are covered by Medicaid on a fee for service basis.</td>
</tr>
</tbody>
</table>

The Benefits in the table below, and found online by clicking [this link](#), are available with Medicaid fee-for-service identification.

<table>
<thead>
<tr>
<th>Benefit Package for UnitedHealthcare Dual Advantage</th>
<th>Description</th>
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<tbody>
<tr>
<td>Personal Care Services</td>
<td>Personal care services (PCS) involve the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the member's health and safety in his or her own home. The services must be ordered by a physician, and there has to be a medical need for the services. Licensed home care services agencies, as opposed to certified home health agencies, are the primary care providers of PCS. Members receiving PCS must have a stable medical condition and are generally expected to be in receipt of such services for an extended period of time (years). Services rendered by a personal care agency which are approved by the LDSS are not covered under the Medicare or Medicaid benefit packages. Should it be medically necessary for the PCP to order personal care agency services, the PCP (or UnitedHealthcare on the physician’s behalf) must first contact the member’s LDSS contact person for personal care. The district will determine the member’s need for personal care agency services and coordinate a plan of care with the personal care agency.</td>
</tr>
<tr>
<td>Medicaid Pharmacy Benefits allowed by State Law (select drug categories excluded from the Medicare Part D benefit and certain medications included in the Part D benefit when the member is unable to receive them from his/her Medicare Advantage Plan), also certain Medical Supplies and Enteral Formula when not covered by Medicare</td>
<td>NYS Medicaid continues to provide coverage for categories of drugs excluded from the Medicare Part D benefit such as barbiturates, benzodiazepines, and some prescription vitamins, and some non-prescription drugs. NYS also provides a wrap around program which covers medications that are included in the Part D benefit when the recipient is unable to receive them from his or her Part D plan.</td>
</tr>
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</table>
### Benefit Package for UnitedHealthcare Dual Advantage

<table>
<thead>
<tr>
<th>Benefit</th>
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</thead>
<tbody>
<tr>
<td>Methadone Maintenance Treatment Programs (MMTP)</td>
<td>MMTP consists of drug detoxification, drug dependence counseling, and rehabilitation services which include chemical management of the patient with methadone. Facilities authorized to provide methadone maintenance treatment certified by the Office of Alcohol and Substance Abuse Services (OASAS) under Part 828 of 14 NYCRR.</td>
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<table>
<thead>
<tr>
<th>Benefit</th>
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<tbody>
<tr>
<td>a. Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)</td>
<td>IPRT is a time-limited active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments and to intervene with psychiatric rehabilitative technologies to overcome functional disabilities. IPRT services are certified by OMH under Part 587 of 14 NYCRR.</td>
</tr>
<tr>
<td>b. Day Treatment</td>
<td>Day Treatment is a combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. These services are certified by OMH under Part 587 of 14 NYCRR.</td>
</tr>
<tr>
<td>c. Continuing Day Treatment</td>
<td>Continuing Day Treatment is designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. It includes: assessment and treatment planning, discharge planning, medication therapy, medication education, case management, health screening and referral, rehabilitative readiness development, psychiatric rehabilitative readiness determination and referral, and symptom management. These services are certified by OMH under Part 587 of 14 NYCRR.</td>
</tr>
<tr>
<td>d. Case Management for Seriously and Persistently Mentally Ill Sponsored by State or Local Mental Health Units</td>
<td>The target population consists of individuals who are seriously and persistently mentally ill (SPMI), require intensive, personal and proactive intervention to help them obtain those services which will permit functioning in the community and either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system. Three case management models are currently operated pursuant to an agreement with OMH or a local governmental unit, and receive Medicaid reimbursement pursuant to Part 506 of 14 NYCRR.</td>
</tr>
<tr>
<td>e. Partial Hospitalization Not Covered by Medicare</td>
<td>Provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient hospitalization, or reduces the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral and crisis intervention. These services are certified by OMH under Part 587 of 14 NYCRR.</td>
</tr>
</tbody>
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**Please note:** See generic definition of Comprehensive Medicaid Case Management (CMCM) in this section.
## Chapter 8: UnitedHealthcare Dual Advantage (Medicaid)

### Benefit Package for UnitedHealthcare Dual Advantage

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
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<tbody>
<tr>
<td>Certain Mental Health Services (Continued)</td>
<td></td>
</tr>
<tr>
<td>f. Assertive Community Treatment (ACT)</td>
<td>ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting. ACT programs deliver integrated services to recipients and adjust services over time to meet the recipient’s goals and changing needs. They are operated pursuant to approval or certification by OMH; and receive Medicaid reimbursement pursuant to Part 508 of 14 NYCRR.</td>
</tr>
<tr>
<td>g. Personalized Recovery Oriented Services (PROS)</td>
<td>PROS, licensed and reimbursed pursuant to Part 512 of 14 NYCRR, are designed to assist individuals in recovery from the disabling effects of mental illness through the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations. Specific components of PROS include Community Rehabilitation and Support, Intensive Rehabilitation, Ongoing Rehabilitation and Support and Clinical Treatment.</td>
</tr>
<tr>
<td>Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs</td>
<td></td>
</tr>
<tr>
<td>a. OMH Licensed CRs</td>
<td>Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior defects associated with a person’s mental illness.</td>
</tr>
<tr>
<td>b. Family-Based Treatment</td>
<td>Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the family, community, school or independent living situations. Such services are provided in consideration of a child’s developmental stage. Children determined eligible for admission are placed in surrogate family homes for care and treatment. These services are certified by OMH under Section 586.3, and Parts 594 and 595 of 14 NYCRR.</td>
</tr>
<tr>
<td>Office of Mental Retardation and Developmental Disabilities (OMRDD) Services</td>
<td></td>
</tr>
<tr>
<td>a. Long Term Therapy Services Provided by Article 16-Clinic Treatment Facilities or Article 28 Facilities</td>
<td>These services are provided to persons with developmental disabilities including medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. It also includes the fitting, training, and modification of assistive devices by licensed practitioners or trained others under their direct supervision. Such services are designed to ameliorate or limit the disabling condition and to allow the person to remain in or move to, the least restrictive residential and/or day setting. These services are certified by OMRDD under Part 679 of 14 NYCRR (or they are provided by Article 28 Diagnostic and Treatment Centers that are explicitly designated by the SDOH as serving primarily persons with developmental disabilities). If care of this nature is provided in facilities other than Article 28 or Article 16 centers, it is a covered service.</td>
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### Benefit Package for UnitedHealthcare Dual Advantage

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<tr>
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</thead>
<tbody>
<tr>
<td><strong>Office of Mental Retardation and Developmental Disabilities (OMRDD) Services</strong> (Continued)</td>
<td></td>
</tr>
<tr>
<td><strong>b. Day Treatment</strong></td>
<td>A planned combination of diagnostic, treatment and rehabilitation services provided to developmentally disabled individuals in need of a broad range of services, but who do not need intensive twenty-four (24) hour care and medical supervision. The services provided as identified in the comprehensive assessment may include nutrition, recreation, self-care, independent living, therapies, nursing, and transportation services. These services are generally provided in an Intermediate Care Facility (ICF) or a comparable setting. These services are certified by OMRDD under Part 690 of 14 NYCRR.</td>
</tr>
<tr>
<td><strong>c. Medicaid Service Coordination (MSC)</strong></td>
<td>Medicaid Service Coordination (MSC) is a Medicaid state plan service provided by OMRDD which assists persons with developmental disabilities and mental retardation to gain access to necessary services and supports appropriate to the needs of the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning process in developing, implementing and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities and mental retardation. MSC promotes the concepts of a choice, individualized services and consumer satisfaction. MSC is provided by authorized vendors who have a contract with OMRDD, and who are paid monthly pursuant to such contract. Persons who receive MSC must not permanently reside in an ICF for persons with developmental disabilities, a developmental center, a skilled nursing facility or any other hospital or Medical Assistance institutional setting that provides service coordination. They must also not concurrently be enrolled in any other comprehensive Medicaid long term service coordination program/service, including the Care at Home Waiver. Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) in this section.</td>
</tr>
<tr>
<td><strong>d. Home And Community Based Services Waivers (HCBS)</strong></td>
<td>The Home and Community-Based Services Waiver serves persons with developmental disabilities who would otherwise be admitted to an ICF/MR if waiver services were not provided. HCBS waivers services include residential habilitation, day habilitation, prevocational, supported work, respite, adaptive devices, consolidated supports and services, environmental modifications, family education and training, live-in caregiver, and plan of care support services. These services are authorized pursuant to a waiver under Section 1915(c) of the Social Security Act (SSA).</td>
</tr>
<tr>
<td><strong>e. Services Provided Through the Care At Home Program (OMRDD)</strong></td>
<td>The OMRDD Care at Home III, Care at Home IV, and Care at Home VI waivers, serve children who would otherwise not be eligible for Medicaid because of their parents’ income and resources, and who would otherwise be eligible for an ICF/MR level of care. Care at Home waiver services include service coordination, respite and assistive technologies. Care at Home waiver services are authorized pursuant to a waiver under Section 1915(c) of the (SSA).</td>
</tr>
</tbody>
</table>
### Benefit Package for UnitedHealthcare Dual Advantage

<table>
<thead>
<tr>
<th>Benefit</th>
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</thead>
<tbody>
<tr>
<td>Comprehensive Medicaid Case Management</td>
<td>A program which provides “social work” case management referral services to a targeted population (e.g., teens, mentally ill). A CMCM case manager will assist a client in accessing necessary services in accordance with goals contained in a written case management plan. CMCM programs do not provide services directly, but refer to a wide range of service care providers. The nature of these services include: medical, social, psycho-social, education, employment, financial, and mental health. CMCM referral to community service agencies and/or medical care providers requires the case manager to work out a mutually agreeable case coordination approach with the agency/medical care providers. Consequently, if a member of the Contractor is participating in a CMCM program, the Contractor should work collaboratively with the CMCM case manager to coordinate the provision of services covered by the Contractor. CMCM programs will be instructed on how to identify a managed care member on eMedNY so that the program can contact the Contractor or to coordinate service provision.</td>
</tr>
<tr>
<td>Directly Observed Therapy for Tuberculosis Disease</td>
<td>Tuberculosis directly observed therapy (TB/DOT) is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician’s prescribed medication regimen. While the clinical management of tuberculosis is covered in the Benefit Package, TB/DOT where applicable, can be billed directly to MMIS by any SDOH approved fee-for-service Medicaid TB/DOT care provider. The contractor remains responsible for communicating, cooperating and coordinating clinical management of TB with the TB/DOT care provider.</td>
</tr>
<tr>
<td>AIDS Adult Day Health Care</td>
<td>Adult Day Health Care Programs (ADHCP) are programs designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services. Registrants in ADHCP require a greater range of comprehensive health care services than can be provided in any single setting, but do not require the level of services provided in a residential health care setting. Regulations require that a person enrolled in an ADHCP must require at least three hours of health care delivered on the basis of at least one visit per week. While health care services are broadly defined in this setting to include general medical care, nursing care, medication management, nutritional services, rehabilitative services, and substance abuse and mental health services, the latter two cannot be the sole reason for admission to the program. Admission criteria must include, at a minimum, the need for general medical care and nursing services.</td>
</tr>
<tr>
<td>HIV COBRA Case Management</td>
<td>The HIV COBRA (Community Follow-up Program) Case Management Program is a program that provides intensive, family-centered case management and community follow-up activities by case managers, case management technicians, and community follow-up workers. Reimbursement is through an hourly rate billable to Medicaid. Reimbursable activities include intake, assessment, reassessment, service plan development and implementation, monitoring, advocacy, crisis intervention, exit planning, and case specific supervisory case-review conferencing.</td>
</tr>
<tr>
<td>Adult Day Health Care</td>
<td>Adult Day Health Care means care and services provided to a registrant in a residential health care facility or approved extension site under the medical direction of a physician and which is provided by personnel of the adult day health care program in accordance with a comprehensive assessment of care needs and an individualized health care plan, and providing ongoing implementation and coordination of the health care plan, and transportation. Registrant means a person who is a nonresident of the residential health care facility, who is functionally impaired and not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services provided by a general hospital, or residential health care facility; and whose assessed social and health care needs, in the professional judgment of the physician of record, nursing staff, Social Services and other professional personnel of the adult day health care program can be met satisfactorily in whole or in part by delivery of appropriate services in such program.</td>
</tr>
<tr>
<td>Personal Emergency Response Services (PERS)</td>
<td>Personal Emergency Response Services (PERS) are not covered by the Benefit Package. PERS are covered on a fee-for-service basis through contracts between the LDSS and PERS vendors.</td>
</tr>
</tbody>
</table>
6. What about the patient’s plan premium or copay amounts?
UnitedHealthcare Dual Advantage will cover all Part C member cost sharing, encompassing all deductibles, copays and coinsurance amounts, as well as any subscriber premium. Members are responsible for copays associated with Medicare Part D prescription drug benefit.

It is the expectation that a care provider will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any UnitedHealthcare Dual Advantage member who is eligible for both Medicare and Medicaid, or his or her representative, or the UnitedHealthcare Dual Advantage organization for Medicare Part A and B cost sharing (e.g., copays, deductibles, coinsurance) when the state is responsible for paying such amounts. The care provider will either:

a. accept payment made by or on behalf of the UnitedHealthcare Dual Advantage organization as payment in full; or
b. bill the appropriate state source for such cost sharing amount.

7. Who do I contact for additional information?
Should you require additional information or have questions, please call the Physician Hotline at 866-0362-3368, 8:00 a.m. – 5:00 p.m. CST.

New Regulatory Requirements

NYSDOH Chapter 237 of the Laws of 2009
Chapter 237 of the Laws of 2009 was enacted July 2009 and amended current statues relating to claims processing; credentialing procedures; utilization review and external appeal procedures; and specific requirements when modifying reimbursement arrangements in care provider contracts. The following is a summary of the impact of this legislation.

Adverse Reimbursement Change – Effective January 1, 2010, UnitedHealthcare health care professionals began receiving written notice from the health plan at least 90 days prior to an adverse reimbursement change to the care provider’s contract. If a care provider objects to the change that is the subject of the notice by UnitedHealthcare, the care provider may, within thirty days of the date of notice, give written notice to the health plan to terminate the contract effective upon the implementation of the adverse reimbursement change. An adverse reimbursement change is one that “could reasonably be expected to have an adverse impact on the aggregate level of payment to a health care professional.” A health care professional under this section is one who is licensed, registered or certified under Title 8 of the New York Education Law.

Claims Processing Timeframes – Effective January 1, 2010, claims submitted electronically must be paid within 30 days and paper or facsimile claim submissions must be paid within 45 days. The 30 day timeframe for requesting additional information or for denying the claim was not changed.

Coordination of Benefits – Effective January 1, 2010, UnitedHealthcare started denying claims, in whole or in part, on the basis that it is coordinating benefits and the member has other insurance, unless the health plan has a “reasonable basis” to believe that the member has other health insurance coverage that is primary for the claimed benefit. In addition, if UnitedHealthcare requests information from the member regarding other coverage, and does not receive the information within 45 days; the health plan will adjudicate the claim. However, the claim will not be denied on the basis of non-receipt of information about other coverage.

Timeframe for Care Provider Claims Submission – Effective for dates of service on or after April 1, 2010, care providers must initially submit claims within 120 days after the date of the service to be valid, unless a timeframe more favorable to the care provider was agreed to by the care provider and UnitedHealthcare, or a different timeframe is required by law. The right to reconsideration will not apply to a claim submitted 365 days after the service and in such cases UnitedHealthcare may deny the claim in full.

Overpayment Recovery – Effective January 1, 2010, the health plan must provide health care professionals or care providers with an opportunity to challenge the overpayment recovery.
Claims From a Participating Hospital Association With a Non-Participating Health Care Provider Claim; and Claims From a Participating Health Care Provider Associated With a Non-Participating Hospital Claim – Starting January 1, 2010, UnitedHealthcare is prohibited from treating a claim from a network hospital as out-of-network solely on the basis that a non-participating health care provider treated the member. Likewise, claim from a participating health care provider cannot be treated as out-of-network solely because the hospital is non-participating with UnitedHealthcare.

Credentialing – A newly licensed health care professional or health care professional relocating from another state, who is joining a group practice of in-network providers, can be considered a “provisionally” credentialed provider on the 91st day after submission of a complete application to UnitedHealthcare, if the health plan does not approve or decline the application within 90 days. During the provisional period the health care professional is considered an in-network care provider for the provision of covered services to members, but may not act as a primary care provider. If the application is ultimately denied, the care provider reverts back to non-participating status. The group practice wishing to include the newly licenses or relocated health care professional must agree to refund any payments made by UnitedHealthcare for in-network services delivered by the provisionally credentialed care provider that exceed any out-of-network benefits. In addition, the care provider group must agree to hold the member harmless for payment of any services denied during the provisional period except for collection of copayments that would have been payable had the member received services from an in-network care provider. This stipulation became effective on October 1, 2009. UnitedHealthcare is actively working to help ensure that the appropriate procedures are in place to comply with this requirement.

Health Care Provider External Appeal Rights (effective January 2010) – Public Health Law §4914 was recently amended to extend external appeal rights to care providers in connection with concurrent adverse determinations. Payment for an external appeal at PHL 4914 was amended to include a health care provider’s responsibility if filing an external appeal of a concurrent adverse determination. A care provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of the Managed Care Organization (MCO); an MCO is responsible for the full cost of an appeal that is overturned; and the care provider and MCO must evenly divide the cost of a concurrent adverse determination that is overturned in-part. The fee requirements do not apply to care providers who are acting as the member’s designee, in which case the cost of the external appeal is the responsibility of the MCO. For the care provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal and the designation. The Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the care provider to file an appeal. A care provider responding within the timeframe will be subject to the external appeal payment provisions described above. If the care provider is unresponsive, the appeal is rejected.

Alternative Dispute Resolution – A facility licensed under Article 28 of the Public Health Law (PHL) and the MCO may agree to alternative dispute resolution (ADR) in lieu of an external appeal under PHL §4906 (2). This provision does not impact a member’s external appeal rights or right of the member to establish the care provider as their designee and if applicable will be communicated in the notice with an initial adverse determination.

New Section of PHL Holds the Member Harmless – Public Health Law was amended to add a new section §4917. A care provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member’s designee, is prohibited from seeking payment, except applicable copays from a member for services determined not medically necessary by an external appeal agent.

Alternative Dispute Resolution – A facility licensed under Article 28 of the Public Health Law and the health plan may agree to alternative dispute resolution (ADR) in lieu of an external appeal. This provision does not impact a member’s external appeal rights or right of the member to establish the care provider as their designee.

Hold Harmless – A care provider requesting an external appeal if a concurrent adverse determination, including a care provider requesting the external appeal as the member’s designee, is prohibited from seeking payment, except applicable copays, from a member for services determined not medically necessary by the external appeal agent.

External Appeal Rare Disease Treatment (Effective January 2010) – As a result of PHL 49 being amended, the right to appeal a rare disease treatment determination is now allowed through an external appeal. The definitions of rare disease treatment is found at PHL §4900(7-g); and the established external appeal right for a final adverse determination involving a rare disease treatment was added to Section 4910. Notices
of final adverse determinations issued by the health plan include the revised standard description and application for Home Health Care Determinations Following An Inpatient Admission (Effective January 2010) – Subdivision 3 of PHL §4903 was amended to change the timeframe for utilization review determinations of home health care (HHC) services following an inpatient hospital admission. The Managed Care Organization (MCO) must provide notice of its determination within one business day of receipt of the necessary information or, if the day after the request for services falls on a weekend or holiday within 72 hours or receipt of necessary information. However, if a request for home health care services and all necessary information is provided to the MCO prior to a member’s inpatient hospital discharge, an MCO cannot deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the UR determination is pending. There may however, be other reasons for denying the service such as exhaustion of a benefit. An appeal of a denial for home health services following a discharge from a hospital admission must be treated as an expedited appeal under PHL §4904(2). For the purposes of the PHL section, the term inpatient hospital admission is limited to services provided to a member in a general hospital that provides inpatient care. This may include inpatient services in an Article 28 rehabilitation facility.

Chapter 238 Law of New York, 2010
AN ACT to amend the education law and the insurance law, in relation to the definition of the practice of midwifery became a law July 30, 2010, with the approval of the Governor.

The People of the State of New York, Represented in Senate and Assembly, do Enact as Follows:

Section 1. Subdivisions 1 and 2 of section 6951 of the education law, subdivision 1 as amended by chapter 328 of the laws of 1992 and subdivision 2 as added by chapter 327 of the laws of 1992, are amended to read as follows:

The practice of the profession of midwifery is defined as the management of normal pregnancies, child birth and post-partum care as well as primary preventive reproductive health care of essentially healthy women, and still include newborn evaluation, resuscitation and referral for infants. A midwife will have collaborative relationships with (i) a licensed physician who is board certified as an obstetrician-gynecologists by a national certifying body or (ii) a licensed physician who practices obstetrics and has obstetric privileges at a general hospital licensed under article twenty-eight of the public health law or (iii) a hospital, licensed under articles twenty-eight of the public health law, that provides obstetrics through a licensed physician having obstetrical privileges as such institution, that provide for consultation, collaborative management and referral to address the health status and risks for his or her patients and that include plans for emergency medical gynecological and/ or obstetrical coverage. A midwife will maintain documentation of such collaborative relationships and will make information about such collaborative relationships available to his or her patients. Failure to comply with the requirements found in this subdivision will be subject to professional misconduct provisions as set forth in article one hundred thirty of this title. 2. A licensed midwife will have the authority, as necessary, and limited to the practice of midwifery, to prescribe and administer drugs, immunizing agents, diagnostic tests and devices, and to order laboratory tests, as established by the board in accordance with the commissioner’s regulations. A midwife will obtain a certificate from the department upon successfully completing a program including a pharmacology component, or its equivalent, as established by the commissioner’s regulations prior to prescribing under this section.

§ 2. Item (i) of subparagraph (A) of paragraph 10 of subsection (i) of section 3216 of the insurance law, as amended by chapter 495 of the laws of 1998, as amended to read as follows: (i) Every policy which provides hospital, surgical or medical coverage will provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided for illness or disease under the policy. Such maternity care coverage, other than coverage for perinatal complications, will include inpatient hospital coverage for mother and for newborn for at least forty-eight hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours after a caesarean section. Such coverage for maternity care will include the services of a midwife licensed pursuant to article 140 of the education law, practicing consistent with section 6951 of the education law and affiliated or practicing in conjunction with a facility licensed pursuant to article 28 of the public health law, but no insurer will be required to pay for duplicative routine services actually provided by both a licensed midwife and a physician.

§ 3. Item (i) of subparagraph (A) of paragraph 5 of subsection (k) of section 3221 of the insurance law, as amended by chapter 495 of the laws of 1998, is amended to read as follows: (i) Every group or blanket policy delivered or issued for delivery in this state which provides hospital, surgical or medical coverage will include coverage for maternity care, including hospital, surgical or medical care to the same extent that such coverage is provided for illness or disease under the
policy. Such maternity care coverage, other than coverage for perinatal complications, will include inpatient hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours after a caesarean section. Such coverage for maternity care will include the services for a midwife licensed pursuant to article 140 of the education law, practicing consistent with section 6951 of the education law and affiliated or practicing in conjunction with a facility licensed pursuant to article 28 of the public health law, but no insurer will be required to pay for duplicative routine services actually provided by both a licensed midwife and a physician.

§ 4. Subparagraph (A) of paragraph 1 of subsection (c) of section 4303 of the insurance law, as amended by chapter 495 of the laws of 1998, is amended to read as follows: (A) Every contract issued by a corporation subject to the provisions of this article which provides hospital services, medical expense indemnity or both will provide coverage for maternity care including hospital, surgical or medical care to the same extent that hospital service, medical expense indemnity or both are provided for illness or disease under the contract. Such maternity care coverage, other than coverage for perinatal complications, will include inpatient hospital coverage for mother and for newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours following a caesarean section. Such coverage for maternity care will include the services of a midwife licensed pursuant to article 140 of the education law, practicing consistent with section 6951 of the education law and affiliated or practicing in conjunction with a facility licensed pursuant to article 28 of the public health law, but no insurer will be required to pay for duplicative routine services actually provided by both a licensed midwife and a physician.

§ 5. This act will take effect on the 19th day after it will have become a law.
Chapter 9: Medicare (Dual Complete) Introduction

Welcome

Welcome to UnitedHealthcare of New York Dual Complete. We recognize that quality care providers are the key to delivering quality health care to members. To better assist you, UnitedHealthcare Dual Complete has provided this manual as a resource to answer questions regarding care for enrolled members. Our goal is to assist you in helping ensure our members receive the highest quality health care. This care provider manual explains the policies and procedures of the UnitedHealthcare Dual Complete network. We hope it provides you and your office staff with helpful information and guide you in making the best decisions for your patients.

Background

UnitedHealthcare Dual Complete is a Medicare Advantage Special Needs Plan, serving members who are dually eligible for Medicare and Medicaid within the UnitedHealthcare Dual Complete Service Area. Members of the Dual Complete must be eligible and enrolled in Medicare Part A, Medicare Part B, and New York Medicaid.

UnitedHealthcare Dual Complete is currently available in the Kings, Queens, Nassau, Richmond, New York and Bronx counties.

Contacting UnitedHealthcare Dual Complete

UnitedHealthcare Dual Complete manages a comprehensive care provider network of independent practitioners and facilities across New York. The network includes health care professionals such as primary care physicians, specialist physicians, medical facilities, allied health professionals, and ancillary service providers.

UnitedHealthcare offers several options to support care providers who require assistance.

Provider Service Center

This is the primary point of contact for care providers who require assistance. The Provider Service Center is staffed with Provider Service Representatives trained specifically for UnitedHealthcare Dual Complete. The Provider Service Center can assist you with questions on benefits, eligibility, claims resolution, forms required to report specific services, billing questions, etc. They can be reached at 866-362-3368 24 hours per day, seven days per week to meet your needs. The Provider Service Center works closely with all departments in UnitedHealthcare Dual Complete.

Provider Services: 866-362-3368

UnitedHealthcare Provider Portal

The web-based provider portal offers the convenience of online support 24 hours a day, seven days a week. The site was developed specifically with you in mind allowing for personal support. On the provider portal, you can verify member eligibility, check claim status, submit claims, request an adjustment, review a remittance advice, or review a member roster. To access the provider portal, go to UHCprovider.com > Link. Follow the instructions for obtaining a user ID. You will receive your user ID and password within 48 hours.

Provider Central Service Unit (PCSU)

The PCSU provides assistance for all contracted UnitedHealthcare Dual Complete care providers to resolve escalated issues, including complex and large volume issues involving UnitedHealthcare Dual Complete claims. A PCSU representative tracks each issue until agreement that it is resolved, even if it is referred to an outside expert or adjuster for resolution. When calling the PCSU, you should be prepared to provide the representative a detailed explanation of specific issues and what was expected under the terms of the contract. To contact the PCSU, call 800-718-5360.

MediFAX (Emdeon)

MediFax is an integrated healthcare information system who provides transcription services. Primary Care Physicians that subscribe can log on to MediFax to determine the eligibility of Medicaid members at emdeon.com (Click on Business Services tab). You can also call 800-533-6869.

Dual Complete Roster

Primary Care Physicians (PCPs) are given a roster of all assigned members. PCPs should use this to determine if they are responsible for providing primary care to a particular member. Rosters can be viewed electronically on UnitedHealthcare Provider Portal (UHCprovider.com > Link).
**Chapter 9: Medicare (Dual Complete) Introduction**

**The UnitedHealthcare Dual Complete Network**

UnitedHealthcare Dual Complete maintains and monitors a network of participating care providers including physicians, hospitals, skilled nursing facilities, ancillary providers and other health care providers through which members obtain covered services.

UnitedHealthcare Dual Complete members must choose a PCP to coordinate their care. PCPs are the basis of the managed care philosophy. UnitedHealthcare Dual Complete works with contracted PCPs who manage the health care needs of members and arrange for medically necessary covered medical services. Care providers may, at any time, advocate on behalf of the member without restriction to help ensure the best care possible for the member. To help ensure coordination of care, members must coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women’s routine preventive health services, routine dental, routine vision, and behavioral health. Contracted health care professionals are required to coordinate member care within the UnitedHealthcare Dual Complete provider network. If possible, all member referrals should be directed to UnitedHealthcare Dual Complete contracted care providers. Referrals outside of the network are permitted, but only with prior authorization from UnitedHealthcare Dual Complete.

The referral and prior authorization procedures explained in this manual are particularly important to the UnitedHealthcare Dual Complete program. Understanding and adhering to these procedures are essential for successful participation as an UnitedHealthcare Dual Complete provider.

Occasionally UnitedHealthcare Dual Complete distributes communication documents on administrative issues and general information of interest regarding UnitedHealthcare Dual Complete to you and your office staff. It is very important that you and/or your office staff read the newsletters and other special mailings and retain them with this care provider manual, so you can incorporate the changes into your practice.

**Participating Care Providers**

**Primary Care Physicians**

UnitedHealthcare Dual Complete contracts with certain physicians/care providers that members may choose to coordinate their health care needs. These physicians/care providers are known as PCPs. With the exception of member self-referral covered services (Chapter 2) the PCP is responsible for providing or authorizing Covered Services for members of UnitedHealthcare Dual Complete. PCP’s are generally physicians of Internal Medicine, Pediatrics, Family Practice or General Practice. However, they may also be other provider types, who accept and assume primary care provider roles and responsibilities. All members must select a PCP when they enroll in UnitedHealthcare Dual Complete and may change their designated PCP once a month.

**Specialists**

A specialist is any licensed participating care provider (as defined by Medicare) who provides specialty medical services to members. A PCP may refer a member to a specialist as medically necessary.

**Demographic Updates**

When you submit demographic updates, list only those addresses where a member may make an appointment and see the care provider. On-call and substitute care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

**UnitedHealthcare Dual Complete (HMO SNP)**

For additional information regarding UnitedHealthcare Dual Complete, please see the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products at UHCprovider.com/guides > UnitedHealthcare Administrative Guide.
### Quick Reference Guide

<table>
<thead>
<tr>
<th>Resource</th>
<th>Uses</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Provider Portal</td>
<td>Verify member eligibility, check claim status, submit claims, request adjustment, review remits, review member rosters.</td>
<td>UHCCommunityPlan.com</td>
</tr>
<tr>
<td>Provider Service Center</td>
<td>Operates 8 a.m. - 5 p.m. weekdays eligibility, claim inquiries, benefit questions, form requests.</td>
<td>866-362-3368</td>
</tr>
<tr>
<td>Provider Central Service Unit (PCSU)</td>
<td>Escalated claim issues not resolved (PCSU) through Provider Service.</td>
<td>800-718-5360</td>
</tr>
<tr>
<td>Language Interpretation Line</td>
<td></td>
<td>866-362-3368</td>
</tr>
<tr>
<td>Admission Notification</td>
<td></td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Prior Authorization-Medical</td>
<td></td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Member Transportation</td>
<td>Prior auth handles facility-to-facility and hospital discharge to home transport. Medicare only covers 24 one-way car service trips per year which is coordinated by LogistiCare. Once the 24 one-way trips have been utilized, the member is eligible for transportation through their FFS Medicaid benefits. They call HRA or DSS to arrange.</td>
<td>866-326-3368</td>
</tr>
<tr>
<td>Prior Authorization-Pharmacy</td>
<td></td>
<td>800-711-4555</td>
</tr>
<tr>
<td>Prior Authorization Behavioral Health</td>
<td>New York City Adults can call Optum at 866-604-3267. The rest of the state should call 888-291-2506.</td>
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<tr>
<td>UnitedHealthcare Dental</td>
<td>Dental Care Providers</td>
<td>800-304-0634</td>
</tr>
<tr>
<td>March Vision Care</td>
<td>Vision Care Providers</td>
<td>888-493-4070</td>
</tr>
</tbody>
</table>
Chapter 10: Medicare (Dual Complete) Covered Services

Covered Benefits

The Evidence of Coverage included below list those services covered by UnitedHealthcare Dual Complete. Member benefit coverage information can also be found online at UHCprovider.com/eligibility. Coverage includes Medicare Part A and Part B benefits, as well as additional benefits offered as part of the UnitedHealthcare Dual Complete plan. Covered services must be provided by or arranged by the member’s PCP. Some services must be prior authorized by UnitedHealthcare Dual Complete. The Evidence of Coverage can also be found on the UHCCommunityPlan.com website.

Inpatient Services

<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital Care</strong></td>
<td>Members pay an initial deductible of $0 for services received at a network hospital.</td>
</tr>
<tr>
<td></td>
<td>There is no copayment for Inpatient Hospital services received at a network hospital.</td>
</tr>
<tr>
<td></td>
<td>Except in an emergency, their care provider must obtain authorization from UnitedHealthcare Dual Complete. If a member receives inpatient care at a non-plan hospital after their emergency condition is stabilized, their cost is the cost sharing they would pay at a plan hospital.</td>
</tr>
<tr>
<td>Members are covered for 90 days each benefit period.</td>
<td></td>
</tr>
<tr>
<td>Covered services include, but are not limited to, the following:</td>
<td></td>
</tr>
<tr>
<td>• Semiprivate room (or a private room if medically necessary).</td>
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<tr>
<td>• Meals including special diets.</td>
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<tr>
<td>• Regular nursing services.</td>
<td></td>
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<tr>
<td>• Costs of special care units (such as intensive or coronary care units).</td>
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<tr>
<td>• Drugs and medications.</td>
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<tr>
<td>• Lab tests.</td>
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<tr>
<td>• X-rays and other radiology services.</td>
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</tr>
<tr>
<td>• Necessary surgical and medical supplies.</td>
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<tr>
<td>• Use of appliances, such as wheelchairs.</td>
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</tr>
<tr>
<td>• Operating and recovery room costs.</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, occupational therapy, and speech therapy.</td>
<td></td>
</tr>
<tr>
<td>• Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral.</td>
<td></td>
</tr>
<tr>
<td>• Blood – including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that members need - members pay for the first three pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. Coverage of storage and administration begins with the first pint of blood that members need.</td>
<td></td>
</tr>
<tr>
<td>• Physician Services.</td>
<td></td>
</tr>
</tbody>
</table>
### Benefits chart – Members covered services

<table>
<thead>
<tr>
<th>Inpatient Mental Health Care</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes mental health care services that require a hospital stay.</td>
<td>Members pay one initial deductible of $0 for services received at a network hospital.</td>
</tr>
<tr>
<td>Members are covered for 90 days each benefit period.</td>
<td>There is no copayment for services received at a network hospital.</td>
</tr>
<tr>
<td>Medicare beneficiaries may only receive 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</td>
<td>Except in an emergency, their care provider must obtain authorization from UnitedHealthcare Dual Complete. Failure to get authorization can result in significantly higher costs to them. Contact UnitedHealthcare Dual Complete for details.</td>
</tr>
<tr>
<td>Prior Authorization required.</td>
<td>Members pay:</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td>• $0 each day for days 1-20</td>
</tr>
<tr>
<td>Members are covered for 100 days each benefit period.</td>
<td>• $0 each day for days 21-100</td>
</tr>
<tr>
<td>Covered services include, but are not limited to, the following:</td>
<td>No prior hospital stay is required.</td>
</tr>
<tr>
<td>• Semiprivate room (or a private room if medically necessary).</td>
<td></td>
</tr>
<tr>
<td>• Meals, including special diets.</td>
<td></td>
</tr>
<tr>
<td>• Regular nursing services.</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, occupational therapy, and speech therapy.</td>
<td></td>
</tr>
<tr>
<td>• Drugs (this includes substances that are naturally present in the body, such as blood clotting factors).</td>
<td></td>
</tr>
<tr>
<td>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that members need - members pay for the first three pints of unreplaced blood. All other components of blood are covered beginning with the first pint used</td>
<td></td>
</tr>
<tr>
<td>• Medical and surgical supplies.</td>
<td></td>
</tr>
<tr>
<td>• Laboratory tests.</td>
<td></td>
</tr>
<tr>
<td>• X-rays and other radiology services.</td>
<td></td>
</tr>
<tr>
<td>• Use of appliances such as wheelchairs.</td>
<td></td>
</tr>
<tr>
<td>• Physician services.</td>
<td></td>
</tr>
<tr>
<td>Prior authorization required.</td>
<td></td>
</tr>
</tbody>
</table>
## Benefits chart – Members covered services

<table>
<thead>
<tr>
<th>Inpatient Services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(When the hospital or SNF days are not or are no longer covered)</td>
<td>Members pay 20% of the cost of each Medicare-covered visit.</td>
</tr>
<tr>
<td>• Physician services.</td>
<td></td>
</tr>
<tr>
<td>• Tests (like X-ray or lab tests).</td>
<td></td>
</tr>
<tr>
<td>• X-ray, radium, and isotope therapy including technician materials and services.</td>
<td></td>
</tr>
<tr>
<td>• Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.</td>
<td></td>
</tr>
<tr>
<td>• Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.</td>
<td></td>
</tr>
<tr>
<td>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, speech therapy, and occupational therapy.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agency Care:</td>
<td>Members pay $0 for each Medicare-covered home health visit.</td>
</tr>
<tr>
<td>• Part-time or intermittent skilled nursing and home health aide services.</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, occupational therapy, and speech therapy.</td>
<td></td>
</tr>
<tr>
<td>• Medical social services.</td>
<td></td>
</tr>
<tr>
<td>• Medical equipment and supplies.</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization required.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospice care provides non-curative medical and support services for members certified by a physician to be terminally ill with a life expectancy of one (1) year or less. Hospice may be provided in your home or in an inpatient setting.</td>
<td>Services require prior authorization. Members responsibility will vary based on the service approved.</td>
</tr>
<tr>
<td>• Hospice programs provide patients and their families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses experienced during the final stages of illness, and during dying and bereavement.</td>
<td></td>
</tr>
<tr>
<td>• For children under age twenty-one (21) who are receiving hospice services, medically necessary curative services are covered, in addition to palliative care.</td>
<td></td>
</tr>
</tbody>
</table>
### Outpatient Services

<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
</table>
| **Physician Services, Including Doctor Office Visits**  
  - Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center.  
  - Consultation, diagnosis, and treatment by a specialist.  
  - Second opinion by another plan care provider prior to surgery.  
  - Outpatient hospital services.  
  - Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor).  
  - Routine Physical Exams.  
  
  Members pay $0 for each primary care doctor office visit for Medicare-covered services.  
  Members pay $0 for each specialist visit for Medicare-covered services. | |
| **Chiropractic Services**  
  - Manual manipulation of the spine to correct subluxation.  
  
  Members pay $0 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). | |
| **Podiatry Services**  
  - Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).  
  - Routine foot care for members with certain medical conditions affecting the lower limbs.  
  - Up to four visits per year.  
  
  Members pay $0 of the cost for each Medicare covered visit (medically necessary foot care).  
  Members pay $0 for each routine visit. | |
| **Outpatient Mental Health Care (Including Partial Hospitalization Services)**  
  Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.  
  Prior Authorization required for partial hospitalization and mental health testing.  
  
  For Medicare-covered Mental Health services, members pay $0 for each individual/group therapy visit. | |
| **Outpatient Substance Abuse Services**  
  Prior authorization required.  
  
  For Medicare-covered services, members pay $0 for each individual/group visit.  
  Except in emergency, their care provider must obtain authorization from UnitedHealthcare Dual Complete. |
### Chapter 10: Medicare (Dual Complete) Covered Services

<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
</table>
| **Outpatient Surgery**                   | Members pay $0 for each Medicare-covered visit to an ambulatory surgical center.  
                                           | Members pay $0 for each Medicare-covered visit to an outpatient hospital facility. |
| Prior authorization is required for some outpatient surgeries. |                                           |
| **Ambulance Services**                   | Members pay $0 for Medicare-covered ambulance services.  
                                           | Authorization rules may apply for services. Contact plan for details. |
| Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to their home, and services dispatched through 911, where other means of transportation could endanger their health. |                                           |
| **Emergency Care**                       | Members pay $0 for each Medicare-covered emergency room visit; they do not pay this amount if they are admitted to the hospital within 24 hour(s) for the same condition.  
                                           | If a member receives inpatient care at a non-plan hospital after their emergency condition is stabilized, their cost is the cost sharing they would pay at a plan hospital. |
| These copayments or coinsurances may be paid by the state of New York once member becomes eligible for Medicaid. |                                           |
| World-wide coverage.                     |                                           |
| **Urgently Needed Care**                 | Members pay $0 for each Medicare-covered urgently needed care visit. |
| World-wide coverage.                     |                                           |
| **Outpatient Rehabilitation Services**   | Members pay $0 for each Medicare-covered Occupational Therapy visit.  
                                           | Members pay $0 for each Medicare-covered Physical therapy and/or Speech/Language Therapy visit. |
| (Physical Therapy, Occupational Therapy, Cardiac Rehabilitation, and Speech and Language Therapy) |                                           |
| Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris. |                                           |
| **Durable Medical Equipment and Related Supplies** | Members pay $0 of the cost for each Medicare-covered item. |
| Such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. |                                           |
| Prior Authorization required.             |                                           |
### Benefits chart – Members covered services

<table>
<thead>
<tr>
<th>Prosthetic Devices and Related Supplies</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” below for more detail. Prior Authorization required.</td>
<td>Members pay $0 for each Medicare-covered item.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes Self-Monitoring, Training and Supplies</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all people who have diabetes (insulin an non-insulin users).</td>
<td>Members pay $0 for Medicare-covered Diabetes self-monitoring training.</td>
</tr>
<tr>
<td>- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors.</td>
<td>Members pay $0 for the cost for each Medicare-covered Diabetes Supply item.</td>
</tr>
<tr>
<td>- One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts.</td>
<td></td>
</tr>
<tr>
<td>Self-management training is covered under certain conditions. For persons at risk of diabetes: Fasting plasma glucose tests are covered as follows:</td>
<td></td>
</tr>
<tr>
<td>- For individuals diagnosed with pre-diabetes: two screening tests per calendar year.</td>
<td></td>
</tr>
<tr>
<td>- For individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested and one screening test per year.</td>
<td></td>
</tr>
<tr>
<td>- Insulin (injectable) is covered.</td>
<td></td>
</tr>
</tbody>
</table>

### Medical Nutrition Therapy

Nutrition education for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor. Members pay $0 of the cost for Medicare-covered medical nutrition therapy.
Benefits chart – Members covered services

### Outpatient Diagnostic Tests and Therapeutic Services and Supplies

- X-rays.
- Outpatient Radiation therapy.
- Surgical supplies, such as dressings.
- Supplies, such as splints and casts.
- Laboratory tests.
- Blood - Coverage begins with the fourth pint of blood that members need – members pay for the first three pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that members need.

What members must pay when they get these covered services

Members pay:
- $0 for each Medicare-covered clinical/diagnostic lab service.
- $0 for each Medicare-covered radiation therapy service.
- $0 for each Medicare-covered x-ray visit.

### Preventive Care and Screening Tests

**Bone Mass Measurements**

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every two years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.

What members must pay when they get these covered services

Members pay $0 for each Medicare-covered Bone Mass Measurements.

**Colorectal Screening**

For people 50 and older, the following are covered:
- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.
- Fecal occult blood test, every 12 months.

For people at high risk of colorectal cancer, the following are covered:
- Screening colonoscopy (or screening barium enema as an alternative) every 24 months.

For people not at high risk of colorectal cancer, the following is covered:
- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.

What members must pay when they get these covered services

Members pay $0 for each Medicare-covered Colorectal Screening Exam.
<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
</table>
| **Immunizations**                        | Members pay $0 for Medicare-covered Pneumonia or Flu vaccines.  
                                            | Members pay $0 for Medicare-covered Hepatitis B vaccines.  
                                            | No referral necessary for Medicare-covered influenza and pneumonia vaccines. |
| • Pneumonia vaccine (members can get this service on their own, without a referral from their PCP as long as they get the service from a plan care provider).  
  • Flu shots, once a year in the fall or winter. Members can get this service on their own, without a referral from their PCP (as long as they get the service from a plan care provider).  
  • If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine.  
  • Other vaccines, if you are at risk. |  
| **Mammography Screening**                | Members pay $0 for each Medicare-covered Mammography Screening.  
                                            | No referral necessary for Medicare-covered screenings. |
| (Members can get this service on their own, without a referral from their PCP as long as they get it from a plan care provider):  
  • One baseline exam between the ages of 35 and 39.  
  • One screening every 12 months for women age 40 and older. |  
| **Pap Smears, Pelvic Exams, and Clinical Breast Exams** | Members pay:  
  • $0 for each Medicare-covered pap smears.  
  • $0 for each Medicare-covered pelvic exams |  
| Members can get these routine women’s health services on their own, without a referral from their PCP as long as they get the services from a plan care provider:  
  • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months.  
  • If members are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months. |  
| **Prostate Cancer Screening Exams**      | Members pay $0 for each Medicare-covered Prostate Cancer Screening Exams. |
| For men age 50 and older, the following are covered once every 12 months:  
  • Digital rectal exam.  
  • Prostate Specific Antigen (PSA) test. |  
| **Cardiovascular Disease Testing**       | Members pay $0 of Medicare-covered cardiovascular screening blood tests. |
| Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Contact UnitedHealthcare Dual Complete Helpline for information on how often we will cover these tests. |  

## Benefits chart – Members covered services

### Physical Exams

For members whose Medicare Part B coverage begins on or after January 1, 2005: A one-time physical exam within the first six months that they have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests. Members are covered for up to one routine physical exam per year.

<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Exams</strong></td>
<td>Members pay $0 for each Medicare covered services.</td>
</tr>
<tr>
<td></td>
<td>Members pay $0 for each exam.</td>
</tr>
</tbody>
</table>

### Other Services

#### Renal Dialysis (Kidney)

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area).
- Inpatient dialysis treatments (if you are admitted to a hospital for special care).
- Self-dialysis training (includes training for members and others for the person helping them with their home dialysis treatments).
- Home dialysis equipment and supplies.

Certain home support services (such as, when necessary, visits by trained dialysis workers to check on their home dialysis, to help in emergencies, and check their dialysis equipment and water supply).

<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Renal Dialysis (Kidney)</strong></td>
<td>Members pay $0 of the cost of Medicare-covered outpatient dialysis treatments.</td>
</tr>
<tr>
<td></td>
<td>Members do not pay coinsurance for inpatient dialysis treatment.</td>
</tr>
<tr>
<td></td>
<td>Members pay $0 of the cost of Medicare-covered home dialysis equipment and supplies.</td>
</tr>
</tbody>
</table>
## Prescription Drugs

That are covered under Original Medicare (Part B) (these drugs are covered for everyone with Medicare). “Drugs” includes substances that are naturally present in the body, such as blood clotting factors.

- Drugs that usually are not self-administered by the patient and are injected while receiving physician services.
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by UnitedHealthcare Dual Complete.
- Clotting factors members give themselves by injection if they have hemophilia.
- Immunosuppressive drugs, if they have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if members are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.
- Other outpatient prescription drugs, such as insulin.

Prescription drugs that are covered if members are enrolled in UnitedHealthcare Dual Complete because they have enrolled for Medicare Prescription Drug coverage.

<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>Depending upon their income level, members pay the $0 deductible. For the initial coverage, depending upon members income level, they pay the lesser of $0 to $2.65 per prescription (including brand drugs treated as generic) and $0 to $6.60 per prescription for all other drugs. For catastrophic coverage, $0 copay.</td>
</tr>
</tbody>
</table>
### Additional Benefits

<table>
<thead>
<tr>
<th>Benefits chart – Members covered services</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Services</strong></td>
<td>• In general, members pay 100% for preventive dental services.</td>
</tr>
<tr>
<td></td>
<td>• Plan offers additional comprehensive dental benefits.</td>
</tr>
<tr>
<td></td>
<td>• $2,500 plan coverage limit for comprehensive dental benefits every year.</td>
</tr>
<tr>
<td></td>
<td>• Member pays $0 for three units of fixed bridgework per year.</td>
</tr>
<tr>
<td></td>
<td>• Member pays $0 for the first $500 per unit of implants, for the first two implants per year.</td>
</tr>
</tbody>
</table>

- Services by a dentist are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. Dental covers Fixed Bridgework, Implants and Bleaching. Comprehensive dental services have a $2,500 calendar year maximum.

- In general, members pay 100% for preventive dental services.
- Plan offers additional comprehensive dental benefits.
- $2,500 plan coverage limit for comprehensive dental benefits every year.
- Member pays $0 for three units of fixed bridgework per year.
- Member pays $0 for the first $500 per unit of implants, for the first two implants per year.

<table>
<thead>
<tr>
<th><strong>Hearing Services</strong></th>
<th>Members pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnostic hearing exams.</td>
<td>• $0 copay for each Medicare-covered hearing exam (diagnostic hearing exams).</td>
</tr>
<tr>
<td>• Routine hearing exams.</td>
<td>• $0 copay for each routine hearing test up to one test per year.</td>
</tr>
<tr>
<td>• Hearing aid fitting and evaluation.</td>
<td>• $0 copay for each fitting-evaluation every year.</td>
</tr>
<tr>
<td>• Hearing aids covered up to $750 every 2 years.</td>
<td>• $0 copay for each hearing aid every two years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Vision Care</strong></th>
<th>Members pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient physician services for eye care.</td>
<td>• $0 copay for Medicare-covered eye wear.</td>
</tr>
<tr>
<td>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.</td>
<td>• $0 copay for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</td>
</tr>
<tr>
<td>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</td>
<td>• $0 copay for each routine eye exam.</td>
</tr>
<tr>
<td>• One routine eye exam per calendar year.</td>
<td>• $0 copay for contacts.</td>
</tr>
<tr>
<td>• One pair of glasses, contacts or lenses per calendar year.</td>
<td>• $0 copay for lenses.</td>
</tr>
<tr>
<td>• One pair of frames per two years.</td>
<td>• $0 copay for frames.</td>
</tr>
<tr>
<td>• Members are covered up to $150 for eye wear every two years.</td>
<td>• $0 copay for frames.</td>
</tr>
</tbody>
</table>
### Benefits chart – Members covered services

<table>
<thead>
<tr>
<th>Health and Wellness Education Programs</th>
<th>What members must pay when they get these covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members are covered for the following:</td>
<td>There are no copayments or coinsurances for these services when obtained through UnitedHealthcare Dual Complete Plan.</td>
</tr>
<tr>
<td>• Health Ed Classes</td>
<td></td>
</tr>
<tr>
<td>• Newsletter</td>
<td></td>
</tr>
<tr>
<td>• Nutritional Training</td>
<td></td>
</tr>
<tr>
<td>• Smoking Cessation</td>
<td></td>
</tr>
<tr>
<td>• Congestive Heart Program</td>
<td></td>
</tr>
<tr>
<td>• Disease Management</td>
<td></td>
</tr>
<tr>
<td>• Other Wellness Services</td>
<td></td>
</tr>
<tr>
<td>Contact Member Services for details.</td>
<td></td>
</tr>
</tbody>
</table>

No coinsurance, copayment or deductible for the following:

- Abdominal Aortic Aneurysm Screening.
- Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
- Cardiovascular Screening.
- Cervical and Vaginal Cancer Screening. Covered once every two years. Covered once a year for women with Medicare at high risk.
- Colorectal Cancer Screening.
- Diabetes Screening.
- Influenza Vaccine.
- Hepatitis B Vaccine for people with Medicare who are at risk.
- HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor’s visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to 3 times during a pregnancy.

Members who are enrolled in UnitedHealthcare Dual Complete may also be covered by New York’s Medicaid benefits. Members should be referred to their Medicaid Member Handbook for further details on Medicaid benefits. Members who are enrolled in another Medicaid plan must coordinate their benefits with that plan.

### Prior Authorization

The presence or absence of a procedure or service on the list does not define whether or not coverage or benefits exist for that procedure or service. A facility or practitioner must contact UnitedHealthcare Dual Complete for prior authorization. Requests for Prior Authorization are to be directed to the UnitedHealthcare Dual Complete Prior Authorization Department at 866-604-3267.

### Referral Guidelines

PCP’s are generally responsible for initiating and coordinating referrals of members for medically necessary services beyond the scope of their practice. PCP’s are to monitor the progress of referred members’ care and see that members are returned to the PCP’s care as soon as possible.
All referrals require the completion of a referral form with the following exceptions:

- Contracted Vision care providers
- Contracted Dental care providers
- Contracted Radiologists
- Female members who self refer for their well-woman exam

Elective referrals are to be written on the same UnitedHealthcare referral form that you use for UnitedHealthcare Medicaid members. Referrals must be written to contracted care providers. If a contracted care provider is not available, a referral to a non-contracted provider may be requested but UnitedHealthcare must authorize the referral.

The PCP is to complete, date, and sign (a signature stamp is acceptable) the referral form. Forward a copy of the referral form to the contracted specialist. Referrals are limited to an initial consultation and up to two follow-up visits. Follow-up visits must be completed within 180 calendar days from the date the referral is signed and dated.

Referrals for hematology/oncology, radiation oncology, gynecology oncology, allergy, orthopedic services, and nephrology are valid for unlimited visits within the 180 day timeframe.

Emergency and Urgent Care

Definitions

“Emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a care provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Members with an emergency medical condition should be instructed to go to the nearest emergency care provider. Members who need urgent (but not Emergency) care are advised to call their PCP, if possible, prior to obtaining urgently needed services. However, prior authorization is not required.

Urgently needed services are covered services that are not emergency services provided when:

- The member is temporarily absent from the UnitedHealthcare Dual Complete Service Area, and
- When such services are Medically Necessary and immediately required 1) as a result of an unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through an UnitedHealthcare Dual Complete network provider.

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area, but UnitedHealthcare Dual Complete’s provider network is temporarily unavailable or inaccessible.

Out-of-Area Renal Dialysis Services

A member may obtain medically necessary dialysis services from any qualified care provider the member selects when they are temporarily absent from UnitedHealthcare Dual Complete’s service area and cannot reasonably access UnitedHealthcare Dual Complete dialysis care providers. No prior authorization or notification is required. However, a member may voluntarily advise UnitedHealthcare Dual Complete if they are temporarily out of the service area. UnitedHealthcare Dual Complete may provide medical advice and recommend that the member use a qualified dialysis care provider.

Direct Access Services

Members may access Behavioral Health services without a referral from their PCP as long as the member obtains these services from a participating care provider. Those services are discussed below in this section. Members requiring Behavioral
Health Services may call UnitedHealthcare Behavioral Health at 866-362-3368. Telephonic access is available 24 hours a day, seven days a week. Mental Health Inpatient services as well as Detoxification Programs are available after coordination for emergency admissions or mental health care provider’s evaluation has taken place.

Preventive Services

Members may access the following services from a participating care provider without a referral from a PCP:

- Influenza and pneumonia vaccinations
- Routine and preventive women’s health services (such as pap smears, pelvic exams and annual mammograms)
- Routine Vision
- Routine Hearing

Members may not be charged an additional copayment beyond office visit for influenza or pneumonia vaccinations or pap smears.

Hospital Services

Acute Inpatient Admissions

All elective inpatient admissions require prior authorization from the UnitedHealthcare Dual Complete Prior Notification Service Center.

UnitedHealthcare Dual Complete Concurrent Review nurses and staff, in coordination with admitting physicians and hospital based physicians (hospitalists) will be in charge of coordinating and conducting Continued Stay Reviews, providing appropriate authorizations for extended care facilities and coordinating services required for adequate discharge. UnitedHealthcare Dual Complete Case Managers will assist in coordinating services identified as necessary in the discharge planning process as well as coordinating the required follow-up by the corresponding Primary Care Providers.

Inpatient Copays and Deductibles

Effective January 1, 2012, the following inpatient copays and deductibles apply:

**Inpatient Hospital**
- Days 1-60: $0 deductible.
- Days 61-90: $0 per day.
- Days 91-150: $0 per lifetime reserve day.

**Inpatient SNF**
- Days 1-20: $0 per day.
- Days 21-100: $0 per day.
  
No prior hospital stay is required. Plan covers up to 100 days each benefit period.

**Inpatient Mental Health in a Psychiatric Hospital**
- Days 1-60: $0 deductible.
- Days 61-90: $0 per day.
- Days 91-150: $0 per lifetime reserve day
Chapter 11: Medicare (Dual Complete) Non-Covered Benefits and Exclusions

Some medical care and services are not covered ("excluded") or are limited by UnitedHealthcare Dual Complete. The list below tells about these exclusions and limitations. The list describes services that are not covered under any conditions, and some services that are covered only under specific conditions.

If members receive services that are not covered, they must pay for them themselves.

UnitedHealthcare Dual Complete will not pay for the exclusions that are listed in this section and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered.

Services Not Covered by UnitedHealthcare Dual Complete

1. Services that are not covered under Original Medicare, unless such services are specifically listed as covered.

2. Services that members receive from non-plan care providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan’s service area, and care from non-plan care providers that is arranged or approved by a plan care provider.

3. Services that members receive without prior authorization, when prior authorization is required for getting those services.

4. Services that are not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a covered service.

5. Emergency facility services for non-authorized, routine condition that do not appear to a reasonable person to be based on a medical emergency.

6. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by UnitedHealthcare Dual Complete and Original Medicare to not be generally accepted by the medical community.

7. Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare.

8. Private room in a hospital, unless medically necessary.

9. Private duty nurses.

10. Personal Convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.

11. Nursing care on a full-time basis in your home.

12. Custodial care is not covered by UnitedHealthcare Dual Complete unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating, and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

13. Homemaker services.

14. Charges imposed by immediate relatives or members of your household.

15. Meals delivered to your home.

16. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.

17. Cosmetic surgery or procedures, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.

18. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.

19. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine) and is limited according to Medicare guidelines.

20. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

21. Supportive devices for the feet. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

22. Hearing aids and routine hearing examinations.
23. Routine eye examinations and eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

24. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.

25. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)


27. Naturopath services.

28. Services provided to veterans in Veteran’s Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under UnitedHealthcare Dual Complete, we will reimburse veterans for the difference. Members are still responsible for the UnitedHealthcare Dual Complete cost sharing amount.
Chapter 12: Medicare (Dual Complete) Care
Provider Responsibilities

General Care Provider Responsibilities

UnitedHealthcare Dual Complete contracted care providers are responsible for:

a. Verifying the enrollment and assignment of the member via UnitedHealthcare Dual Complete roster, using the UnitedHealthcare Provider Portal, MediFAX (Emdeon), or contacting Provider Services prior to the provision of covered services. Failure to verify member enrollment and assignment may result in claim denial.

b. Rendering covered services to UnitedHealthcare Dual Complete members in an appropriate, timely, and cost effective manner and in accordance with their specific contract and CMS requirements.

c. Maintaining all licenses, certifications, permits, or other prerequisites required by law to provide covered services, and submitting evidence that each is current and in good standing upon the request of UnitedHealthcare Dual Complete.

d. Rendering services to members who are diagnosed as being infected with the Human Immunodeficiency Virus (HIV) or having Acquired Immune Deficiency Syndrome (AIDS) in the same manner and to the same extent as other members, and under the compensation terms set forth in their contract.

e. Meeting all applicable Americans with Disabilities Act (ADA) requirements when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats, or assistance with physical accessibility.

f. Making a concerted effort to educate and instruct members about the proper utilization of the practitioner’s office in lieu of hospital emergency rooms. The practitioner will not refer or direct members to hospital emergency rooms for non-emergent medical services at any time.

g. Abiding by the UnitedHealthcare Dual Complete referral and prior authorization guidelines.

h. Admitting members in need of hospitalization only to contracted hospitals unless: (1) prior authorization for admission to some other facility has been obtained from UnitedHealthcare Dual Complete; or, (2) the member’s condition is emergent and use of a contracted hospital is not feasible for medical reasons. The practitioner agrees to provide covered services to members while in a hospital as determined medically necessary by the practitioner or a medical director.

i. Using contracted hospitals, specialists, and ancillary care providers. A member may be referred to a non-contracted practitioner or care provider only if the medical services required are not available through a contracted practitioner or provider and if prior authorization is obtained.

j. Reporting all services provided to UnitedHealthcare Dual Complete members in an accurate and timely manner.

k. Obtaining authorization from UnitedHealthcare Dual Complete for all hospital admissions.

l. Providing culturally competent care and services.

m. Maintaining compliance with Health Insurance Portability and Accountability Act (HIPAA) provisions.

n. Adhering to Advance Directives (Patient Self Determination Act). The federal Patient Self-Determination Act requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive. Advance directives are oral or written statements either outlining a member’s choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions. Care providers are required to maintain policies and procedures regarding advance directives and document in individual medical records whether or not they have executed an advanced directive. Information about advance directives is included in the UnitedHealthcare Dual Complete Member Handbook.

o. Establishing standards for timeliness and in office waiting times that consider the immediacy of member needs and common waiting times for comparable services in the community.

p. Helping ensure there is an appropriate back up for absences.

q. Providing hours of operation that do not discriminate any Medicare members relative to other members.

r. Maintain medical records according to UnitedHealthcare Medical Records Documentation Standards contained in this manual and maintain patient confidentiality.

Member Eligibility and Enrollment

Medicare and Medicaid beneficiaries who elect to become members of UnitedHealthcare Dual Complete must meet the following qualifications:

1. Be entitled to Medicare Part A and be enrolled in Medicare Part B.

2. Be entitled and enrolled in Medicaid Title XIX benefits.

3. Reside in the Dual Complete Service Area: Kings, Brooklyn, Nassau, Richmond, New York and Queens counties.

4. Maintain a permanent residence within the Service Area, and must not reside outside the Service Area for more than six months.
5. Have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Each UnitedHealthcare Dual Complete member receives an UnitedHealthcare Dual Complete identification (ID) card containing the member’s name, member number, PCP name, and information about their benefits. The Dual Complete ID membership card does not guarantee eligibility. It is for identification purposes only.

**Verifying Member Enrollment**

Once a member has been assigned to a PCP, UnitedHealthcare Dual Complete documents the assignment and provides each PCP a roster indicating the members assigned to them. Rosters can be viewed electronically on the UnitedHealthcare Provider Portal. PCP’s should verify eligibility by using their rosters in conjunction with:

- Provider Portal ([UHCprovider.com](http://UHCprovider.com))
- MediFAX (Emdeon)
- UnitedHealthcare Provider Service Center (available 8 a.m. to 5 p.m.) 866-362-3368
- Medicaid web-based eligibility verification system

At each office visit, your office staff should:

- Ask for the member’s ID card and have a copy of both sides in the member’s office file.
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes.
- Refer to the member’s ID card for the appropriate telephone number to verify eligibility in the UnitedHealthcare Dual Complete, deductibles, coinsurance amounts, copayments, and other benefit information.
- PCP office staff should check their UnitedHealthcare Dual Complete Panel Listing to be sure the PCP is the member’s primary care physician. If the member’s name is not listed, your office staff should contact UnitedHealthcare Dual Complete Customer Service to verify PCP selection before the member is seen by the participating care provider.

All care providers should verify member eligibility prior to providing services.

**Coordinating 24-Hour Coverage**

PCP’s are expected to provide coverage for UnitedHealthcare Dual Complete members 24 hours a day, seven days a week. When a PCP is unavailable to provide services, the PCP must help ensure that he or she has coverage from another participating care provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating care providers. Participating care providers can consult their UnitedHealthcare Dual Complete Provider Directory, or contact the UnitedHealthcare Dual Complete Member Services with questions regarding which care providers participate in the UnitedHealthcare Dual Complete network. New York care providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare for Medicare and Medicaid benefits, will be able to take advantage of single-claim submission. Claims submitted to UnitedHealthcare for dual-enrolled members will process first against Medicare benefits under UnitedHealthcare Dual Complete, and then will automatically process against Medicaid benefits under the appropriate Medicaid or Division of Developmental Disabilities (DDD) benefits. Care providers do not need to submit separate claims for the same member.
Chapter 13: Medicare (Dual Complete) Claims Process/Coordination of Benefits/Claims

Claims Submission Requirements

UnitedHealthcare Dual Complete requires that you initially submit your claim within your contracted deadline. Please consult your contract to determine your initial filing requirement. The timely filing limit is set at 180 days after the date of service.

A “clean claim” is defined in New York Revised Statutes as one that can be processed without obtaining additional information from the care provider of service or from a third party. It does not include a claim from a care provider who is under investigation for fraud or abuse or a claim selected for medical review by UnitedHealthcare Dual Complete.

Please mail your paper claims to:

UnitedHealthcare of New York
P.O. Box 5240
Kingston, NY 12402-5240

For Electronic submission of claims, please access UnitedHealthcare Provider Portal at UHCprovider.com and sign up for electronic claims submission. If you have questions about gaining access to UnitedHealthcare Provider Portal, choose the Provider Portal tab and follow the instructions to gain access.

Practitioners

Participating care providers should submit claims to UnitedHealthcare Dual Complete as soon as possible after service is rendered, using the standard HCFA-1500 Claim Form or electronically as discussed below.

To expedite claims payment, identify the following items on your claims:

- Prior Authorization number, when applicable
- Member name
- Member’s date of birth and sex
- Member’s UnitedHealthcare Dual Complete ID number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-10 Diagnosis Codes
- CPT-4 Procedure Codes
- Place of Service Code
- Date of services
- Charge for each service
- Provider’s ID number and locator code, if applicable
- Provider’s Tax Identification Number
- Name/address of Participating Provider
- Signature of Participating Provider providing services

UnitedHealthcare Dual Complete will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to UnitedHealthcare Dual Complete should comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

Hospitals

Hospitals should submit claims to the UnitedHealthcare Dual Complete claims address as soon as possible after service is rendered, using the standard UB-04 Form.

To expedite claims payment, identify the following items on your claims:

- Member name
- Member’s date of birth and sex
- Member’s UnitedHealthcare Dual Complete ID number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Provider’s ID number and locator code, if applicable
- Provider’s Tax Identification Number
- Name/address of Participating Provider
- Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims
- Current other diagnosis codes, if applicable (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims

UnitedHealthcare Dual Complete will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to UnitedHealthcare Dual Complete should comply with HIPAA requirements.
Balance Billing

The balance billing amount is the difference between Medicare’s allowed charge and the care provider’s actual charge to the patient. You are prohibited from billing, charging, or otherwise seeking payment from members for covered services. UnitedHealthcare members cannot be billed for covered services in accordance with A.A.C (UFC) R9-22-702 and A.A.C (HCG) R9-27-702. Services to members cannot be denied for failure to pay copayments. If a member requests a service that is not covered by UnitedHealthcare, you should have the member sign a release form indicating understanding that the service is not covered by UnitedHealthcare, and the member is financially responsible for all applicable charges.

You may not bill a member for a non-covered service unless:
1. You have informed the member in advance that the service is not covered, and
2. The member has agreed in writing to pay for the services if they are not covered.

Coordination of Benefits

If a member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by UnitedHealthcare Dual Complete will be governed by the amount paid by the primary plan and Medicare secondary payer law policies.

Processing of Medicare/Medicaid Claims

New York care providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare for Medicare and Medicaid benefits, will be able to take advantage of single-claim submission. Dual Complete members have FFS Medicaid and have to bill CSC for secondary benefits. This will be true for Medicaid Advantage when the product rolls out. Claims submitted to UnitedHealthcare for dual-enrolled members will process first against Medicaid benefits under UnitedHealthcare Dual Complete, and then will automatically process against Medicaid benefits under the appropriate Medicaid or Division of Developmental Disabilities (DDD) benefits.

Medicaid Cost Sharing Policy

A group of UnitedHealthcare members are dual eligible for both Medicaid and Medicare services. Claims for dual eligible members will be paid according to the Medicaid Cost Sharing Policy. UnitedHealthcare will not be responsible for cost sharing should the payment from the primary payer be equal to or greater than what the care provider would have received under Medicaid. Please refer to the Appendix: 2007 New York Dual Complete Cost Sharing for Contracted Providers.

Cost-Sharing for Dual Eligible Members

You will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any UnitedHealthcare Dual Complete member who is eligible for both Medicare and Medicaid, or his or her representative, or the UnitedHealthcare Dual Complete organization for Medicare Part A and B cost sharing (e.g. copays, deductibles, coinsurance) when the state is responsible for paying such amounts. You will either: (a) accept payment made by or on behalf of the UnitedHealthcare Dual Complete organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

Care Provider Claim Dispute and Appeal

Claims must be received within the timely filing requirements of your agreement with UnitedHealthcare. You may dispute a claims payment decision by requesting a claim review. However, care providers have no appeal rights to dispute a claim under Medicare Advantage. But, if the claim is in a Medicaid covered service then Provider has appeal rights under Medicaid.

Provider Claims Dispute:

Stated as “Administrative Appeals by Practitioner” on Provider Remit. If a care provider is not able to resolve a claim denial through Provider Service Center, or the PCSU, the care provider may challenge the claim denial or adjudication by filing a formal claim dispute.

UnitedHealthcare Dual Complete Policy requires that the dispute, with required documentation, must be received within 60 days of the original denial notice. Failure to meet the timely request a claims dispute is deemed a waiver of all rights to further administrative review.

A claim dispute must be in writing and state with particularity the factual and legal basis and the relief requested, along with any supporting documents (i.e. claim, remit, medical review sheet, medical records, correspondence, etc.). Particularity usually means a chronology of pertinent events and a statement as to why the provider believes the action by UnitedHealthcare was incorrect.

Care providers may submit claim disputes for reconsideration as follows:

- Electronically access UnitedHealthcare’s Provider Portal at UHCprovider.com.
- Or mail claim dispute to: UnitedHealthcare Dual Complete Claims Dispute PO Box 31364 Salt Lake City, UT 84131-03641
Care Provider Filing an Appeal on Behalf of a Member

This applies to “Appeals for Inpatient Administrative Denials and Medical Necessity Determinations by Practitioner”.

Reasons for filing an appeal include:

- A denied authorization.
- A denied payment for a service either in whole or part resulting in member liability.
- UnitedHealthcare Dual Complete reducing or terminating services.
- UnitedHealthcare Dual Complete failing to provide services to a member in a timely manner.
- UnitedHealthcare Dual Complete failing to act within the time frame given for grievances and appeals.

Care providers can send written appeals and documentation of member’s authorization to appeal on behalf of members to:

UnitedHealthcare Dual Complete
Attention: Appeals Department
PO Box 31364
Salt Lake City, UT 84131-03641

Appeal inquiries are directed to Provider Services at: 866-362-3368.
Chapter 14: Medicare (Dual Complete) Medical Management, Quality Improvement and Utilization Review Programs

UnitedHealthcare Dual Complete seeks to improve the quality of care provided to its members. Thus, UnitedHealthcare Dual Complete encourages care provider participation in health promotion and disease prevention programs. You are encouraged to work with UnitedHealthcare Dual Complete in its efforts to promote healthy lifestyles through member education and information sharing.

You must comply and cooperate with all UnitedHealthcare Dual Complete medical management policies and procedures and in UnitedHealthcare Dual Complete quality assurance and performance improvement programs. All care providers and practitioners are required to participate in and cooperate with the UnitedHealthcare Quality Improvement and Medical Management programs. The UnitedHealthcare Quality Improvement and Medical Management programs are allowed to use practitioner and care provider performance data to conduct quality activities.

Referrals and Prior Authorization

You are required to coordinate member care within the UnitedHealthcare Dual Complete provider network. If possible, all UnitedHealthcare Dual Complete member referrals should be directed to UnitedHealthcare Dual Complete care contracted providers. Referrals outside of the network are permitted, but only with prior authorization from UnitedHealthcare Dual Complete.

The referral and prior authorization procedure are particularly important to the UnitedHealthcare Dual Complete managed care program. Understanding and adhering to these procedures is essential for successful participation as a UnitedHealthcare Dual Complete care provider. Prior authorization is one of the tools used by UnitedHealthcare Dual Complete to monitor the medical necessity and cost-effectiveness of the health care members receive. Contracted and non-contracted health professionals, hospitals, and other care providers are required to comply with UnitedHealthcare Dual Complete prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the primary care physician (PCP) coordinates most services provided to a member, it is typically the PCP who initiates requests for prior authorization; however, specialists and ancillary care providers also request prior authorization for services within their specialty areas.

Unless another department or unit has been specially designated to authorize a service, requests for prior authorization are routed through the Prior Authorization Department where Nurses and Medical Directors are available. Requests are made by telephone to Provider Services at: 866-604-3267.

Primary Care Provider Referral Responsibilities

If a member self-refers, or the PCP is making a referral to a specialist, the PCP should check the UnitedHealthcare Dual Complete Provider Directory to help ensure the specialist is a contracted care provider in the UnitedHealthcare Dual Complete network.

The PCP should provide the specialist with the following clinical information:

- Members name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Specialist Referral Guidelines

PCP’s may refer UnitedHealthcare Dual Complete members to contracted network specialists. To help ensure coordination of care, if a member desires to receive care from a different specialist, the PCP should try to coordinate specialty referrals within the list of contracted network specialists. When no additional physician within the required specialty is contracted in the network, PCP will contact UnitedHealthcare Dual Complete for prior authorization.

PCP’s are authorized to make referrals, using an UnitedHealthcare-specified referral form, to specialists within the guidelines of UnitedHealthcare’s Prior Authorization List. Members will not directly access specialty care, other than for specified self-referral services, without a referral from their PCP. Services requiring referral (but not prior authorization) are all referrals except to contracted vision care providers, contracted dentists, contracted radiologists, behavioral health, and female members who self-refer for their well-woman exam.
SERVICES REQUIRING PRIOR AUTHORIZATION/NOTIFICATION

The presence or absence of a procedure or service on the list below does not define whether or not coverage or benefits exist for that procedure or service. The new notification requirements do not change or otherwise affect current requirements for outpatient prescription drug benefits or behavioral health benefits.

REQUESTING PRIOR AUTHORIZATION

Care providers and facilities should utilize the following steps to obtain authorization for services:

1. Requests for prior authorization are to be directed to UnitedHealthcare Dual Complete Prior Authorization Department
   • 866-604-3267 iExchange (contact the Provider Service Center if you are interested in using UnitedHealthcare’s internet based Prior Authorization system)

2. All requests for prior authorization require:
   • A valid member ID number
   • Name of referring physician
   • The current applicable CPT, ICD-10, and HCPCS codes for the services being requested
   • The designated place of service

3. The PCP is responsible for initiating and coordinating requests for prior authorization. However, UnitedHealthcare Dual Complete recognizes that specialists, ancillary care providers, and facilities may need to request prior authorization for additional services in their specialty area and will process these requests as necessary.

4. Non-contracted care providers must obtain prior authorization from UnitedHealthcare Dual Complete before rendering any non-emergent services. Failure to do so will result in claims being denied.

The Prior Authorization Department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization, including:

- Verification that the member is enrolled with UnitedHealthcare Dual Complete at the time of the request for authorization and on each date of service.
- Verification that the requested service is a covered benefit for the member.
- Assessment of the requested service’s medical necessity and appropriateness.
- UnitedHealthcare medical review criteria based on CMS/Medicaid program requirements, applicable policies and procedures, contracts, and law.
- Verification that the service is being provided by a contracted care provider and in the appropriate setting.
- Verification of other insurance for coordination of benefits.

The Prior Authorization Department is also responsible for receiving and documenting facility notifications of inpatient admissions.

Requests for elective services generally need review and approval by a medical director and frequently require additional documentation.

DENIAL OF REQUESTS FOR PRIOR AUTHORIZATION

Denials of authorization requests occur only after an UnitedHealthcare Dual Complete Medical Director has reviewed the request. An UnitedHealthcare Dual Complete Medical Director is always available to speak to a care provider and review a request.

Prior authorization requests are frequently denied because they lack supporting medical documentation. You are encouraged to call or submit additional information for reconsideration. If additional information is requested and not received within five business days, then the request is denied.

PRE-ADMISSION AUTHORIZATION

For coordination of care, PCP’s or the admitting hospital facilities should notify UnitedHealthcare Dual Complete if they are admitting an UnitedHealthcare Dual Complete member to a hospital or other inpatient facility.

To notify UnitedHealthcare Dual Complete of an admission, the admitting hospital should call UnitedHealthcare Dual Complete at 866-604-3267 and provide the following information:

- Notifying PCP or hospital
- Name of admitting PCP
- Members’ name, sex, and UnitedHealthcare Dual Complete ID number
- Admitting facility
- Primary diagnosis
- Reason for admission
- Date of admission
Concurrent Hospital Review

UnitedHealthcare Dual Complete reviews all member hospitalizations within 48 hours of admission to confirm that the hospitalization and/or procedures were medically necessary. Reviewers will assess the usage of ancillary resources, service and level of care according to professionally recognized standards of care. Concurrent hospital reviews validate the medical necessity for continued stay.

Discharge Planning

UnitedHealthcare Dual Complete assists participating care providers and hospitals in the inpatient discharge planning process implemented in accordance with requirements under the Medicare Advantage Program. At the time of admission and during the hospitalization, the UnitedHealthcare Dual Complete Medical Management staff may discuss discharge planning with the participating care provider, member, and family.

Outpatient Services Review

Outpatient review involves the retrospective evaluation of outpatient procedures and therapies to determine medical necessity and appropriateness. Outpatient treatment plans for members with complex or chronic conditions may be developed.

Second Medical or Surgical Opinion

A member may request a second opinion if:

- The Member disputes reasonableness decision.
- The Member disputes necessity of procedure decision.
- The Member does not respond to medical treatment after a reasonable amount of time.

To receive a second opinion, a member should first contact his or her PCP to request a referral. If the member does not wish to discuss their request directly with the PCP, he or she may call UnitedHealthcare Dual Complete for assistance. Members may obtain a second opinion from a participating care provider within the UnitedHealthcare Dual Complete network. The member is responsible for the applicable copayments.

Medical Criteria

Qualified professionals who are members of the UnitedHealthcare Dual Complete Quality Improvement Committees and the Board of Directors will approve the medical criteria used to review medical practices and determine medical necessity. UnitedHealthcare Dual Complete currently uses nationally recognized criteria, such as Diagnostic Related Groups Criteria and MCG Care Guidelines, to guide the prior authorization, concurrent review and retrospective review processes. These criteria are used and accepted nationally as clinical decision support criteria. For more information or to receive a copy of these guidelines, please contact UnitedHealthcare Dual Complete at 800-514-4912 (TTY 711).

UnitedHealthcare Dual Complete may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines are communicated to participating care providers through the UnitedHealthcare Dual Complete newsletters.

UnitedHealthcare Dual Complete has established the Quality and Utilization Management Peer Review Committee to allow physicians to provide guidance on medical policy, quality assurance and improvement programs and medical management procedures. Participating care providers may recommend specific clinical guidelines to be used for a specific diagnosis. These requests should be supported with current medical research and/or data and submitted to the UnitedHealthcare Dual Complete Quality and Utilization Management Peer Review Committee.

A goal of the Quality and Utilization Management Peer Review Committee is to help ensure that practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.
- Consider the needs of the enrolled population.
- Are developed in consultation with participating physicians.
- Are reviewed and updated periodically.

The guidelines will be communicated to care providers, and, as appropriate, to members.

Decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply will be consistent with the guidelines. If you would like to propose a discussion topic to be considered for discussion with UnitedHealthcare Dual Complete Quality and Utilization Management Peer Review Committee, please contact an UnitedHealthcare Dual Complete Medical Director.

Case Management

UnitedHealthcare Dual Complete assists in managing the care of members with acute or chronic conditions that can benefit from care coordination and assistance. UnitedHealthcare Dual Complete care providers will assist and cooperate with UnitedHealthcare Dual Complete case management programs. UnitedHealthcare Dual Complete case management programs include but are not limited to:
• **Special Needs Populations** – Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs who has a medical condition that simultaneously meets the following criteria:
  - Lasts or is expected to last one year or longer, and
  - Requires ongoing care not generally provided by a primary care provider.

The following populations meet the criteria for the designation of Special Needs:

- Members who are recipients of services provided through the New York Department of Health Services Children’s Rehabilitative Services program.
- Members who are recipients of services provided through the New York Department of Health Services/Division of Behavioral Health-contracted Regional Behavioral Health Authorities.
- Members diagnosed with HIV/AIDS.
- Members enrolled in the New York Long Term Care program who are developmentally disabled.
- Members diagnosed with End Stage Renal Disease receiving dialysis.

• **Organ Transplantation** – A Transplant Nurse Care Coordinator coordinates care provider requests for authorization of organ transplants. The transplant Case Manager works cooperatively with the Medicaid Office of Medical Management, contracted care providers, and internal UnitedHealthcare Dual Complete departments to coordinate the delivery of services included in the transplantation process.

• **Emergency Department** – (ED) Care Coordination Program assists members with multiple ED visits to obtain necessary and appropriate medical and specialty care. Members over utilizing the ED may or may not be demonstrating drug seeking behavior(s).

• **HIV+/AIDS** – This program is offered in conjunction with the Medicaid guidelines for managing HIV/AIDS members’ treatment regimens. The Medicaid guidelines also require that any member receiving antiretroviral therapy be assigned to an UnitedHealthcare HIV/AIDS Nurse Care Coordinator. Physicians are to contact the department whenever a member is diagnosed with HIV or AIDS or whenever an HIV/AIDS-diagnosed member is noncompliant. The HIV/AIDS Nurse Care Coordinator will assist in coordinating care for these members.

• **Chronic Pain** – Care provider requests for assistance with members with chronic pain and related drug seeking behavior and/or emergency department abuse are managed by the Specialty Care Coordination Department.

You may refer candidates for case management by contacting the Provider Service Center at 866-362-3368.

Members are educated about available programs through the enrollment process, marketing materials, and discussions with participating care providers. UnitedHealthcare Dual Complete actively identifies members who could benefit from case management and help ensure they are enrolled in the case management program.

**Evidence Based Medicine/Clinical Practice Guidelines**

Disease management programs for asthma, congestive heart failure and diabetes are offered within the Medical Case Management Department. These programs utilize nationally recognized clinical practice guidelines and the practitioner’s treatment plan as a basis to educate members and coordinate preventive services.

UnitedHealthcare Dual Complete promotes the use of evidence-based clinical practice guidelines to improve the health of its members and provide a standardized basis for measuring and comparing outcomes. Outcomes are compared with the standards of care defined in the evidence based clinical practice guidelines for these diseases.

The UnitedHealthcare Dual Complete Case Management Department supports education for UnitedHealthcare Dual Complete staff, practitioners, care providers and members. UnitedHealthcare Dual Complete reinforces and supports the implementation of clinical practice guidelines by providing training programs for care providers and their staff on how best to integrate practice guidelines into everyday physician practice patterns.

UnitedHealthcare Dual Complete provides individual practitioners feedback regarding their performance as well as information regarding the overall network performance as related to the guidelines. Evidence-based clinical practice guidelines are reviewed and revised on an annual basis and approved through the Medical Management and Quality Management processes.

Clinical practice guidelines can be accessed by care providers on the UnitedHealthcare Dual Complete Provider Portal (UHCprovider.com) or at (guidelines.gov). Care providers may also call the Provider Service Center at 866-362-3368 to request a hard copy of these guidelines.
This section of the manual is specific for dentists and explains the policies and procedures of the UnitedHealthcare Dual Complete network for dental care services to facilitate delivery of services to UnitedHealthcare Dual Complete members. The dental benefit pertains only to UnitedHealthcare Dual Complete members enrolled in Dual Complete and who choose UnitedHealthcare as their Medicare health plan. The plan does not pertain to other general Medicare members, for example, retirees.

**Eligibility**

UnitedHealthcare encourages you to verify eligibility prior to every dental office visit and offers three primary methods for eligibility verification:

- UnitedHealthcare Dental member eligibility verification at 800-304-0634. Hours of Operation Monday through Friday, 8 a.m. – 6 p.m. ET.
- UnitedHealthcare Provider Service Center (available 8 a.m. – 5 p.m.) 866-362-3368.

**Covered Services**

The plan has a $2,500 calendar year maximum and the covered services are:

- Bleaching - up to $250 per year
- Fixed bridgework - three units per year
- Implants - Up to $500 each, for two units per year

All covered services subject to the $2,500 calendar year maximum

**Dental Claim Submission**

To facilitate prompt payment of claims please include the following information:

- Always use the Dental Provider’s NPI on claim.
- You only need to submit one claim form. DBP will process coordination of benefits, if applicable, for both Medicare and Medicaid during claims processing. EOB and payments for each coverage will be issued separately so your office will receive two EOBs and two checks for each applicable claim.
- Claims must be submitted within one year of the date of service.

All UnitedHealthcare Dual Complete dental claims should be submitted directly to:

**Dental Benefit Providers**
P.O. Box 2061
Milwaukee, WI 53201

Claims Address is:
P.O. Box 638
Thiensville, WI 53092

DBP phone number is 800-304-0634 and hours of operation are Monday through Friday, 8 a.m. – 6 p.m. EST.

**Questions**

UnitedHealthcare staff is available to assist your office with any questions. Please contact:

- UnitedHealthcare Dental member eligibility verification at 800-304-0634. Hours of Operation Monday through Friday, 8 a.m. – 6 p.m. EST.
- UnitedHealthcare Provider Service Center (available 8 a.m. – 5 p.m.) 866-362-3368.
Chapter 16: Medicare (Dual Complete) Care Provider Performance Standards and Compliance Obligations

Care Provider Evaluation

When evaluating the performance of a participating care provider, UnitedHealthcare Dual Complete, we review, at a minimum, the following areas:

- **Quality of Care** – Measured by clinical data related to the appropriateness of member care and member outcomes.
- **Efficiency of Care** – Measured by clinical and financial data related to a member’s health care costs.
- **Member Satisfaction** – Measured by the members’ reports regarding accessibility, quality of health care, Member-Participating Provider relations, and the comfort of the practice setting.
- **Administrative Requirements** – Measured by the participating care provider’s methods and systems for keeping records and transmitting information.
- **Participation in Clinical Standards** – Measured by the care participating care provider’s involvement with panels used to monitor quality of care standards.

Care Provider Compliance to Standards of Care

You must comply with all applicable laws and licensing requirements. In addition, you must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. You must also comply with UnitedHealthcare Dual Complete standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity).
- All federal, state, and local laws regarding the conduct of their profession.

You must also comply with UnitedHealthcare Dual Complete policies and procedures regarding the following:

- Committee and clinical task force participation to improve the quality and cost of care.
- Prior Authorization requirements and timeframes.
- Participating care provider credentialing requirements.
- Referral Policies.
- Case management Program referrals.
- Appropriate release of inpatient and outpatient utilization and outcomes information.
- Accessibility of member medical record information to fulfill the business and clinical needs of UnitedHealthcare Dual Complete.
- Cooperating with efforts to assure appropriate levels of care.
- Maintaining a collegial and professional relationship with UnitedHealthcare Dual Complete personnel and fellow Participating Providers.
- Providing equal access and treatment to all Medicare members.

Compliance Process

The following types of non-compliance issues are key areas of concern:

- Out-of-network referrals/utilization without prior authorization by UnitedHealthcare Dual Complete.
- Failure to pre-notify UnitedHealthcare Dual Complete of admissions.
- Member complaints/grievances that are determined against you.
- Underutilization, over-utilization, or inappropriate referrals.
- Inappropriate billing practices.
- Non-supportive actions and/or attitude noncompliance is tracked, on a calendar year basis. Using an educational approach, the compliance process is composed of four phases, each with a documented educational component. Corrective actions will be taken.

You, acting within the lawful scope of practice, are encouraged to advise patients who are members of UnitedHealthcare Dual Complete about:

1. The patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options.
2. The risks, benefits, and consequences of treatment or non-treatment.
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.
4. The importance of preventive changes at no cost to the member.

Such actions will not be considered non-supportive of UnitedHealthcare Dual Complete.

Laws Regarding Federal Funds

Payments that you receive for furnishing services to UnitedHealthcare Dual Complete members are, in whole or part, from Federal funds. Therefore, you and any of your subcontractors must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

Marketing

You may not develop and use any materials that market UnitedHealthcare Dual Complete without the prior approval of UnitedHealthcare Dual Complete in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS and not disapproved within 45 days.

Sanctions Under Federal Health Programs and State Law

You must help ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by you. You must disclose to UnitedHealthcare Dual Complete whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of New York, the federal government, or any public insurer. You must notify UnitedHealthcare Dual Complete immediately if any such sanction is imposed on you, a staff member or subcontractor.

Selection and Retention of Participating Care Providers

UnitedHealthcare is responsible for arranging covered services that are provided to thousands of members through a comprehensive care provider network of independent practitioners and facilities that contract with UnitedHealthcare. The network includes health care professionals such as primary care physicians, specialist physicians, medical facilities, allied health professionals, and ancillary service care providers.

UnitedHealthcare’s network has been carefully developed to include those contracted health care professionals who meet certain criteria such as availability, geographic service area, specialty, hospital privileges, quality of care, and acceptance of UnitedHealthcare managed care principles and financial considerations.

UnitedHealthcare continuously reviews and evaluates participating provider information and recredentials participating care providers every three years. The credentialing guidelines are subject to change based on industry requirements and UnitedHealthcare standards.

Termination of Participating Provider Privileges

Termination Without Cause

UnitedHealthcare Dual Complete and a contracting care provider must provide at least 60 days written notice to each other before terminating a contract without cause.

Appeal Process for Provider Participation Decisions

Physicians

If UnitedHealthcare Dual Complete decides to suspend, terminate or non-renew a physician’s participation status, UnitedHealthcare Dual Complete must:

- Give the affected physician written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by UnitedHealthcare Dual Complete.
• Allow the physician to appeal the action to a hearing panel, and give the physician written notice of his/her right to a hearing and the process and timing for requesting a hearing.

• Help ensure that the majority of the hearing panel members are peers of the affected physician.

If a suspension or termination is the result of quality of care deficiencies, UnitedHealthcare Dual Complete must give written notice of that action to the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician groups must provide that these procedures apply equally to physicians within those subcontracted groups.

Other Care Providers
UnitedHealthcare Dual Complete decisions subject to appeal include decisions regarding reduction, suspension, or termination of your participation resulting from quality deficiencies. UnitedHealthcare Dual Complete notifies the National Practitioner Data Bank, the Department of Professional Regulation, and any other applicable licensing or disciplinary body to the extent required by law. Written communication to you will detail the limitations and inform you of the rights to appeal.

Notification of Members of Care Provider Termination
When a contract termination involves a Primary Care Physician, UnitedHealthcare Dual Complete notifies all members who are patients of that Primary Care Physician of the termination. UnitedHealthcare Dual Complete will make a good faith effort to provide written notice of a termination of a participating care provider to all members who are patients seen on a regular basis by that provider at least 30 calendar days before the termination effective date, regardless of the reason for the termination.
Chapter 17: Medicare (Dual Complete)
Medical Records

Medical Record Review

A UnitedHealthcare Dual Complete representative may visit your office to review the medical records of UnitedHealthcare Dual Complete members to obtain information regarding medical necessity and quality of care. Medical records and clinical documentation are evaluated based on the Standards for Medical Records listed below. The Quality and Utilization Management Subcommittee, the Provider Affairs Subcommittee and the Quality Management Oversight Committee will review the medical record results quarterly. The results will be used in the re-credentialing process.

Standards for Medical Records

You must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the members’ medical chart. Each medical record chart must have documented at a minimum:

- Member name.
- Member identification number.
- Member age.
- Member sex.
- Member date of birth.
- Date of service.
- Allergies and any adverse reaction.
- Past medical history.
- Chief complaint/purpose of visit.
- Subjective findings.
- Objective findings, including diagnostic test results.
- Diagnosis/assessment/impression.
- Plan, including services, treatments, procedures and/or medications ordered; recommendation and rational.
- Name of participating care provider including signature and initials.
- Instructions to member.
- Evidence of follow-up with indication that test results and/or consultation was reviewed by PCP and abnormal findings discussed with member/legal guardian.
- Health risk assessment and preventive measures.

In addition, you must document in a prominent part of the member’s current medical record whether or not the member has executed an advance directive. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the New York and signed by a patient; that explain the patient’s wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Confidentiality of Member Information

You must comply with all state and federal laws concerning confidentiality of health and other information about members. You must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Member Record Retention

You must retain the original or copies of patient’s medical records as follows:

- Keep records for at least six years after last medical or health care service for all adult patients.
- Keep records for three years after 18th birthday for all child patients or for at least six years after last medical or health care service.

You must comply with all state (A.R.S. 12-2297) and federal laws on record retention.
Chapter 18: Medicare (Dual Complete) Reporting Obligations

Cooperation in Meeting the Centers for Medicaid and Medicare Services (CMS) Requirements

UnitedHealthcare Dual Complete must provide to CMS information that is necessary for CMS to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates; information on member satisfaction; and information on health outcomes. You must cooperate with UnitedHealthcare Dual Complete in its data reporting obligations by providing to UnitedHealthcare Dual Complete any information that it needs to meet its obligations.

Certification of Diagnostic Data

UnitedHealthcare Dual Complete is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a care provider, supplier, physician, or other practitioner (encounter data. Participating care providers that furnish diagnostic data to assist UnitedHealthcare Dual Complete in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief the accuracy, completeness, and truthfulness of the data.

Risk Adjustment Data

You are encouraged to comprehensively code all members’ diagnoses to the highest level of specificity possible. All members’ medical encounters must be submitted to UnitedHealthcare.
Initial Decisions

The “initial decision” is the first decision UnitedHealthcare Dual Complete makes regarding coverage or payment for care. In some instances, a participating care provider, acting on behalf of UnitedHealthcare Dual Complete may make an initial decision regarding whether a service will be covered.

- If a member asks us to pay for medical care the member has already received, this is a request for an “initial decision” about payment for care.
- If a member or participating care provider acting on behalf of a member, asks for preauthorization for treatment, this is a request for an “initial decision” about whether the treatment is covered by UnitedHealthcare Dual Complete.
- If a member asks for a specific type of medical treatment from a participating care provider, this is a request for an “initial decision” about whether the treatment the member wants is covered by UnitedHealthcare Dual Complete.

UnitedHealthcare Dual Complete will generally make decisions regarding payment for care that members have already received within 30 days.

A decision about whether UnitedHealthcare Dual Complete will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days) or it can be an expedited decision that is made more quickly (typically within 72 hours).

A member can ask for an expedited decision only if the member or any physician believes that waiting for a standard decision could seriously harm the member’s health or ability to function. The member or a physician can request an expedited decision. If a physician requests an expedited decision, or supports a member in asking for one, and the physician indicates that waiting for a standard decision could seriously harm the member’s health or ability to function, UnitedHealthcare Dual Complete will automatically provide an expedited decision.

At each patient encounter with an UnitedHealthcare Dual Complete member, the participating care provider must notify the member of his or her right to receive, upon request, a detailed written notice from UnitedHealthcare Dual Complete regarding the member’s services. The care participating care provider’s notification must provide the member with the information necessary to contact UnitedHealthcare Dual Complete and must comply with any other requirements specified by CMS. If a member requests UnitedHealthcare Dual Complete to provide a detailed notice of a participating care provider’s decision to deny a service in whole or part, UnitedHealthcare Dual Complete must give the member a written notice of the determination.

If UnitedHealthcare Dual Complete does not make a decision within the timeframe and does not notify the member regarding why the timeframe must be extended, the member can treat the failure to respond as a denial and may appeal, as set forth below.

Appeals and Grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints they can make. All participating care providers must cooperate in the Medicare Appeals and Grievances process.

- An “appeal” is the type of complaint a member makes when the member wants UnitedHealthcare Dual Complete to reconsider and change an initial decision (by UnitedHealthcare Dual Complete or a Participating Physician) about what services are necessary or covered or what UnitedHealthcare Dual Complete will pay for a service.
- A “grievance” is the type of complaint a member makes regarding any other type of problem with UnitedHealthcare Dual Complete or a participating care provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating care provider’s facilities are grievances. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (refer to Appeal).

Resolving Appeals

A member may appeal an adverse initial decision by UnitedHealthcare Dual Complete or a participating care provider concerning authorization for, or termination of coverage of, a health care service. A member may also appeal an adverse initial decision by UnitedHealthcare Dual Complete concerning payment for a health care service. A member’s appeal of an initial decision about authorizing health care or terminating coverage of a service must generally be resolved by UnitedHealthcare Dual Complete within 30 calendar days or sooner, if the member’s health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.
Chapter 19: Medicare (Dual Complete) Initial Decisions, Appeals and Grievances

Participating care providers must also cooperate with UnitedHealthcare Dual Complete and members in providing necessary information to resolve the appeals within the required time frames. Participating care providers must provide the pertinent medical records and any other relevant information to UnitedHealthcare Dual Complete. In some instances, participating care providers must provide the records and information very quickly to allow UnitedHealthcare Dual Complete to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member’s health or ability to function, the member or the member’s physician can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member’s interest to extend this time period. If a physician requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member’s health or ability to function, we will automatically expedite the appeal.

Special Types
A special type of appeal applies only to hospital discharges. If the member thinks UnitedHealthcare Dual Complete coverage of a hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Professional Research Organization, Inc. However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that UnitedHealthcare Dual Complete coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from UnitedHealthcare Dual Complete.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). SNFs, HHAs and CORFs are responsible for providing members with a written notice at least two days before their services are scheduled to end. If the member thinks his/her coverage is ending too soon, the member can appeal directly and immediately to the Quality Improvement Professional Research Organization, Inc. If the member gets the notice 2 days before coverage ends, the member must request an appeal to Quality Improvement Professional Research Organization, Inc. no later than noon of the day after the member gets the notice. If the member gets the notice more than 2 days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to Quality Improvement Professional Research Organization, Inc., the member can request an expedited appeal from UnitedHealthcare Dual Complete.

Resolving Grievances
If an UnitedHealthcare Dual Complete member has a grievance about UnitedHealthcare Dual Complete, a care provider or any other issue; Participating care providers should instruct the member to contact UnitedHealthcare Dual Complete Member Services at 800-514-4912 (TTY 711). A written grievance should be faxed to 973-565-5269 or mailed to:

UnitedHealthcare Dual Complete
Attn: Appeals and Grievance Coordinator
P.O Box 200449
One Riverfront Plaza
Newark, NJ 07102

UnitedHealthcare Dual Complete will send a received letter within five days of receiving your grievance request. A final decision will be made as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

UnitedHealthcare Dual Complete members may ask for an expedited grievance upon initial request. We will respond to “expedited” or “fast” grievance request within 24 hours.

Further Appeal Rights
If UnitedHealthcare Dual Complete denies the member’s appeal in whole or part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of UnitedHealthcare Dual Complete. This organization will review the appeal and, if the appeal involves authorization for health care service, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ’s decision, the member may request review by the Department Appeal Board (DAB). If the Department Appeal Board (DAB) refuses to hear the case or issues an adverse decision, the member may be able to appeal to a District Court of the United States.
UnitedHealthcare Dual Complete members have the right to timely, high quality care, and treatment with dignity and respect. Participating care providers must respect the rights of all UnitedHealthcare Dual Complete members. Specifically, UnitedHealthcare Dual Complete members have been informed that they have the following rights:

**Timely Quality Care**
- Choice of a qualified contracting primary care physician and contracting hospital.
- Candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Timely access to their primary care physician and recommendations to specialists when medically necessary.
- To receive emergency services when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists.
- To actively participate in decisions regarding their health and treatment options.
- To receive urgently needed services when traveling outside UnitedHealthcare Dual Complete’s service area or in UnitedHealthcare Dual Complete’s service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating care provider.
- To request the number of grievances and appeals and dispositions in aggregate.
- To request information regarding physician compensation.
- To request information regarding the financial condition of UnitedHealthcare Dual Complete.

**Treatment With Dignity and Respect**
- To be treated with dignity and respect and to have their right to privacy recognized.
- To exercise these rights regardless of the member’s race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To confidential treatment of all communications and records pertaining to the member’s care.
- To access, copy and/or request amendment to the member’s medical records consistent with the terms of HIPAA.
- To extend their rights to any person who may have legal responsibility to make decisions on the member’s behalf regarding the member’s medical care.
- To refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision).
- To complete an Advance Directive, living will or other directive to the member’s medical care providers.

**Member Satisfaction**
UnitedHealthcare Dual Complete periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from participating care providers. Survey information is reviewed by UnitedHealthcare Dual Complete and results are shared with the participating care providers. The Centers for Medicare and Medicaid Services (CMS) conducts annual surveys of members to measure their overall customer satisfaction as well as satisfaction with the care received from participating care providers. Surveys results are available upon request.

**Member Responsibilities**
Member responsibilities include:
- Reading and following the Evidence of Coverage (EOC).
- Treating all UnitedHealthcare staff and health care providers with respect and dignity.
- Protecting their Medicaid or DDD ID card and showing it before obtaining services.
- Knowing the name of their PCP.
- Seeing their PCP for their healthcare needs.
- Using the emergency room for life threatening care only and going to their PCP or urgent care center for all other treatment.
- Following their doctor’s instructions and treatment plan and telling the doctor if the explanations are not clear.
• Bringing the appropriate records to the appointment, including their immunization records until the child is 18 years old.
• Making an appointment before they visit their PCP or any other UnitedHealthcare health care provider.
• Arriving on time for appointments.
• Calling the office at least one day in advance if they must cancel an appointment.
• Being honest and direct with their PCP, including giving the PCP the member’s health history as well as their child’s.
• Telling their Medicaid, UnitedHealthcare, and their DDD support coordinator if they have changes in address, family size, or eligibility for enrollment.
• Tell UnitedHealthcare if they have other insurance.
• Give a copy of their living will to their PCP.

Services Provided in a Culturally Competent Manner

UnitedHealthcare Dual Complete is obligated to help ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating care providers must cooperate with UnitedHealthcare Dual Complete in meeting this obligation.

Member Complaints/Grievances

UnitedHealthcare Dual Complete tracks all complaints and grievances to identify areas of improvement for UnitedHealthcare Dual Complete. This information is reviewed in the Quality Improvement Committee, Service Improvement Subcommittee and reported to the UnitedHealthcare Dual Complete Board of Directors. Please refer to Chapter 11 for members appeal and grievances rights.
Member Access to Health Care Guidelines

The following appointment availability goals should be used to help ensure timely access to medical care and behavioral health care:

- Routine Follow-Up or Preventive Care – within 30 days
- Routine/ Symptomatic – within seven days
- Non-Urgent Care – within one week
- Urgently Needed Services – within 24 hours
- Emergency – Immediately

Adherence to member access guidelines will be monitored through the office site visits, long-term care visits and the tracking of complaints/grievances related to access and/or discrimination. Variations from the policy will be reviewed by the Network Management for educational and/or counseling opportunities and tracked for participating care provider re-credentialing.

All participating care providers and hospitals will treat all UnitedHealthcare Dual Complete members with equal dignity and consideration as their non-UnitedHealthcare Dual Complete patients.

Care Provider Availability

PCP’s will provide coverage 24 hours a day, seven days a week. When a Participating Provider is unavailable to provide services, he or she must help ensure that another participating care provider is available.

The member should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g. emergency cases) and be provided with an alternative appointment.

After hours access will be provided to assure a response to emergency phone calls within 30 minutes, response to urgent phone calls within one hour. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek emergency services.

Physician Office Confidentiality Statement

UnitedHealthcare Dual Complete members have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage program. Participating care providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member’s personnel file.

Transfer and Termination of Members From Participating Physician’s Panel

UnitedHealthcare Dual Complete will determine reasonable cause for a transfer based on written documentation submitted by you. You may not transfer a member to another participating care provider due to the costs associated with the member’s covered services. You may request termination of a member due to fraud, disruption of medical services, or repeated failure to make the required reimbursements for services.

Closing of Care Provider Panel

When closing a practice to new UnitedHealthcare Dual Complete members or other new patients, you are expected to:

- Give UnitedHealthcare Dual Complete prior written notice that the practice will be closing to new members as of the specified date.
- Keep the practice open to UnitedHealthcare Dual Complete members who were members before the practice closed.
- Uniformly close the practice to all new patients including private payers, commercial or governmental insurers.
- Give UnitedHealthcare Dual Complete prior written notice of the reopening of the practice, including a specified effective date.

Prohibition Against Discrimination

Neither UnitedHealthcare Dual Complete or you may deny, limit, or condition the coverage or furnishing of services to members on the basis of any factor that is related to health status, including, but not limited to the following:

1. Medical condition including mental as well as physical illness
2. Claims experience
3. Receipt of health care
4. Medical history
5. Genetic information
6. Evidence of insurability including conditions arising out of acts of domestic violence; or
7. Disability
Chapter 22: Medicare (Dual Complete) Prescription Benefits

Network Pharmacies

With a few exceptions, UnitedHealthcare members must use network pharmacies to get their outpatient prescription drugs covered. A network pharmacy is a pharmacy where members can get their outpatient prescription drugs through their prescription drug coverage. We call them “network pharmacies” because they contract with our plan. In most cases, their prescriptions are covered only if they are filled at one of our network pharmacies. Once a member goes to one, they are not required to continue going to the same pharmacy to fill their prescription; they can go to any of our network pharmacies.

Covered drugs is the general term we use to describe all of the outpatient prescription drugs that are covered by our plan. Covered drugs are listed in the formulary.

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before a prescription is filled at an out-of-network pharmacy, please contact the UnitedHealthcare Dual Complete Member Services to see if there is a network pharmacy available.

1. We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, members will have to pay the full cost (rather than paying just the copayment) when they fill their prescription. UnitedHealthcare members can ask us for reimbursement for their share of the cost by submitting a paper claim form.

2. If a UnitedHealthcare member is traveling within the US, but outside of the Plan’s service area and become ill, lose or run out of their prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. In this situation, the member will have to pay the full cost (rather than paying just their copayment) when they fill their prescription. The member can ask us to reimburse them for our share of the cost by submitting a claim form. Remember, prior to filling a prescription at an out-of-network pharmacy call our UnitedHealthcare Dual Complete Member Services to find out if there is a network pharmacy in their area where the member is traveling. If there are no network pharmacies in that area, our Member Services may be able to make arrangements for the member to get their prescriptions from an out-of-network pharmacy.

3. If a UnitedHealthcare member is unable to get a covered drug in a timely manner within our service area because there are not network pharmacies within a reasonable driving distance that provide 24 hour service.

4. If a member is trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail (these drugs include orphan drugs or other specialty pharmaceuticals).

Paper Claim Submission

When UnitedHealthcare members go to a network pharmacy, their claims are automatically submitted to us by the pharmacy. However, if they go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, members will have to pay the full cost of their prescription. Please call the Pharmacy held desk at 800-797-9791 for a claim form and instructions on how to obtain reimbursement for covered prescriptions. Mail the claim form and receipts to:

Prescription Solutions
P.O. Box 6082
Cypress, CA 90630-0082

Formulary

A formulary is a list of all the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy, or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.
Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. In other cases, we have decided not to include a particular drug. We may also add or remove drugs from the formulary during the year. If we change the formulary we will notify you of the change at least 60 days before the effective date of change. If we don’t notify you of the change in advance, the member will get a 60-day supply of the drug when they request a refill. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will NOT give a 60-days notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

To find out what drugs are on the formulary or to request a copy of our formulary, please contact UnitedHealthcare Dual Complete Member Services at 800-514-4912 (TTY 711). You can also get updated information about the drugs covered by us by visiting our website at UHCprovider.com/NYcommunityplan > Pharmacy Resources and Physician Administered Drugs.

Exception Request
You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drugs. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan’s formulary would not be as effective in treating the member’s condition and/or would cause the member to have adverse medical effects. Please call our UnitedHealthcare Dual Complete Member Services at 800-514-4912 (TTY 711) to request a formulary exception. If we approve your exception request, our approval is valid for the remainder of the plan year, as long as the physician continues to prescribe the drug and it continues to be safe and effective for treating the patients’ condition.

Drug Management Programs
(Utilization Management)

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements help ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our plan to help us to provide quality coverage to our members. Examples of utilization management tools are described below:

- **Prior Authorization**: We require UnitedHealthcare members to get prior authorization for certain drugs. This means that UnitedHealthcare physician or pharmacist will need to get approval from us before a member fills their prescription. If they don’t get approval, we may not cover the drug.
- **Quantity Limits**: For certain drugs, we limit the amount of the drug that we cover per prescription or for a defined period of time. For example, we will provide up to 30 tablets per prescription for ALTOPREV. This quantity limit may be in addition to a standard 30-day supply limit.
- **Step Therapy**: In some cases, we require members to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
- **Generic Substitution**: When there is a generic version of a brand-name drug available our network pharmacies will automatically give the member the generic version, unless their doctor has told us that they must take the brand-name drug.

You can find out if the drugs you prescribe are subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. Please refer to the section above for Exception Requests.
Chapter 23: Medicare (Dual Complete)
Behavioral Health

UnitedHealthcare Dual Complete (Medicare) members can receive mental health and substance abuse services through UnitedHealthcare.

Screening for Behavioral Health Problems

Primary Care Physicians (PCPs) are required to screen UnitedHealthcare members for behavioral health problems (a.k.a. chemical dependence) and mental health. PCPs should file the completed screening tool in the patient's medical record.

Role of the Behavioral Health Unit

UnitedHealthcare’s Behavioral Health Unit is an important resource to all care providers when members experience mental health or substance abuse problems. You may call 866-604-3267 for New York City adults. The rest of the state should call 888-291-2506.

- Operates 9 a.m. – 5 p.m., weekdays.
- Responsible for member emergencies and requests for inpatient behavioral health admissions 24 hours, seven days a week.
- Fully supports primary care providers with assessment and referrals to mental health and chemical dependence services.
- Provides behavioral health case management.
- Reviews, monitors, and authorizes behavioral health care.
- Responsible for provider relations for behavioral health care providers.
- Staffed by professionals with extensive experience in mental health and chemical dependence services.

Behavioral Health Emergencies

If you believe the member is having a psychiatric emergency, you should either call 911 or direct the member to the designated county screening center or nearest hospital emergency room. If you are unsure about the member’s mental status, call the UnitedHealthcare Behavioral Health Unit. New York City Adults can call 866-604-3267. The rest of the state should call 888-291-2506.

Referrals for Behavioral Health Services

PCPs and behavioral health providers should communicate with the Behavioral Health Unit by calling (866-604-3267 for New York City adults. The rest of the state should call 888-291-2506). You can also send requests through the Behavioral Health confidential fax for New York City Adults to 866-950-4490. You should note the referral or request in the patient’s medical record.

A member can self-refer to a participating behavioral health care provider for the first outpatient visit at a participating provider. The Behavioral Health Unit generally approves a maximum of six initial outpatient visits to allow for full clinical evaluation.

The initial treatment assessment must include a full psychosocial history, a mental status examination, and M.D. psychiatric evaluation. The assessment and development of a comprehensive treatment plan must be developed within the first 30 days of treatment.

Behavioral Health Guidelines and Standards

UnitedHealthcare utilizes the following diagnostic assessment tools and placement criteria guideline, consistent with current standards of care:

- DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), 4th edition
- ASAM PPC-2 (American Society of Addiction Medicine)

UnitedHealthcare uses MCG Care Guidelines for appropriateness of care and discharge reviews. Behavioral health providers may not refer patients to another provider without notifying the Behavioral Health Unit and obtaining prior authorization. UnitedHealthcare expects behavioral health providers to comply with Section 13.4: Timeliness Standards for Appointment Scheduling.
### Services That Require Prior Notification

For Dual Complete, fixed bridgework and implants require prior authorization also.  
*(Applicable only to contracted care providers)*

<table>
<thead>
<tr>
<th>Service Needed</th>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Adult Day Care</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Durable Medical Equipment &gt; $1,000 Per Item</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Hearing Aide</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Home Health Care Services (HHC)</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Personal Medical Emergency Response</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Rehabilitation (including CORF)</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Skilled Nursing Facility Services</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Sub-Acute</td>
<td>866-604-3267</td>
<td>866-604-3267</td>
</tr>
</tbody>
</table>
SCREENING TOOL FOR SUBSTANCE ABUSE*

Patient Name ______________________ Date Completed ______________________

CIN# ___________________________ PCP Name _____________________________

DURING THE PAST MONTH:

1. Have you thought you should cut down on your drinking or alcohol? .............☐ ........... ☐
   If Yes, why? __________________________________________________________

2. Has anyone complained about your drinking? .............................................☐ ........... ☐
   If Yes, who, why? ____________________________________________________

3. Have you felt guilty or upset about your drinking? .....................................☐ ........... ☐

4. Was there ever a single day in which you had five or more drinks of beer, wine or liquor? ................................................................. ☐ ........... ☐
   How often have you had that much to drink in the past 6 months? ............
   Has that cause any problems? ................................................................. ☐ ........... ☐

HAVE ANY OF THE FOLLOWING HAPPENED TO YOU MORE THAN ONE TIME IN THE LAST SIX MONTHS:

5. Were you drinking, high from alcohol or other substance (marijuana, cocaine, heroin) or hung over while you were working, going to school or taking care of other responsibilities? .............................................☐ ........... ☐

6. What about missing or being late for work, school, or other responsibilities because you were drinking, high from other substances (marijuana, cocaine, heroin) or hung over ................................................................. ☐ ........... ☐

7. What about having a problem getting along with other people while you were drinking or high from other substances (marijuana, cocaine, heroin)? ................................................................. ☐ ........... ☐

8. What about driving a car after having several drinks or after too much of using marijuana, cocaine, heroin ................................................................. ☐ ........... ☐
# SCREENING TOOL FOR MENTAL HEALTH*

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIN#</td>
<td>PCP Name</td>
</tr>
</tbody>
</table>

**DURING THE PAST MONTH:**

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you feel tired or have low energy?</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Do you have trouble sleeping? Too much or too little?</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Do you have little interest or pleasure in doing things?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Are you feeling down, unhappy, hopeless?</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Have you been feeling bad about yourself, that you are a failure or have let yourself or your family down?</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Have you had trouble concentration on things, such as watching TV, reading the newspaper, or a book?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Have you been overeating or is your appetite poor?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Have you been feeling on edge, anxious, nervous?</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Have you been worrying about a lot of different little things?</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Have you suddenly felt fear or panic?</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Have you had thoughts that you would be better off dead? or of hurting yourself?</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Have you been so angry with someone else that you have thought of ways of hurting him/her?</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>When you eat this way, do you often feel that you can’t control what or how much you eat?</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Does this type of eating occur often, on average, as much as twice a week for the last 3 months?</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>After eating this way, do you make yourself vomit, or take more than twice the recommended dosage of laxatives, or exercise more than an hour, to not gain weight?</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>On average, how many times during the week do you do this?</td>
<td></td>
</tr>
</tbody>
</table>
UnitedHealthcare Personal Assist Overview

A managed long-term care plan receives Medicaid funding to arrange, coordinate and pay for health and long-term care services for people who are chronically ill and/or have disabilities.

UnitedHealthcare Personal Assist has been approved by the New York State Department of Health to offer members managed long-term care. Through UnitedHealthcare Personal Assist, members will receive coordination of services to help maintain or improve their quality of life and overall health, despite chronic illness or disability. Through our coordination and oversight, we will help members live safely in their home and/or community for as long as possible. Members of UnitedHealthcare Personal Assist will also receive:

- A RN Care Coordinator who will visit them in their home, assess their needs and work with them to help ensure they receive appropriate, timely care to meet their specific needs;
- A personalized plan of care, developed to address their specific needs;
- Extensive choices in care providers that offer them managed long-term care benefits; and
- Access to UnitedHealthcare Personal Assist, 24 hours a day, seven days a week.

Members also receive a personalized plan of care, encompassing a wide range of long-term care and health-related services in their home, the community and if necessary, in a nursing home. Care coordinators assist in referral to, and coordination of, other necessary medical, social, educational, psychosocial, financial and other services of the care plan irrespective of whether such services are covered by the plan. They also assist members in obtaining other services that are not covered by UnitedHealthcare Personal Assist.

How to Contact Us

For care provider claims and contracting questions – 866-362-3368.

For MLTC plan referrals – 866-214-1746.

Member Identification Cards

UnitedHealthcare Personal Assist members receive an ID card containing information that helps you submit claims accurately and completely.

Be sure to check the member’s ID card at each visit and to copy both sides of the card for your files.

Enrollment Eligibility Criteria

Any applicant who completes the enrollment agreement and the appropriate releases of information and meets all of the following enrollment criteria is eligible for UnitedHealthcare Personal Assist:

- Be 18 years of age or older;
- Be eligible for New York State Medicaid;
- Live in the plan’s service area;
- Require at least 120 days of home and community-based services;
- If 18 to 20 years old, require nursing home level of care*; and
- Upon enrollment, be able to return to or remain safely at home without jeopardy to his/her health*.
*Determination is made based upon individual circumstances in accordance with New York State assessment guidelines.

An applicant who is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based waiver program or an Office of People with Developmental Disabilities (OPWDD) Day Treatment Center or is receiving services from a hospice, may be enrolled with UnitedHealthcare Personal Assist upon termination from these other programs or plans. Eligible persons may choose to transfer from other Medicaid programs to an MLTC plan at any time. Applicants/referrers can contact the plan the person is interested in transferring to and the plan can assist them with this process.

An applicant who is an inpatient or resident of a hospital or residential facility operated under the auspices of the Office of People with Developmental Disabilities State of Mental Retardation and Developmental Disabilities, may enroll upon discharge to the applicant’s home in the community.

Applicants cannot be discriminated against based on their health status and/or the need for or cost of covered services. Eligibility for enrollment in UnitedHealthcare Personal Assist must be determined through a New York State Department of Health approved clinical assessment, which is completed in the applicant's home by a UnitedHealthcare Personal Assist registered nurse.

**Service Area**

UnitedHealthcare Personal Assist offers its benefit plan within the following counties:

- New York
- Bronx
- Kings (Brooklyn)
- Queens
- Richmond (Staten Island)
Our Claims Process
Here’s what you can do to help ensure prompt payment for the services you provide.

1. Review and copy both sides of the member’s ID card. UnitedHealthcare Community Plan members receive an ID card containing information that helps you process claims accurately. These ID cards display information such as claims address, copayment information (if applicable), and telephone numbers such as those for Provider and Member services.

2. If you have questions regarding an LTC member’s approved services, please contact Care Coordination at 866-214-1746.

3. Prepare a complete and accurate electronic or paper claim form. Complete a CMS 1500 or UB-04 form.

4. Submit claims electronically and use our electronic payer ID: 87726. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315. If you do not have access to internet services, you can mail the completed claim to:

   UnitedHealthcare Community Plan
   P.O. Box 5270
   Kingston NY 12402-5240

Electronic Important Information

Electronic Claims Submission
Payer ID: 87726

Claims Address
United Healthcare Community Plan – New York
P.O. Box 5240
Kingston, NY 12402-5240

Claim Appeal Mailing Address
UnitedHealthcare Community Plan – New York
Attention: Claims Administrative Appeals
PO Box 31364
Salt Lake City, UT 84131-03641

For Claims Questions please contact
Provider Services at 888-362-3368

To Report Fraud & Abuse
Contact Provider Services at 888-362-3368

National Credentialing Center
(Skilled Service Care Providers Only)
877-842-3210

Home & Community-Based Services (HCBS)
Care Provider Credentialing (Non-Skilled Care Providers)
If you are a non-skilled HCBS care provider and wish to join our network, please call 886-362-3368 and ask to speak with your Provider Advocate.

Vision Services
March Vision (Eye exams for diabetes and eye infections. Eyeglasses and contacts are covered annually for those under age 21).

Call Provider Customer Service at 888-493-4070. Available Monday through Friday, 8 a.m. to 7 p.m. local time, or go online to marchvisioncare.com.
## Covered Services

**Services Covered by UnitedHealthcare Personal Assist:**
Covered Services are those services available through membership in UnitedHealthcare Personal Assist. The MLTC benefit package includes Medicare covered services, and for dual members, Medicare is the primary payer for those services. Benefits and services that require authorization can be found in the Service Authorizations and Actions section. Authorizations will be provided when medically necessary. Specific services and their frequency and duration are based upon the member’s condition and health and social needs.

Member benefit coverage information can be found online at [UHCprovider.com/eligibility](http://UHCprovider.com/eligibility). Following is a list of UnitedHealthcare Personal Assist covered services:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Management</strong></td>
<td>A process to assist members to access necessary covered services as identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist members to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered by the plan.</td>
</tr>
<tr>
<td><strong>Home Health Care +</strong></td>
<td>Includes the following services which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.</td>
</tr>
<tr>
<td><strong>Medical Social Services</strong></td>
<td>Assessing the need for, arranging for and providing aid for social problems related to the maintenance of a member in the home where such services are performed by a qualified social worker and provided within a plan of care.</td>
</tr>
<tr>
<td><strong>Adult Day Health Services</strong></td>
<td>Care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental pharmaceutical, and other ancillary services.</td>
</tr>
<tr>
<td><strong>Personal Care</strong></td>
<td>Some or total assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, ordered by a physician and provided by a qualified person in accordance with a plan of care.</td>
</tr>
<tr>
<td><strong>Medical/Surgical Supplies</strong></td>
<td>Items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment +</strong></td>
<td>Includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prosthetics and Orthotics +</td>
<td>Prosthetic appliances and devices are appliances and devices, which replace any missing part of the body. Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.</td>
</tr>
<tr>
<td>Enteral and Parenteral Supplements</td>
<td>Enteral supplements are nutrients delivered directly into the stomach, or small intestines. Parenteral supplements are nutrients delivered intravenously, bypassing the usual process of eating and digestion. Coverage is limited to nutritional supplements to those who can only ingest food by tube feeding, those with rare metabolic disorder, those with low body mass or children up to 21 years of age, who require liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized.</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>An electronic device which enables certain high-risk patients to secure help if there is a physical, emotional or environmental emergency. If there is an emergency, the signal is received and appropriately acted on by a response center.</td>
</tr>
<tr>
<td>Non-emergency Transportation</td>
<td>Transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the member’s condition for the member to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or the Medicare Program. The Contractor is required to use only approved Medicaid ambulette vendors to provide ambulette transportation services to members.</td>
</tr>
<tr>
<td>Podiatry +</td>
<td>Services by a podiatrist which must include routine foot care when the member’s physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and an integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Includes but will not be limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition, including one which affects employability.</td>
</tr>
<tr>
<td>Optometry/Eyeglasses</td>
<td>Services of an optometrist and an ophthalmic dispenser, and includes eyeglasses; medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member’s condition.</td>
</tr>
<tr>
<td>Audiology/Hearing Aids, Hearing Aid Batteries</td>
<td>Include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.</td>
</tr>
<tr>
<td>Home Delivered or Congregate Meals</td>
<td>Home-delivered and congregate meals provided in accordance with each individual member’s plan of care.</td>
</tr>
</tbody>
</table>
### Benefit Description

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Day Care</td>
<td>A structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.</td>
</tr>
<tr>
<td>Physical, Occupational, Speech or Other Therapies in a Setting Other than the Home +</td>
<td>Provision of professional Physical, Occupational, Speech or other therapies in a setting other than the member’s home. Physical therapy, occupational therapy and speech therapy will be limited to 20 Medicaid visits each, per therapy, per 12-month benefit year. This benefit limit applies to rehabilitation visits in private practitioners’ offices, certified hospital outpatient departments, and diagnostic and treatment centers (free-standing clinics). The 12-month benefit year is a calendar year, beginning January 1 of each year and running through December 31 of the same year.</td>
</tr>
<tr>
<td>Respiratory Therapy +</td>
<td>The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures, including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual’s physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within the patient’s home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, provision of in-service education to health agency staff as well as consultation on specific dietary problems of patients and nutrition teaching to patients and families.</td>
</tr>
<tr>
<td>Social Supports and Modifications to the home</td>
<td>Services and items that support the member’s medical needs and are included in a member’s plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services and housing improvement.</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Continuous and skilled nursing care provided in a member’s home by properly licensed registered professional or licensed practical nurses.</td>
</tr>
<tr>
<td>Nursing Home Care +</td>
<td>Care provided to members by a licensed NYS Nursing Home facility.</td>
</tr>
</tbody>
</table>

+ Medicare coverage may apply
Coordinated Services

Coordinated services are services that are not part of the UnitedHealthcare Personal Assist benefit package. Members may choose any care provider for these non-covered services provided the provider accepts Medicaid and/or Medicare, as applicable by service. You should not bill UnitedHealthcare Personal Assist for these services. The member’s UnitedHealthcare Personal Assist care coordinator is available to assist them in arranging and coordinating these services. The care coordinator’s primary job is to serve as a liaison between the member and all of their health care providers to assure that they receive services in a smooth and seamless manner.

The following is a list of UnitedHealthcare Personal Assist coordinated services:

<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency Room Services +</td>
</tr>
<tr>
<td>• Physician Services (including services provided in an office setting, a clinic, a facility or in the home) +</td>
</tr>
<tr>
<td>• Inpatient Hospital Services +</td>
</tr>
<tr>
<td>• Outpatient Hospital Services +</td>
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<tr>
<td>• Laboratory Services +</td>
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<tr>
<td>• Radiology and Radioisotope Services +</td>
</tr>
<tr>
<td>• Prescription and Non-prescription Drugs +</td>
</tr>
<tr>
<td>• Emergency Transportation +</td>
</tr>
<tr>
<td>• Rural Health Clinic Services +</td>
</tr>
<tr>
<td>• Chronic Renal Dialysis +</td>
</tr>
<tr>
<td>• Mental Health Services +</td>
</tr>
<tr>
<td>• Alcohol/Substance Abuse Services +</td>
</tr>
</tbody>
</table>

+ Medicare coverage may apply
If a Member has Both Medicaid and Medicare:
If a member has both Medicaid and Medicare, they have more than one insurance coverage. Medicare is considered their primary insurance and Medicaid is their secondary insurance. If Medicare does not cover the entire cost of the service, then UnitedHealthcare Personal Assist will be billed for any deductibles or coinsurance. The member’s Medicaid benefits will not change their primary insurance benefits. The member will continue to be covered by Medicare for their physician visits, hospitalizations, lab tests, ambulance and other Medicare benefits. The member does not need authorization from UnitedHealthcare Personal Assist to receive Medicare services. If the member’s Medicare benefits are exhausted and UnitedHealthcare Personal Assist becomes the primary payer for a covered service, the member will need to switch to one of our network care providers.

The member’s care coordinator will work with their primary insurance to help set up their health care. For Medicare covered services, UnitedHealthcare Personal Assist care coordinators can:
- Assist with referral to physicians if needed;
- Schedule health appointments and arrange non-emergency transportation;
- Assist with discharge planning if they are admitted to a hospital; and
- Arrange Medicare-covered home care services.

If the member is currently receiving a Medicare-covered service, they can continue using that care provider. However, UnitedHealthcare Personal Assist recommends that they use a care provider in our network so that they do not have to change care providers if Medicare coverage limits are met and UnitedHealthcare Personal Assist becomes responsible for primary payment for the care.

The Care Coordination Team
A member’s UnitedHealthcare Personal Assist care team will consist of their Care Coordinator, their PCP and other UnitedHealthcare Personal Assist support staff. Support staff may consist of member services associates, social workers, pharmacists and our medical director.

An important benefit of joining UnitedHealthcare Personal Assist is that a member will be assigned a Care Coordinator who will be responsible for developing a personalized plan of care and coordinating the member’s services. He/she will have expertise in community-based home care and will also make periodic visits to the member’s home to reassess their condition. A member’s Care Coordinator will work with them to help them manage their chronic condition and live in their home as independently as possible, for as long as possible with the goal to enhance their functionality and quality of life. A member’s Care Coordinator will be matched, based upon availability, to best meet their individual language and cultural needs.

When a member enrolls in UnitedHealthcare Personal Assist, their Care Coordinator and PCP will work together with the member to help develop a plan of care that meets their needs. Their plan of care is a written description of all the types of services they will receive to help maintain and improve their health status and be as independent as possible. Their plan of care will include both UnitedHealthcare Personal Assist-covered services and non-covered services and will change based on initial and follow-up assessments as their health care needs change.

A member’s initial plan of care will be based upon the results of an in-home RN assessment visit in collaboration with their PCP. Reassessments will be completed as warranted by changes in their condition, but no longer than 180 days from the last assessment. A member will receive a confirmation letter indicating the covered services listed in their plan of care and will include the service type, the duration (length of time) and frequency (how often) of each covered service, as well as the date that the authorization expires.

A member’s plan of care will be periodically reviewed to help ensure that their authorized services continue to meet their specific needs. As a member’s health care needs change, they may require changes to the types and/or frequency of services they receive. This will require a change to their plan of care. Their Care Coordinator will review the plan of care with them and their PCP and discuss the changes.

Because a member is an important part of their health care team, it is very important for them to let UnitedHealthcare Personal Assist know what they need. They should talk to their PCP or their Care Coordinator if they have a need for services that they are not currently receiving, or if they would like to make a change to their plan of care.

Coordination of Care/Care Provider Responsibilities
Care coordination and management is integral to the UnitedHealthcare Personal Assist program. Regardless of a member’s eligibility for Medicare, the participating care providers have a responsibility to cooperate with UnitedHealthcare’s care management team.

It is essential that the care management team at UnitedHealthcare is able to work with care providers to promote
Chapter 24: Managed Long Term Care (MLTC)

scheduling of services and remove barriers to care. Care providers have a responsibility to communicate any other insurance coverage of which they may become aware. UnitedHealthcare will work with care providers to set goals for UnitedHealthcare Personal Assist members, developing a plan of care and working together to achieve those goals.

If a member refuses the care/services outlined in the member’s plan of care, UnitedHealthcare Personal Assist will not place, or will terminate those services after all parties have been fully informed of the health risks and consequences.

You must notify UnitedHealthcare Personal Assist immediately if an authorized or requested service is refused.

In addition to all applicable requirements outlined in the Physician Standards and Policies section of your contract, Home Care Providers are responsible for:

- Obtaining physician orders;
- Developing the aide care plan for requested services;
- Notifying member of assigned staff in advance of service delivery;
- Notifying UnitedHealthcare Personal Assist and members in advance of need for replacements and name of replacement staff;
- Submitting evaluation and progress notes upon request;
- Confirming aide daily attendance: Effective Jan. 1, 2012, all Licensed Home Care Service Agencies (LHCSAs) must implement an electronic call-in/call-out attendance program in addition to other manual random verification. Agency protocols on Aide attendance verification must be available to UnitedHealthcare Personal Assist Provider Relations upon request. The agency is responsible for having an alternative tracking system in place if the standard process cannot be followed; and
- Maintain full compliance with the New York State Home Care Worker Wage Parity Law (New York State Public Health Law Section 3614-c, as amended, and all New York State Health Department regulations and guidance with respect thereto) (the “Wage Parity Law”); and will provide UnitedHealthcare Personal Assist with all information to verify such compliance.

Residential Health Care Providers are Responsible for:

For Short-Term Stay (up to 6 months):

- Determining the type of health insurance coverage the prospective resident has and whether or not the RHCF is authorized to serve the member;
- Submitting progress notes to UnitedHealthcare Personal Assist upon request;
- Obtaining authorization for any covered service outside of daily rate; and
- Assisting in the Medicaid recertification process.

For Long-Term Care:
- Determining eligibility for Institutional Medicaid and other third-party health insurance and whether or not the RHCF is authorized to serve the member;
- Submitting conversion applications for members placed for long-term care; identifying the admission as a Managed Long Term Care admission;
- Collecting the NAMI (NAMI will be deducted from payments);
- Submitting Resident Monthly Summaries to the UnitedHealthcare Personal Assist upon request;
- Including UnitedHealthcare Personal Assist Care Coordinator in case conferences;
- Obtaining authorization for any covered service outside of daily rate; and
- Assisting in the Medicaid recertification process.

Note: UnitedHealthcare Personal Assist members must be eligible for Institutional Medicaid to remain in a RHFC for long-term care.

DME and Medical Supply Care Providers are Responsible for:

- Verifying primary payer coverage and eligibility prior to delivery;
- Acquiring physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or third-party reimbursement;
- Exhausting all other payment sources prior to billing UnitedHealthcare Personal Assist; and
- Timely delivery of requested products.

Note: It is the responsibility of the care provider to determine whether Medicare covers the item or service being billed. If the service or item is covered or if the care provider does not know if the service or item is covered, the care provider must first submit a claim to Medicare, as UnitedHealthcare Personal Assist is always the payer of last resort. If the item is normally covered by Medicare but the care provider has prior information that Medicare will not reimburse due to duplicate or excessive deliveries, the information should be communicated to the UnitedHealthcare Personal Assist Care Coordinator prior to delivery.
Service Authorizations and Actions

Some covered services require prior authorization (approval in advance) from the member’s physician, UnitedHealthcare Personal Assist or both, before the member can receive them or be able to continue receiving them. A member or someone they trust can ask for this. Below is a list of the UnitedHealthcare Personal Assist Benefits. The check mark (✓) will tell you if the treatment or service requires prior authorization from UnitedHealthcare Personal Assist or an order form from the member’s PCP, or both, before the member can access the benefit.

<table>
<thead>
<tr>
<th>UnitedHealthcare Personal Assist Benefits</th>
<th>Prior Authorization Required</th>
<th>Physician Order Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health Care</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Audiology/Hearing Aids</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Consumer Directed Personal Assistance Program (CDPAP)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dentistry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Home Care Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Optometry/Eyeglasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy/Occupational Therapy/Speech Therapy provided in a setting other than home</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Podiatry</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Social Day Care</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Social and Environmental Supports</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Note: All services rendered by non-participating care providers require prior authorization.
Approval of a treatment or service is called a Service Authorization. To get a service authorization request, the member or care provider must call Member Services at 877-512-9354. The Member Services representative will assist or transfer the request to the appropriate party.

For those UnitedHealthcare Personal Assist Benefits with no check mark (✓), these services may be accessed without a Service Authorization.

Authorization Process

Requesting New or Additional Services
Requests for new or additional benefits or services can be made by calling Member Services at 877-512-9354. For some requests, the member’s Care Coordinator or their physician will conduct a medical necessity determination to help ensure that the request for a particular service or quantity of services is most appropriate for the member’s condition. If an assessment is required, it will be conducted as fast as the member’s condition requires or within 3 business days of receipt of the request.

Prior Authorization (New Services)
When a new service is requested that the member has never had before, it is considered to be a prior authorization request. A request to change a service in the plan of care for a future authorization period is also considered a prior authorization. For these requests, a decision will be made as fast as the member’s condition requires or within 3 business days of receipt of all necessary information, but no more than 14 days from the receipt of the request. The member will be notified by phone and in writing about the decision. For an expedited prior authorization, the member will be notified via phone and in writing as fast as your condition requires.

Concurrent Review (More of Same Service)
When a member requests additional services that are currently authorized in the plan of care, the request is considered a concurrent review.

For these requests, a decision will be made as fast as the member’s condition requires or within one business day of receipt of all necessary information, but no more than 14 days from the receipt of the request. For an expedited concurrent review, the member will be notified of the decision no more than one business day from the receipt of necessary information but no more than three business days from receipt of the request for service.

Expedites Reviews
If UnitedHealthcare Personal Assist determines, or the member’s care provider indicates, that a delay in approving any service request would seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function, the request will be expedited. The member may also request an expedited review. If we deny the request for an expedited review, we will complete the review using the standard time frames. We will send a written notice to the member to indicate that the request will not be handled as an expedited request, but will be handled as a standard request. The member or their care provider may file a grievance regarding the determination by UnitedHealthcare Personal Assist to complete the review using standard time frames. The member’s Care Coordinator will notify them of any decision by phone and in writing as fast as your condition requires.

Extensions of Request Time Frames
UnitedHealthcare Personal Assist may extend the review period by up to 14 days if there is a need for additional information and the extension is in the member’s best interest. The member, or their care provider, can also request an extension, verbally or in writing. We will send the member a written notice of any extension that is initiated.

Denials of Requests (Plan Action)
If UnitedHealthcare Personal Assist denies coverage of the member’s prior authorization or concurrent review request, they will receive a notice of plan action letter in the mail which will explain the decision. The member or their care provider may appeal the UnitedHealthcare Personal Assist decision.

Transitional, Out-of-Network and Out-of-Area Care

Transitional Care
Upon enrollment in UnitedHealthcare Personal Assist, a member can continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider. If a member’s care provider chooses to leave the UnitedHealthcare Personal Assist network, the member’s ongoing treatment may be continued for a transitional period of up to 90 days. The following care provider criteria must be met for UnitedHealthcare Personal Assist to authorize and pay for transitional care:

- Accepts UnitedHealthcare Personal Assist payment in full;
- Makes any medical information related to the member’s care available to UnitedHealthcare Personal Assist;
- Agrees to follow UnitedHealthcare Personal Assist policies and procedures.

If a member feels that they have a condition that meets the criteria for transitional care services, this should be discussed with their care coordinator.
Members entering an MLTC plan through mandatory enrollment have a 60-day transition of care period. This requires that plans continue to provide the same level of home-care services that the member was receiving prior to enrolling in the plan. The plan will have 30 days from the date of enrollment to complete a home assessment.

**Out-of-Network Care**

If UnitedHealthcare Personal Assist does not have a care provider in our network with appropriate training or experience to meet a member’s needs, they may obtain a referral to an out-of-network health care provider. If a member feels that they need an out-of-network care provider, they should contact their care coordinator so he/she can assist them in obtaining an authorization.

Before a member sees any out-of-network care provider for covered services, they must get an authorization from UnitedHealthcare Personal Assist. If the member sees the care provider without an authorization, the care provider will not be paid. If the member has any questions regarding out-of-network care and/or authorizations, they should call Member Services at 877-512-9354.

**Out-of-Area Care: Leaving the Plan’s Service Area**

Members of UnitedHealthcare Personal Assist can spend time out of the plan’s service area for 60 days or less. If they are planning to spend time away from home, they should let their care coordinator know as early as possible, so he/she can make every effort to assist them in arranging temporary services for them while they are away or obtaining authorizations for out-of-area services. If they will be out of the service area for more than 60 days, it will be difficult for UnitedHealthcare Personal Assist to continue to monitor their health care needs and services and they will be disenrolled from the program. If they know that they will be out of the service area for more than 60 days, they should call their care coordinator to discuss their options.

**Medicaid Surplus (Spend Down and NAMI)**

In New York State, some individuals can receive Medicaid even if their monthly income is over the Medicaid limit, as long as they are willing to pay what Medicaid calls a spend-down. The monthly spend-down is an amount determined by HRA/LDSS. UnitedHealthcare Personal Assist is ultimately responsible for collecting the spend-down amount for its members that have a spend-down requirement.

UnitedHealthcare Personal Assist will collect spend-down amounts in one of two ways. Members with a spend-down amount, who are receiving home and community-based services, will receive a monthly bill from UnitedHealthcare Personal Assist for the spend-down amount that is owed.
Member Rights and Responsibilities

**Member Rights**

Members of UnitedHealthcare Personal Assist have the right to:

- Receive medically necessary care;
- Timely access to care and services;
- Privacy about your medical record and when you get treatment;
- Get information on available treatment options and alternatives presented in a manner and language you understand;
- Get information in a language you understand; you can get oral translation services free of charge;
- Get information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Take part in decisions about your health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to get the services you need from your managed long-term care plan, including how you can get covered benefits from out-of-network care providers if they are not available in the plan network;
- Complain to the New York State Department of Health or your local Department of Social Services; and, the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate;
- Appoint someone to speak for you about your care and treatment; and
- Make advance directives and plans about your care.

**CDPAP Member Responsibilities**

Members, not the health plan, are responsible for training personal assistants and overseeing all aspects of care. Also, CDPAP members are responsible for making sure that care is actually delivered and verifying the time worked for payment. As the manager of care, the member is responsible for scheduling their assistants. The consumer also needs to make sure that there is alternative coverage if their assistant cannot make it to work. The consumer also needs to keep track of their time worked and sign off on time sheets and other important documents. Members work with entities called Fiscal Intermediaries, which, on behalf of the member, administers payroll and tax withholdings, required by state and federal law, disability, worker’s compensation, health insurance, unemployment insurance and more.

Members of UnitedHealthcare Personal Assist have a responsibility to:

- Receive all covered services through UnitedHealthcare Personal Assist;
- Use UnitedHealthcare Personal Assist network care providers for covered services;
- Obtain prior authorization for covered services, except for pre-approved covered services;
- Be seen by your physician if a change in your health status occurs;
- Share complete and accurate health information with your health care providers;
- Inform UnitedHealthcare Personal Assist staff of any changes in your health and making it known if you do not understand or are unable to follow instructions;
- Follow the Plan of Care recommended by UnitedHealthcare Personal Assist;
- Notify UnitedHealthcare Personal Assist within two business days, preferably before, or if not then after, receiving either non-covered services or pre-approved covered services;
- Notify UnitedHealthcare Personal Assist in advance whenever you will not be home to receive services or care that have been arranged for you;
- Inform UnitedHealthcare Personal Assist before permanently moving out of the service area, or of any lengthy absence from the service area;
- Make every effort to pay UnitedHealthcare Personal Assist any Medicaid surplus amount owed; and
- Maintain Medicaid eligibility.

**Member Grievances and Appeals to Grievances**

UnitedHealthcare Personal Assist will try its best to deal with members’ concerns or issues as quickly as possible and to the member’s satisfaction. A member may use either the grievance process or our appeal process, depending on what kind of problem they have.

There will be no change in a member’s services or the way they are treated by UnitedHealthcare Personal Assist staff or a health care provider because they file a grievance or appeal. UnitedHealthcare Personal Assist will maintain the member’s privacy. UnitedHealthcare Personal Assist will give the member
any help they may need to file a grievance or appeal. This includes providing them with interpreter services or help if they have vision and/or hearing problems. The member may choose someone (like a relative, friend or a care provider to act for them).

To file a grievance or appeal, a member can call 877-512-9354, or write to:

UnitedHealthcare Personal Assist
Attn: UM Appeals and Grievance Coordinator
P.O. Box 31364
Salt Lake City, UT 84131-0364

Member Grievances
A grievance is any communication by a member to UnitedHealthcare Personal Assist of dissatisfaction about the care and treatment they receive from our staff or care providers of covered services. For example, if someone was rude to the member or they do not like the quality of the care or services they have received from us, the member can file a grievance with UnitedHealthcare Personal Assist.

A member may file a grievance orally or in writing with UnitedHealthcare Personal Assist. The person who received the grievance will record it and the appropriate plan staff will oversee the review of the grievance. UnitedHealthcare Personal Assist will send a letter to the member telling them that their grievance was received and it will also give a description of the review process. UnitedHealthcare Personal Assist will review the member’s grievance and give them a written answer within one of two time frames.

1. If a delay would significantly increase the risk to the member’s health, UnitedHealthcare Personal Assist will make a decision within 48 hours of receipt of necessary information.

2. For all other types of grievances, UnitedHealthcare Personal Assist will notify the member of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if the member requests it or if we need more information and the delay is in the member’s interest.

UnitedHealthcare Personal Assist’s answer will describe what was found when we reviewed the member’s grievance and our decision about the grievance.

Members Appeals to Grievances
If a member is not satisfied with the decision UnitedHealthcare Personal Assist makes concerning their grievance, the member may request a second review of their issue by filing a grievance appeal. The member must first file a grievance appeal in writing. It must be filed within 60 business days or receipt of UnitedHealthcare Personal Assist’s initial decision about the member’s grievance. Once UnitedHealthcare Personal Assist receives the member’s appeal, we will send the member a written acknowledgement telling them the name, address and telephone number of the individual we have designated to respond to their appeal. All grievance and appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

For standard appeals, UnitedHealthcare Personal Assist will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to the member’s health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within two business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide the member with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.
Appeal
Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service. These procedures include reconsiderations by UnitedHealthcare Dual Complete, an independent review entity, hearings before Administrative Law Judge, review by the Medicare Appeals Council, and judicial review.

Basic Benefits
All health and medical services that are covered under Medicare Part A and Part B, except hospice services and additional benefits. All UnitedHealthcare Dual Complete members receive all Basic Benefits.

Center for Health Dispute Resolution (CHDR)
An independent CMS contractor that reviews appeals by Members of Medicare managed care plans, including UnitedHealthcare Dual Complete.

CMS
The Centers for Medicare & Medicaid Services, the Federal Agency responsible for administering Medicare.

Contracting Hospital
A hospital that has a contract to provide services and/or supplies to UnitedHealthcare Dual Complete members.

Contracting Medical Group
Physicians organized as a legal entity for the purpose of providing medical care. The Contracting Medical Group has an agreement to provide medical services to UnitedHealthcare Dual Complete members.

Contracting Pharmacy
A pharmacy that has an agreement to provide UnitedHealthcare Dual Complete members with medication(s) prescribed by the member’s participating care providers in accordance with UnitedHealthcare Dual Complete.

Covered Services
Those benefits, services or supplies which are:
- Provided or furnished by participating care providers or authorized by UnitedHealthcare Dual Complete or its participating care providers.
- Emergency Services and Urgently Needed Services that may be provided by non-participating care providers.
- Renal dialysis services provided while you are temporarily outside the Service Area.
- Basic and Supplemental Benefits.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Emergency Services
Covered inpatient or outpatient services that are 1) furnished by a care provider qualified to furnish Emergency Services; and 2) needed to evaluate or stabilize an Emergency Medical Condition.

Experimental Procedures and Items
Items and procedures determined by UnitedHealthcare Dual Complete and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, UnitedHealthcare Dual Complete will follow CMS guidance (through the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

Fee-for-Service Medicare
A payment system by which doctors, hospitals and other care providers are paid for each service performed (also known as traditional and/or original Medicare).

Grievance
Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process are: waiting times in physician offices; and rudeness or unresponsiveness of Customer Service staff.
**Home Health Agency**
A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in your home when medically necessary, when members are confined to their home and when authorized by their Primary Care Physician.

**Hospice**
An organization or agency certified by Medicare, which is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

**Hospital**
A Medicare-certified institution licensed in New York, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

**Hospitalist**
A hospitalist is a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists must complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient’s primary care physician.

**Independent Physicians Association (IPA)**
A group of physicians who function as a contracting medical care provider/group, yet work out of their own independent medical offices.

**Medically Necessary**
Medical services or hospital services that are determined by UnitedHealthcare Dual Complete to be:

- Rendered for the diagnosis or treatment of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the member, the attending participating care provider, or other provider of service.

UnitedHealthcare Dual Complete will make determinations of medical necessity based on peer reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by UnitedHealthcare Dual Complete.

**Medicare**
The Federal Government health insurance program established by Title XVIII of the Social Security Act.

**Medicare Part A**
Hospital insurance benefits including inpatient hospital care, Skilled Nursing Facility Care, Home Health Agency care and Hospice care offered through Medicare.

**Medicare Part A Premium**
Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island, or local government employment to be insured, members do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if members are at least 65 years old and meet certain other requirements.

**Medicare Part B**
Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

**Medicare Part B Premium**
A monthly premium paid to Medicare (usually deducted from a member’s Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive Covered Services whether members are covered by an MA Plan or by Original Medicare.
Medicare Advantage (MA) Plan
A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by UnitedHealthcare Dual Complete. An MAO may offer more than one benefit Plan in the same Service Area. UnitedHealthcare Dual Complete is an MA plan.

Member
The Medicare beneficiary entitled to receive covered services, who has voluntarily elected to enroll in the UnitedHealthcare Dual Complete and whose enrollment has been confirmed by CMS.

Non-Contracting Medical Care Provider or Facility
Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the New York or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract to deliver covered services to UnitedHealthcare Dual Complete members.

Participating Care Provider
Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the New York or Medicare to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to UnitedHealthcare Dual Complete members pursuant to the terms of the Agreement.

Primary Care Physician (PCP)
The participating care provider who a member chooses to coordinate their health care. The PCP is responsible for providing covered services for UnitedHealthcare Dual Complete members and coordinating recommendations to specialists. PCPs are generally participating care providers of Internal Medicine, Family Practice or General Practice.

Service Area
A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for UnitedHealthcare Dual Complete includes the counties of:
- Brooklyn
- Queens
- Bronx
- New York
- Nassau
- Richmond

Please contact UnitedHealthcare Dual Complete if you have any questions regarding the definitions listed above or any other information listed in this manual. Our representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. at 866-362-3368 TTY 711.
UnitedHealthcare Dual Complete welcomes your comments and suggestions about this provider manual. Please complete this form if you would like to see additional information, or expansions on topics, or if you find inaccurate information. Please mail this form to:

UnitedHealthcare Dual Complete
Attn: Senior Network Account Rep.
AZ060-S225
3141 North 3rd Ave.
Phoenix, AZ 85013

Comments and Suggestions:
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Please provide the following information so we can contact you if we need clarification on your comment/suggestion.

Name: ____________________________________________________________

Address: _________________________________________________________

Phone: __________________________________________________________