

2018 Care Provider Manual

Physician, Health Care Professional, Facility and
Ancillary Provider

Ohio 2018

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UnitedHealthcare Community Plan Directory of Departments

UnitedHealthcare Community Plan Website	UHCCommunityPlan.com
Provider Services Department Provider Relations representatives are available to answer your questions regarding policies and procedures, reimbursement, eligibility, medical record transfers, and provider training. Representatives are available Monday through Friday, 8 a.m. to 5 p.m.	800-600-9007 877-877-7697 (Fax)
Interactive Voice Response Line Use our toll-free Interactive Voice Response (IVR) system 24 hours a day, 7 days a week to check member eligibility.	888-586-4766
Interpreter Services UnitedHealthcare Community Plan of Ohio utilizes interpreter and translation services through an arrangement with Language Line. If your office needs to access these services for our patients, please call Member Services at 800-895-2017. The services are covered by UnitedHealthcare Community Plan of Ohio at no cost to you or the patient.	800-895-2017
Utilization Management Department Staff is available 24 hours a day, 7 days a week, to assist with referrals, prior authorizations, admissions, discharges and coordination of members' care.	800-366-7304 866-839-6454 (Fax)
Durable Medical Equipment	866-839-8058 (Fax)
Pharmacy - OptumRx Pharmacy Benefit Manager	Technical Help Desk (pharmacies call): 877-305-8952 Provider Prior Authorization Help Desk: 800-310-6826 Help Desk Fax: 866-940-7328
Optum Physical Health (PT/OT/ST/Chiro)	800-873-4575
MARCH® Vision Care (Vision Provider Services)	844-756-2724 Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH® Vision Care at marchvisioncare.com .
MTM (Transportation Provider Services) Members are eligible for 30 one-way or 15 free round trips per year to and from medical appointments. Coordination of transportation services requires at least 2 business days advance notice. Transportation can be arranged by calling the phone number listed in the right-hand column.	800-895-2017 Relay 711 (TTY)
DentaQuest (Dental Provider Services)	800-341-8478
Member Services Department Representatives are available Monday through Friday, 7 a.m. to 7 p.m. to verify member eligibility and to assist with all aspects of member education.	800-895-2017 Relay 711 (TTY)

Care Management Services Representatives are available Monday through Friday, 8 a.m. to 5 p.m.		800-508-2581
Behavioral Health Care Management Staff is available 24 hours a day, 7 days a week, to assist with referrals, prior authorizations, admissions, discharges and coordination of members' care		866-261-7692
National Credentialing Center All providers who wish to be credentialed for participation in the UnitedHealthcare Community Plan network should contact the National Credentialing Center. Providers can also check their credentialing status by contacting the National Credentialing Center.		877-842-3210
Demographic Changes To submit demographic changes, please call the United Voice Portal at 877-842-3210. Perform the following steps: 1. Say or enter your Tax ID number 2. Say Other Professional Services 3. Say Demographic Changes 4. You will be transferred to a Demographics Health care Professional Services associate		
Fraud and Abuse Hotline Our anonymous and confidential reporting hotline is available 24 hours a day, 7 days a week. Please leave a detailed message regarding the suspected fraud or abuse. You do not have to provide your name. If you leave your telephone number, a UnitedHealthcare Community Plan representative will return your call.		877-766-3844
Paper Claim Submission Paper Claims should be submitted to: UnitedHealthcare Community Plan P.O. Box 8207 Kingston, NY 12402 Covered	General Provider Relations Correspondence General Provider Relations Correspondence should be submitted to: UnitedHealthcare Community Plan 9200 Worthington Road 3rd Floor Worthington, Ohio 43082	
Electronic Payer ID 87726		
Ohio Medicaid Hotline		medicaid.ohio.gov 800-324-8680
Ohio Benefits Check-ins For patients who may/may not know they are eligible.		benefits.ohio.gov

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 UHCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in this manual using the following steps:

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

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

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

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

Important Information about the use of this Manual

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

We amend the manual as policies change.

Welcome to UnitedHealthcare Community Plan

Our Structure and Administration

UnitedHealthcare Community Plan partners with states to offer innovative managed care health plans for the economically disadvantaged, the medically under-served and those without the benefit of employer-funded health care coverage.

UnitedHealthcare Community Plan offers health plan in 25 states, serving more than 3.9 million nationwide.

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 on our website at UHCprovider.com.

Our goal is to 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 administrative guide or about any of our policies or procedures, please do not hesitate to contact Provider Services at 800-600-9007.

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

About This Manual

This manual has been developed as a reference to assist you in delivering high-quality health care to our members. It contains information regarding enrollment and eligibility, referrals and authorizations, claims submission, electronic data interface, specialty care and communication with UnitedHealthcare Community Plan. Understanding UnitedHealthcare Community Plan's policies and procedures is critical. This manual is our way of providing your office with information regarding

our policies and procedures as well as helping you receive an understanding of our health plan. In the event of a conflict of information between your agreement and the manual, the manual controls unless your agreement dictates otherwise.

Provider Information

Enrollment as a participating UnitedHealthcare Community Plan provider requires that you execute a UnitedHealthcare Provider Agreement and an Ohio Department of Medicaid Medicaid Addendum and be credentialed by UnitedHealthcare Community Plan. Following Credentialing Committee approval, your name or practice name and address(es) are listed in our Provider Directory. The directories are made available to the provider and member community. It is extremely important to verify your information as it appears in the Provider Directory.

We ask that you notify us of changes to the following demographic information 30 calendar days prior to the effective date of the change: TIN changes, address changes, additions or departures of health care providers from your practice and new service locations.

To change an existing TIN or to add a physician or health care provider you must include your W-9 form to make a TIN change or to add a physician or other health care provider to your practice. To submit the change, please complete and fax the Provider demographic update to the appropriate fax number listed on the bottom of the fax form. The W-9 form and the Provider demographic update fax form are available at UHCprovider.com > Contact Us > Service & Support > Forms.

Make changes by submitting the detailed information about the change, the effective date of the change, and a W-9 on your office letterhead. This information can be faxed to the fax number on the bottom of the demographic change request form.

Our Provider Network

UnitedHealthcare Community Plan contracts directly with primary care physicians (PCPs), specialists, hospitals and ancillary providers to provide care for our members. Providers and hospitals are recruited in a manner that allows existing referral patterns and member needs to be met. Participating providers treat UnitedHealthcare Community Plan members in their offices as they do non-UnitedHealthcare Community Plan members, and agree not to discriminate in the treatment of, or in the quality of services delivered to UnitedHealthcare Community Plan members.

The PCP's Role

Services other than those designated as (member) self-referred should be provided and arranged by the PCP in accordance with the Primary Care Provider Agreement. PCPs must be accessible 24 hours per day, 7 days per week. PCPs must arrange for another provider to cover in his/her absence. See the Coverage Arrangement section in this manual for more detail. General responsibilities include, but are not limited to:

- Providing primary and preventive care and acting as a member advocate in recommending and arranging care, based on medical necessity.
- Maintaining continuity of the member's health care.
- Arranging referrals to UnitedHealthcare Community Plan participating providers.
- Complying with the UnitedHealthcare Community Plan Healthchek program for children up to age 21.
- Coordinating Mental Health/Substance Abuse services.
- Maintaining, copying or forwarding a member's medical record; documenting all services provided to the member at no cost to the plan or the member. The record must note execution of an advance directive for all adult patients. An advance directive constitutes written instruction, such as a living will or durable power of attorney relating to the provision of health care if the patient is incapacitated.

- A willingness and ability to make distinctions between treatment methods consistent with the member's cultural background; and to maintain consistency in providing quality care across a variety of cultures.
- Providing care to members without regard to race, color, creed, gender, religion, age, national origin, marital status, gender orientation, language, health status, pre-existing conditions, and physical or mental handicap.
- The ability to admit or coordinate inpatient admissions.

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 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 providers to ensure that all participants understand, support, and benefit from the primary care case management system. The coverage shall 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.

Member Education

The Member Services department provides UnitedHealthcare Community Plan members with additional information on their health care benefits, along with answers to any questions and concerns they may have. We encourage our providers to refer members to the Member Services department.

Our Structure and Administration

UnitedHealthcare Community Plan is a member of a family of companies designed to arrange for comprehensive health care services to its members. UnitedHealthcare Community Plan encourages appropriate treatment and efficient use of medical services in the provider's office.

Our members will receive all of their Medicaid services, plus they will get more extra benefits such as: expanded vision care, transportation, a nurse help line and rewards for keeping medical appointments.

UnitedHealthcare Community Plan considers a provider-driven foundation to be the key to success. Therefore, we are committed to providing fair and prompt compensation and efficient service to our contracted providers.

Our Medical Directors will reach out to you if they have questions or require additional information.

UnitedHealthcare Community Plan Products

Product Overview

UnitedHealthcare Community Plan offers a health plan for Ohio Medicaid consumers. UnitedHealthcare Community Plan is available to consumers in the Covered Families and Children (CFC), including Healthy Start and Healthy Families, Foster Care, or the Aged, Blind, or Disabled (ABD) programs.

CFC Medicaid consumers include families, children up to age 19, and pregnant women. ABD Medicaid consumers include adults age 65 and older and people who are blind or disabled at any age.

UnitedHealthcare Community Plan members will receive a membership (ID) card, Member Handbook and Welcome Kit.

In addition to the Medicaid benefits, UnitedHealthcare Community Plan offers:

- No copays.
- Members Matters. Members can contact their personal Members Matter representative to explain things such as: translation services; ordering new ID cards; changing PCPs; Information on participating providers; how to access specialty care; and how to file a grievance or appeal.
- Care coordinators. To develop and manage a family-centered plan of care.
- 24/7 NurseLine. Someone they can call whenever they need advice, day or night.
- Dental. Preventive dental visits to help them maintain healthy teeth and gums.
- Vision. Coverage to help protect them against serious disease.
- Transportation. Rides to and from their doctors' appointments.
- Healthy Rewards. Special rewards for maintaining healthy behaviors.
- Online tools. Easy online tools so they can find doctors, check benefits and more.

Service Areas

UnitedHealthcare Community Plan is a state-approved health care plan in every county in Ohio.

Our members can request a copy of a Provider Directory by calling Member Services at 800-895-2017 (TTY:711) to request a copy, or visiting our website at [UHCCommunityPlan.com](https://www.uhccommunityplan.com).

Medicaid-Covered Services

Medical Advances

When UnitedHealthcare Community Plan receives requests to cover newly developed medical equipment or procedures, our national Technology Assessment Committee reviews them. This committee includes physicians and other health care professionals. The Committee uses national guidelines and scientific evidence from medical literature to help decide whether UnitedHealthcare Community Plan should approve the use of the equipment or procedures.

Medical Policies and Coverage Determination Guidelines

Medical policies and coverage determination guidelines can be found at UHCCommunityPlan.com > For Health Care Professionals > Select Your State > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.

After Hours Care or Care When Traveling Outside the UnitedHealthcare Community Plan Service Area

When a member seeks urgent or emergent care and calls your office, they must receive directions on how to access care. Calls must be answered 24 hours a day, seven days a week. If you direct a member to go to the nearest emergency room, call UnitedHealthcare Community Plan within 24 hours or as soon as possible.

NurseLineSM Services

Members of UnitedHealthcare Community Plan, can take advantage of our NurseLine services. NurseLine provides access 24 hours a day and seven days a week to experienced registered nurses who understand member health care needs and concerns.

Registered nurses with NurseLine have an average of 15 years of experience. NurseLine uses trusted, physician approved information at no cost to the member.

Getting the best health care begins with asking questions and understanding the answers. NurseLine can help members make health related decisions. For example, a NurseLine nurse can give tips on eating healthy and staying fit. The nurse can also help members:

- Decide if the emergency room or a doctor visit is right for them.
- Find a doctor or hospital.
- Understand treatment options.
- Provide information about important health screenings and shots.
- Answer health-related questions.
- Advise members on how to save money on prescriptions.
- Teach members how to take medications safely.

Call NurseLine services at 800-542-8630 (TTY: 800-855-2880).

For information purposes only. Nurses can't diagnose problems nor recommend specific treatment. They are not a substitute for a doctor's care.

Urgent Care

Urgent care is when a member needs care, treatment, or advice within 24 hours.

If a member requires urgent care, they can visit an urgent care center. Prior authorization is not required. Members may call Member Services at 800-895-2017 (hard-of-hearing: 711) and we will help them locate urgent care services.

Members may call their PCP or our NurseLine at 800-542-8630 (TTY: 800-855-2880) for guidance on deciding to seek urgent care services or visit their PCP.

Emergency Services

Emergency services are services for a medical problem so serious that it must be treated right away by a doctor. We cover care for emergencies both in and out of the county where members live. UnitedHealthcare Community Plan considers emergency services to be those covered inpatient and outpatient services that are:

- a. Furnished by a qualified provider; and
- b. Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency services are needed when a member needs immediate medical care because of the sudden onset of a medical condition or severe pain that the average person feels would:

- Place the person's health or the health of an unborn baby at serious risk;
- Result in serious harm to bodily functions; and/or,
- Result in serious harm to an organ or body part.

Members may call their Primary Care Provider or our 24/7 NurseLine services at 800-542-8630 (TTY: 800-855-2880) for guidance determining if emergency services are needed. A member's PCP or the 24/7 NurseLine Representative can talk to them about their medical problem and give advice on what they should do.

Some examples of when emergency services are needed include:

- miscarriage/pregnancy with vaginal bleeding
- heart attacks
- severe chest pain
- severe bleeding that does not stop
- serious breathing difficulties
- possible stroke

Emergency services do not require prior authorization or notification. In an emergency, members should call 911 or go to the NEAREST emergency room (ER) or other appropriate setting.

In an Emergency, Members Should be Instructed to:

- Go to the nearest hospital emergency room or other appropriate setting. Be prepared to present their healthcare ID card.
- If they need emergency transportation, contact 911 or their local emergency service.
- If the provider that is treating them for an emergency takes care of the emergency but thinks that the member needs other medical care to treat the problem that caused the emergency, the provider must call UnitedHealthcare Community Plan.
- Members should call their Primary Care Provider as soon as possible after the emergency is under control.
- If an inpatient hospital stay is required, UnitedHealthcare Community Plan must be notified within 24 hours or as soon as possible. Please call Member Services at 800-895-2017 (hard-of-hearing: 711) or the number listed on your UnitedHealthcare Community Plan Member ID Card.

Prior Authorization

Prior authorization is for services that must be approved by UnitedHealthcare Community Plan. Your doctor must call Utilization Management (UM) at 800-366-7304 before you obtain a service or procedure that is listed as requiring a prior authorization. Our UM team is available Monday through Friday 8 a.m. to 5 p.m. On-call staff is available 24 hours a day, 7 days a week for emergency prior authorizations.

UnitedHealthcare Community Plan also reviews some of your services and care as they are happening. This is called concurrent review. Examples are when you are:

- a patient in the hospital
- receiving home care by nurses
- certain outpatient services such as speech therapy and physical therapy

UnitedHealthcare Community Plan reviews a member's progress with their doctor to be sure services are needed or if other services would be better.

UnitedHealthcare Community Plan has policies and procedures to follow when they make decisions regarding medical services. The UM doctors and nurses make their decision based on the member's coverage and medical condition. The goal is to help ensure services are medically necessary, are provided in an appropriate setting, and quality care is provided.

- UnitedHealthcare Community Plan does not pay employees extra for limiting care.
- Our network doctors do not receive extra money or rewards if they limit care.
- Certain outpatient services such as speech therapy and physical therapy require prior authorization.

If you have questions about UM decisions or processes, call Member Services at 800-895-2017 (hard-of-hearing: 711).

Outpatient Injectable Chemotherapy Prior Authorization Program

Effective Oct. 1, 2017, UnitedHealthcare Community Plan members in Ohio will require prior authorization for injectable outpatient chemotherapy drugs given for a cancer diagnosis.

Hospital Care

If the member requires hospitalization

- If hospital care is not an emergency, the member's Primary Care Provider (PCP) will make the plans for hospitalization.
- If hospital care is an emergency, UnitedHealthcare Community Plan must be notified within 24 hours or as soon as possible.

UnitedHealthcare Community Plan requires notification:

- So UnitedHealthcare Community Plan will pay for covered services.
- So UnitedHealthcare Community Plan sees that the member gets follow-up care.

Informed Consent

Consent means a member has said "yes" to medical treatment. Informed consent means the treatment was explained to and understood by the member.

- Members must consent before receiving any treatment.
- Sometimes the consent must be in writing.
- If a member refuses medical treatment, their PCP should discuss other choices with them.
- Members have the right to say yes or no.

No Medical Coverage Outside of the United States

Any health care services received while out of the country are not covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services received outside of the United States.

Behavioral Health Services

UnitedHealthcare Community Plan members are eligible for all of the behavioral health benefits covered under the Ohio Medicaid Program. Members may self-refer for behavioral health services offered through certified Medicaid Community Mental Health Centers (CMHCs), through certified Medicaid providers affiliated with the Department of Mental Health and Addiction Services (MHA) and through certified providers affiliated with the MHA and any outpatient participating provider for routine outpatient therapy. Access to behavioral health services rendered by providers other than those mentioned above requires prior authorization. This includes: outpatient ECT, home health and psychological testing.

As part of our Quality Improvement Program, and to ensure that all Members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network adhere to specific access standards, which are outlined as follows:

- Respond within 24 hours to a Member request for routine outpatient care.
- An initial MH/SUD appointment must be offered within 10 business days of the request.
- Urgent appointments must be offered within 48 hours.
- Non-life-threatening emergencies must be offered within 6 hours.
- An immediate appointment must be offered for any life-threatening emergencies.
- An outpatient appointment must be offered within 7 days of an acute inpatient discharge.

To access services for mental health/substance abuse, please refer to the mental health number on the back of the member benefit card.

Some medically necessary services must get prior authorization before services are delivered. Please see page 17 of this handbook for more information on prior authorization.

Self-Referred Services

Some services are available without a referral. These are called self-referred services. Examples of services that do not require a referral include:

- Dental care
- Vision care
- Women's routine and preventive health care services provided by a women's health specialist (obstetrics, gynecology, certified nurse midwife)
- Specialty care (except for chemotherapy and pain management specialist services)
- Emergency care
- Services provided by Qualified Family Planning Providers (QFPP)
- Mental health and substance abuse services
- Services provided at Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC)
- Dialysis
- Radiation therapy
- Mammograms

Members must use a participating provider for all self-referred services except for emergency care or for services provided at Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC), Qualified Family Planning Providers (QFPP), community mental health centers, and Ohio Department of Alcohol and Drug Addiction Services facilities which are Medicaid providers. Participating providers would be those providers listed in the UnitedHealthcare Community Plan Provider Directory. The Provider Directory will include specialists such as oncologists, gynecologists, optometrists, dentists, and psychologists. If a provider is not listed, call Member Services or visit UHCCommunityplan.com to find out if

the provider is now accepting UnitedHealthcare Community Plan. To help ensure members receive the best care, they should tell their PCP about any self-referred visits to specialists and other providers. By doing this, the PCP can help coordinate the member's health care. If a member visits a provider that is not a participating provider with UnitedHealthcare Community Plan, these services may require a prior authorization.

Transportation Services

If a member needs a ride to their PCP or other medical provider, we may be able to help. UnitedHealthcare Community Plan will provide members with 30 one-way or 15 round trips per year to and from their PCP, WIC, pharmacy, or other participating health care providers, such as vision or dental. Members may also request help to get to their Medicaid redetermination visits.

If a member must travel 30 miles or more from their home to receive covered health care services, UnitedHealthcare Community Plan will provide transportation to and from the provider's office. These services must be medically necessary and not available in the member's service area. Members must also have a scheduled appointment (except in the case of urgent/emergent care). Please contact Member Services at 800-895-2017 (hearing impaired: 711) at least two business days in advance of the member's appointment for assistance.

In addition to the transportation assistance that UnitedHealthcare Community Plan provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

Vision Services

All members, both children and adults, receive an eye exam every 12 months. They also have a choice of glasses or retail allowance of \$125 toward **any type of contacts** (must use at one time) every 12 months. UnitedHealthcare Community Plan also offers an additional frame selection beyond what Medicaid covers at no cost to the member. Please refer to the Provider Directory for a list of optometrists that are in the UnitedHealthcare Community Plan network to set up eye appointments.

Women, Infants and Children Program (WIC)

WIC is the Special Supplemental Nutrition Program for Women, Infants and Children. The WIC program provides nutritious food at no cost, breast-feeding support, nutrition education and health care referrals. If a member is pregnant, they should ask their doctor to complete a WIC application during their doctor's appointment. Members who are pregnant may ask their doctor to complete a WIC application or call Member Services at 800-895-2017 (hard-of-hearing: 711) for more information about the WIC program. Our Member Services staff can also give information about the Help Me Grow program.

Services Covered and Paid For By UnitedHealthcare Community Plan

UnitedHealthcare Community Plan covers all medically-necessary Medicaid-covered services. The services covered by UnitedHealthcare Community Plan are covered at no cost to the member. These services may or may not require prior authorization before the service is received. Please see the following charts to determine if the member's benefits require prior authorization.

Services That DO NOT Require a Prior Authorization (PA)

UnitedHealthcare Community Plan encourages members to work with their PCP to help coordinate access to these services. However, it is not required that a member see their PCP prior to receiving these services. Please see the following charts to determine if your benefits require prior authorization.

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

Service	Coverage
Adult Yearly Well Exams	Covered
Certified Nurse Midwife Services	Covered
Certified Nurse Practitioner Services	Covered
Emergency Services	Covered
Eye Exams, Routine Vision (Optical) Services, Including Eyeglasses*	1 exam and 1 pair glasses or retail allowance of \$125 toward any type of contacts (must use the entire benefit at one time) per 12 months. Must be for vision correction and not for cosmetic reasons only. Additional replacements may require prior authorization.
Dental Services*	Routine exams and cleanings every six months. Some non-routine dental services may require a prior authorization.
Family Planning Services and Supplies	Covered
Federally Qualified Health Center or Rural Health Clinic Services	Covered
Healthchek (Well-child) Exams	Covered for children under the age of 21
Immunizations (Shots)	Covered
Maternity-Obstetrical Care – Prenatal and Postpartum Including at Risk Pregnancy Services) and Gynecological Services	Covered
Mental Health and Substance Abuse Services	*Prior authorization is required for mental health services not provided at community mental health centers and for substance abuse services not provided at Ohio Department of Alcohol and Drug Addiction Services facilities.
Physical Exam Required For Employment or For Participation in Job Training Programs	Covered if the exam is not provided free of charge by another source
Primary Care Provider Services	Covered
Podiatry (Foot) Services	Covered
Renal Dialysis (Kidney Disease)	Covered
Specialist Services	Covered in network in most cases

Services That DO Require a Prior Authorization (PA)

The provider must call UnitedHealthcare Connected's Utilization Management Department at 800-366-7304 to get approval for the following services. Please note: the absence of a service from this list does not mean that prior authorization is not required. A complete list of codes requiring prior authorization is located at UHCommunityPlan.com.

Service	Coverage
Abortion	Covered with prior authorization.
Bariatric Surgery	Please check the latest information on UHCommunityPlan.com .
Chiropractic (Back) Services*	Members age 21 and over are covered for 15 visits per calendar year. Members under the age of 21 are covered for 30 visits per calendar year. Prior authorization is required for additional visits.
Chemotherapy	<p>Chemotherapy injectable drugs that require authorization:</p> <ul style="list-style-type: none"> ▪ J9000 - J9999, J0640 Leucovorin, J0641 Levoleukovorin ▪ Chemotherapy injectable drugs that have a Q code ▪ Chemotherapy injectable drugs that haven't yet received an assigned code and will be billed under a miscellaneous Healthcare Common Procedure Coding System (HCPCS) code ▪ All outpatient injectable chemotherapy drugs started after the chemotherapy prior authorization effective date <p>Colony-stimulating factors that require prior authorization as of Oct. 1, 2017:</p> <ul style="list-style-type: none"> ▪ J1442 filgrastim (Neupogen) ▪ J1447 tbo-filgrastim (Granix) ▪ J2505 pegfilgrastim (Neulasta) ▪ J2820 sargramostim (Leukine) ▪ Q5101 filgrastim, bio similar (Zarxio)
Cosmetic and Reconstructive Surgery	Covered with prior authorization.
Developmental Therapy Services	Covered with prior authorization.
Gender Dysphoria Treatment	Covered with prior authorization.
Home Health Services	Prior authorization is required for certain services. A list of services requiring prior authorization is located at UHCommunityPlan.com/health-professionals/oh.html .
Hospice Care (Care For Terminally Ill, e.g., Cancer Patients)	Prior authorization required for hospice services provided in a home setting.

Service	Coverage
Inpatient Hospital Services	Covered with prior authorization.
Medically Necessary Plastic or Cosmetic Surgery	Covered (Initial plastic surgery office visit to determine treatment does not require prior authorization.)
Nursing Facility Services For a Short Term Rehabilitative	Covered for up to 60 days (end of month after admission). For example: if admitted March 3rd, coverage lasts from admission date through April 30th.
Pain Management Specialist Services	Covered with prior authorization.
Physical and Occupational Therapy	Covered. Prior authorization is required after 30 visits.
Private Duty Nursing	Covered with prior authorization.
Speech and Hearing Services, Including Hearing Aids	Covered with prior authorization.

Services That MAY Require a Prior Authorization (PA)

Depending on the level of care needed, these services may require prior approval. Members should see their Primary Care Provider (PCP).

Service	Coverage
Ambulance and Ambulette Transportation	Covered
Diagnostic Services (X-ray, Lab)	Covered
Durable Medical Equipment	Covered. Items that are more than \$500 or rental items may require prior authorization. A complete list of items requiring prior authorization is located at UHCommunityPlan.com .
Home Health Care	Skilled nursing requires prior authorization.
Medical Supplies	Covered
Orthotics and Prosthetics	Covered
Outpatient Hospital Services	Covered
Outpatient Surgeries	Covered
Prescription Drugs, Including Certain Prescribed Over-the-counter Drugs	Covered Please refer to Preferred Drug List for details at UHCommunityplan.com .
Radiology	A list of codes requiring prior authorization is located at UHCommunityPlan.com .

***NOTE:** Benefit limits will not apply if treatment or service is deemed medically necessary for members under age 21.

Pharmacy Benefit Information

Pharmacy Services

Prescriptions for all Ohio Medicaid consumers must be billed through the Ohio Medicaid Program Pharmacy Benefit Manager, OptumRx.

BIN/Processor Control Number/Group numbers Claims Processor

Name of Processor	OptumRx
Bank Identification Number (BIN)	610494
Processor Control Number (PCN)	9999
Submitted Group (Group)	ACUOH

The member ID number is indicated on the members' ID card, and should be used for prescription claims processing.

Overview of the Prescription Program

- Prescriptions filled through retail pharmacies are to be billed to OptumRx. All written prescriptions that are given to the patient or patient's representative to present to the pharmacy must be tamper resistant.
- Drugs administered in a physician office, hospital, outpatient department, clinic, dialysis center, or infusion center will be covered by UnitedHealthcare Community Plan and previous prior authorization requirements will still apply.
- Some medical supplies such as diabetic testing supplies, supplies for injection of insulin and other drugs, inhaler spacers and peak flow meters are covered under the pharmacy benefit. More information can be found within our Preferred Drug List (PDL).

Members may receive prescriptions at any of our plan's network pharmacies. If a member is planning to travel out of state, you will need to work with the member to make sure they have enough meds to cover them while they are traveling. Some out-of-state pharmacies are not in our network.

Members with questions may call Member Services at 800-895-2017 (TTY Relay: 711).

UnitedHealthcare Community Plan has developed a PDL of covered pharmaceuticals. The PDL also provides details of the UnitedHealthcare Community Plan pharmacy program. All providers receive a copy of the UnitedHealthcare Community Plan PDL once a year. Providers may contact their Provider Relations representative to order additional copies of the PDL as needed. The PDL, quarterly updates and the complete list of drugs that require prior authorization are also available on our website at UHCprovider.com. Our PDL may also be accessed via mobile devices through Provisor. More information regarding this application can be found at: UHCprovider.com.

Benefits for Opioids

Effective Jan. 1, 2017, UnitedHealthcare Community Plan will implement a 90 MED supply limit for the long-acting opioid class. Prior authorization criteria are 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:

- Interagency Guideline on Prescribing Opioids for Pain: agencymeddirectors.wa.gov > Interagency Guidelines > AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain

- 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 > 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 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 any additional questions, please contact us at 888-362-3368.

Ancillary Benefit Information

Members receive ancillary services from participating providers following referral by the member's PCP or a consulting provider.

Role of the Ancillary Provider

Ancillary providers are expected to deliver care in accordance with the provisions outlined in the UnitedHealthcare Provider Agreement.

Ancillary Provider responsibilities include, but are not limited to:

- Notifying the PCP of the treatment plan and

estimated duration of care. Providers should use established means of communicating this information as appropriate.

- Complying with UnitedHealthcare Community Plan administrative prior authorization guidelines.
- Maintaining a member's medical record and documenting all specialty services provided to the member.
- A willingness and ability to make distinctions between treatment methods consistent with the member's cultural background and to maintain consistency in providing quality care across a variety of cultures.
- As agreed upon in the UnitedHealthcare Provider Agreement, the Provider will (a) not discriminate in providing services to members on the basis of race, color, sex, age, national origin, religion, economic status, source of payment, health status or health care needs; (b) observe, protect and promote the rights of members as patients; (c) maintain a written sexual harassment policy and inform employees of the policy; (d) comply with Title VI of the Civil Rights Act of 1964 in providing Covered Services hereunder; and (e) maintain written procedures as to interpretation and translation services for members requiring such services, including members with Limited English Proficiency.
- Pursuant to regulations implementing the Americans with Disabilities Act (“ADA”), 28 C.F.R. 35.101 et seq., Provider shall not, on the basis of the disability, exclude any individual with a disability from participation herein or from activities provided for hereunder. Provider shall comply with the “General Prohibitions Against Discrimination,” 28 C.F.R. 35.130, and similar regulations or guidelines that apply to the state of Ohio.
- Provider must have a process to identify, keep a record of, and report to UnitedHealthcare Community Plan upon request members requiring oral translation, oral interpretation or sign language services and provide the use of TTY or language assistance all free of charge for members. UnitedHealthcare Community Plan's Members

Matter may be contacted at 800-895-2017 for assistance in arranging these services. Please note that UnitedHealthcare Community Plan may conduct periodic audits of providers' processes to arrange interpreter services.

- Providers are prohibited from advising or recommending to an eligible individual that s/he select membership in a particular MCP.

Durable Medical Equipment

UnitedHealthcare Community Plan's Utilization Department is responsible for arranging the delivery of medically necessary durable medical equipment (DME). Providers may obtain UnitedHealthcare Community Plan's authorization for DME rentals or any purchase with a billable charge greater than \$500. A complete list of items requiring prior authorization is located at UHCCommunityPlan.com. A DME prior authorization form may be faxed to Utilization Management at 866-839-6454.

Incontinence Supplies

All incontinence supplies for UnitedHealthcare Community Plan are provided by Edgepark. To access these services you can contact Edgepark Medical Supply at 844-564-1008.

Home Health Care

UnitedHealthcare Community Plan's Utilization Management department is responsible for the authorization of home health care services. Home health care may include the following types of services:

- Well baby/postpartum care
- Skilled nursing
- Physical therapy
- Respiratory therapy
- Occupational therapy
- Speech therapy
- IV therapy
- DME

Home health care and related DME will be authorized and coordinated by UnitedHealthcare Community Plan's Utilization Management department.

Providers may order home health care from any participating home health care provider. The ordering provider must obtain prior authorization for all home health care services.

Ambulance Services

Ambulance services are covered in emergency situations. Members may access immediate medical transport in true medical emergencies. Ambulance transport for non-emergency cases must be prior authorized by the Utilization Management department.

Chiropractic Care

A participating PCP or chiropractor must obtain prior authorization for children under the age of 21. Prior authorization is not required for chiropractic care for members 21 years and older. There is a benefit limit of 15 visits per year for adults.

Hospice Care

Providers may order hospice care from any participating hospice provider. The ordering provider must obtain prior authorization for hospice services provided in a home setting.

Laboratory Benefit Information

All laboratory testing requiring CLIA certification must be provided by a participating laboratory provider. The ordering provider must obtain prior authorization for any lab test not covered by the Ohio Medicaid program.

Imaging Benefit Information

If necessary, providers may direct a member to any participating hospital, independent licensed imaging facility or portable imaging company for outpatient imaging services. Providers must contact the Utilization Management department for prior authorization respective to the ordered imaging.

Enrollment and Eligibility

Enrollment & Eligibility

UnitedHealthcare Community Plan is offered to all Medicaid consumers in Ohio.

Effective dates for new UnitedHealthcare Community Plan members will be the first of the month. Newly-enrolled members receive a member identification card and a member handbook.

UnitedHealthcare Community Plan members are instructed to carry their ID card at all times. The UnitedHealthcare Community Plan ID number and the effective date of coverage appear on the front of the card. The PCP name and phone number also appear on the front of the card. Although the MMIS Medicaid billing number is also listed on the card, all participating UnitedHealthcare Community Plan providers must use the member's UnitedHealthcare Community Plan ID number when billing UnitedHealthcare Community Plan for services.



All Members

Note: Possession of a UnitedHealthcare Community Plan ID card does not guarantee eligibility, coverage or payment.

Verifying Eligibility

PCPs receive a monthly roster of members who have chosen their practice for primary care services. The lists are sent to the PCP offices the first week of every month. New member additions to the practice will be indicated by an asterisk. Termination dates of members who are disenrolling from the plan or practice will also be indicated. The roster will also note if the member is due for a Healthchek exam. Consulting providers and facilities do not receive monthly rosters. It is the provider's responsibility to verify that their member rosters are accurate.

UnitedHealthcare Community Plan recommends that all PCPs, consulting providers and facilities verify member eligibility prior to each service. UnitedHealthcare Community Plan offers eligibility verification by telephone, on the UnitedHealthcare Community Plan website, or by an electronic transaction system.

UnitedHealthcare Community plan offers three options for checking eligibility:

- On [UHCprovider.com](https://www.uhcprovider.com).
- Via electronic data interchange (EDI) using the Eligibility & Benefit Inquiry & Response (270/271).
- By calling the United Voice Portal at 877-842-3210 or the Customer Care number on the back of the Customer's health care ID card.

Eligibility & benefit information provided is not a guarantee of payment or coverage in any specific amount.

Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date(s) of services rendered and benefit plan terms and conditions.

Enrollment Verification Department

An Enrollment Verification representative attempts to contact each new UnitedHealthcare Community Plan member within one week of enrollment. The representative verifies the member's demographic information and PCP selection. The representative also reinforces education of membership responsibilities, the role of the PCP, and general health plan guidelines

Processing of PCP Changes

Member Initiated

Each member either selects or is assigned a PCP at the time of enrollment. The member may, at any time, contact Member Services to request a PCP change. Members can change their PCPs monthly. PCP changes within the first month of membership will be effective the date of the request. If the member requests a PCP change after the first month of membership, the change will be effective on the first day of the next month. A new identification card will be issued and sent to the member's residence indicating the new PCP's name and the date the member can begin seeing the new PCP.

PCP Initiated

PCPs may recommend that a member be removed from their practice due to member non-compliance or a failure to establish a mutually beneficial relationship. The PCP may not use the member's health status as cause to transfer a member. The PCP must submit a written request to the Provider Relations department.

A new PCP will be selected for the member if UnitedHealthcare Community Plan is unable to contact the member via telephone. A letter is sent to the member indicating the name of the new PCP and the reason(s) for the change.

Additions of Newborns

During a member's pregnancy, a Healthy First Steps pregnancy coach (see the 'OB/GYN' section of this manual for details on the UnitedHealthcare Community Plan Healthy First Steps Program) aids the member in the enrollment and PCP selection process of the newborn.

Unless otherwise specified by the mother, newborns born to UnitedHealthcare Community Plan members will gain UnitedHealthcare Community Plan eligibility on the date of birth. However, in order to enroll the newborn, UnitedHealthcare Community Plan must first notify ODM of the birth. Prior to enrollment and assignment of a member ID number, providers may bill for services rendered to the newborn using the mother's UnitedHealthcare Community Plan ID number. Eligibility will begin on the date of birth and continue through the end of the 12th month. It is also important to remember that sometimes newborns will be added (sometimes retroactively) to UnitedHealthcare Community Plan effective on the date of their birth.

PCP Services

Background

Members obtain the majority of their health care services either directly from or upon referral by their PCP. The PCP is responsible for the coordination of a member's health care needs and access to services provided by hospitals, specialty providers, ancillary services, and other health care services. All of the member's care (except for those services designated as self-referred) should be provided or referred by the PCP except in a medical emergency. By focusing the majority of a member's medical decisions through their PCP, the provider is able to provide comprehensive and high-quality care in a cost-effective manner.

Each member in the family has the freedom to choose any participating PCP, and a member may change to another PCP should a satisfactory patient-provider relationship not develop.

Role of the PCP

Services other than those designated as self-referred or emergent should be provided and arranged by the PCP in accordance with their UnitedHealthcare Provider Agreement. PCPs must be accessible 24 hours per day, 7 days per week. PCPs may arrange for another provider to cover in his/her absence.

PCP responsibilities include, but are not limited to:

- Providing primary and preventive care and acting as a member advocate in recommending and arranging care, based on Medical Necessity. Determinations of Medical Necessity for covered care and services, whether made on a prior authorization, concurrent review or post-utilization basis, shall be in writing and be compensable under the Ohio Medicaid program. UnitedHealthcare Community Plan shall base its determination on medical information provided by the member, the member's family/caretaker and the PCP, as well as any provider, programs, or any agencies that have evaluated the member.

Medical Necessity determinations must be made by qualified and trained providers. The definition of Medical Necessity as defined by 5160-26-01 and 5160-1-01 is as follows:

- Services which are necessary for the diagnosis or treatment of disease, illness or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must: (1) Meet generally accepted standards of medical practice; (2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome; (3) Be appropriate to the intensity of service and level of setting; (4) Provide unique, essential, and appropriate information when used for diagnostic purposes; (5) Be the lowest cost alternative that effectively addresses and treats the medical problem; and (6) Meet the general principles regarding reimbursement for Medicaid-Covered Services set forth in Rule 5160-1-02 of the Ohio Administrative Code.
- Maintaining continuity of the member's health care.
- Arranging referrals to UnitedHealthcare Community Plan participating providers.
- Complying with and coordinating services for Healthchek state of Ohio EPSDT program.
- Coordinating behavioral health services.
- Maintaining, copying or forwarding a member's medical record; documenting all services provided to the member. The record must note execution of an advance directive for all adult patients. An advance directive constitutes written instruction such as a living will or durable power of attorney relating to the provision of health care if the patient is incapacitated
- A willingness and ability to make distinctions between treatment methods consistent with the member's cultural background; and to maintain consistency in providing quality care across a variety of cultures.

- As agreed upon in the UnitedHealthcare Provider Agreement the PCP will (a) not discriminate in providing services to members on the basis of race, color, sex, age, national origin, religion, economic status, source of payment, health status or health care needs; (b) observe, protect and promote the rights of members as patients; (c) maintain a written sexual harassment policy and inform employees of the policy; (d) comply with Title VI of the Civil Rights Act of 1964 in providing Covered Services hereunder; and (e) maintain written procedures as to interpretation and translation services for members requiring such services, including members with Limited English proficiency.
- Pursuant to regulations implementing the Americans with Disabilities Act (“ADA”), 28 C.F.R. 35.101 et seq., PCP shall not, on the basis of the disability, exclude any individual with a disability from participation herein or from activities provided for hereunder. PCP shall comply with the “General Prohibitions Against Discrimination,” 28 C.F.R. 35.130, and similar regulations or guidelines that apply to the state of Ohio.
- PCP must have a process to identify, keep a record of, and report to UnitedHealthcare Community Plan upon request members requiring oral translation, oral interpretation or sign language services and provide the use of TTY or language assistance all free of charge for members. Contact UnitedHealthcare Community Plan Member Services at 800-895-2017 (TTY: 711) for assistance in arranging these services. Please note that UnitedHealthcare Community Plan may conduct periodic audits of providers’ processes to arrange interpreter services.
- PCP will work with UnitedHealthcare Community Plan and local school districts to facilitate access to medically necessary services to school age children, ensuring continuity of care and implementing plans to achieve the ODM’s goals in this area.
- PCPs are prohibited from advising or recommending to an eligible individual that they select membership in a particular MCP.
- Notifying UnitedHealthcare Community Plan of any practice related changes including changes regarding the acceptance of new patients and standard office hours.
- Your office hours of operation may not be less for Medicaid members than the office hours for Commercial members.

Monthly Member Rosters

PCPs receive a monthly roster, identifying members who have chosen their practice for primary care services. Members’ rosters can also be accessed through UHCprovider.com. Although member eligibility with UnitedHealthcare Community Plan remains constant for one year, members do have the option of disenrolling within 90 days of their effective date, and may change their PCP selection at any time. Therefore, UnitedHealthcare Community Plan urges PCPs to check eligibility prior to providing care. The roster will indicate the member’s UnitedHealthcare Community Plan ID number, telephone number, date of birth, coverage start date (and termination date, if applicable), any primary language if other than English, and any hearing or vision impairment. An asterisk will indicate members new to the practice. An additional column of the roster will indicate if a member is due for a Healthchek exam.

Healthchek

The UnitedHealthcare Community Plan pediatric service requirements includes Healthchek screenings for children up to age 21. The PCP is responsible for complying with and coordinating services related to Healthchek.

It is essential that children enrolled in UnitedHealthcare Community Plan receive screening exams at the appropriate ages. The PCP member roster identifies those members who are due for a Healthchek screen in the upcoming month. UnitedHealthcare Community Plan will assist the PCP in notifying members due for a Healthchek screen. The PCP is also responsible for Healthchek outreach and follow-up care.

Developmental Milestones

All Medicaid Recipients by Age 1

1. Healthchek is Ohio's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. It provides a group of services to children and teens younger than age 21 which include: prevention, diagnosis and treatment. The purpose of Healthchek is to discover and treat health problems early. If a potential health problem is found, further diagnosis and treatment are covered.
2. 12-month visit includes anemia and lead screening. Oral health, blood pressure, vision, hearing, lead and tuberculosis screenings can be included.
3. Healthchek services are free and provided by the child's provider.
4. During the 12-month visit, the following topics will be reviewed:
 - a. Family support: adjustment to the child's developmental changes and behavior, family-work balance, parental agreement/disagreement about child issues.
 - b. Establishing routines: family time, bedtime, teeth brushing, nap times.
 - c. Feeding and appetite changes (self-feeding, nutritious foods and choices.
 - d. Establishing a dental home (first dental checkup, dental hygiene).
 - e. Safety (home safety, car safety seat, drowning and guns).
5. Additional information is available at:
jfs.ohio.gov/OHP/consumers/Healthchek.stm.

All Medicaid Recipients by Age 2

1. 18-month visit includes autism, development and reminder lead screening. Oral health, blood pressure, vision, hearing, anemia, lead, and tuberculosis, screenings can be included.
2. Healthchek services are free and provided by the child's provider.
3. During the 18-month visit, the following topics will be reviewed:
 - a. Family support (parental well-being, adjustment to toddler's growing independence and occasional negativity, queries about a new sibling planned or on the way).
 - b. Child development and behavior (adaptation to non-parental care and anticipation of return to clinging, other changes connected with new cognitive gains).
 - c. Language promotion/hearing (encouragement of language, use of simple words and phrases, engagement in reading/singing/talking).
 - d. Toilet training readiness (recognizing signs of readiness, parental expectations).
 - e. Safety (car safety seats, parental use of safety belts, falls, fires, burns, poisoning and guns).
4. Additional information is available at:
jfs.ohio.gov/OHP/consumers/Healthchek.stm.

Developmental Milestones

All Medicaid Recipients at 30 Months

1. 30-month visit includes development screening. Oral health, blood pressure, vision, and hearing screenings can be included.
2. Healthchek services are free and provided by the child's provider.
3. During the 30-month visit, the following topics will be reviewed:
 - a. Family routines (parental consistency, day and evening routines, enjoyable family activities).
 - b. Language promotion and communication (interactive communication through song, play, and reading).
 - c. Promoting social development (play with other children, limited reciprocal play, imitation of others, choices).
 - d. Preschool consideration (readiness for early childhood programs, playgroups, or play dates).
 - e. Safety (water safety, car safety seat, outdoor health and safety (pools, play areas, sun exposure), pets, fires, and burns).
4. Additional information is available at:
jfs.ohio.gov/OHP/consumers/Healthchek.stm.

Every January

1. Healthchek services are free and provided by the child's provider.
2. It's important for children to have regular medical checkups even when they are not sick from the time they are born right up until they are 21.

Doctors say that children should have checkups often when they are very little, then every year or so as they get older. Here are the times when children should get a checkup:

- 2 weeks old
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 2-3 years old
- 3-4 years old
- 4-5 years old
- 5-6 years old
- 6-8 years old
- 8-10 years old
- 10-12 years old
- 12-14 years old
- 14-16 years old

Developmental Milestones

Every January (continued)

16-18 years old
18-21 years old

Some children need checkups more often. Follow your doctor's advice. Be sure your child gets a lead screening by age 1 (12 months old) and another lead screening at age 2 (24 months). If your child is age 3-6 years old and has not had a lead screening test, get your child tested right away.

At regular checkups, the doctor will make sure your child is growing and developing properly. The doctor will:

- Give your child a complete physical exam;
- Check your child's ears, eyes and mouth;
- Make sure your child has up-to-date immunizations (shots); and
- Talk to you about helping your child stay healthy.

Your doctor will need to know your child's medical history. Tell your doctor about any illness or other medical condition your child has. Be sure to give the doctor a list of the medicines your child takes.

Children's Immunizations (Shots)

Most doctors recommend certain shots at certain ages. Those are:

- **Birth:** Hepatitis B (Hep B)
- **1-2 Months:** Hepatitis B (Hep B)
- **2 Months:** Diphtheria, Tetanus and Acellular Pertussis (DTaP), Polio (IPV), Haemophilus Influenzae Type B (Hib), Pneumococcal Conjugate Vaccine (PCV), Rotavirus
- **4 Months:** Diphtheria, Tetanus and Acellular Pertussis (DTaP), Polio (IPV), Haemophilus Influenzae Type B (Hib), Pneumococcal Conjugate Vaccine (PCV), Rotavirus
- **6 Months:** Diphtheria, Tetanus and Acellular Pertussis (DTaP), Haemophilus Influenzae Type B (Hib), Pneumococcal Conjugate Vaccine (PCV), Rotavirus
- **6-18 Months:** Hepatitis B (Hep B), Polio (IPV)
- **6-59 Months:** Influenza (flu)
- **12-15 Months:** Haemophilus Influenzae Type B (Hib), Measles, Mumps and Rubella (MMR), Pneumococcal Conjugate Vaccine (PCV), Varicella (Chicken Pox)
- **12-23 Months:** Hepatitis A (Hep A)
- **15-18 Months:** Diphtheria, Tetanus and Acellular Pertussis (DTaP)

Developmental Milestones	
Every January (continued)	<ul style="list-style-type: none"> ▪ 4-6 Years: Diphtheria, Tetanus and Acellular Pertussis (DTaP), Polio (IPV), Measles, Mumps and Rubella (MMR), Varicella (Chicken Pox) ▪ 11-12 Years: Tetanus, Diphtheria and Acellular Pertussis (Tdap), Meningococcal Conjugate Vaccine (MCV4), Human Papilloma Virus (HPV) for Girls <p>5. Additional information is available at: jfs.ohio.gov/OHP/consumers/Healthchek.stm.</p>
All Medicaid Recipients Between the Ages of 4 and 20 in Late August, Early September	<ol style="list-style-type: none"> 1. Every August. 2. Healthchek services are free and provided by the child's provider. 3. It's important for children to have regular medical checkups even when they are not sick from the time they are born right up until they are 21. <p>Doctors say that children should have checkups often when they are very little, then every year or so as they get older.</p>

Childhood Immunizations

The Healthchek program includes immunizations for members through the age of 18 in compliance with the Vaccines for Children (VFC) Program. The VFC Program provides vaccines to all public and private health care providers who agree to participate in the program. The PCP may distribute biologicals obtained through the VFC program to members requiring immunizations.

The member's immunization encounter must be documented on a CMS-1500 form. The PCP will not be reimbursed for biologicals obtained through the VFC Program.

Lead Screening Guidelines

Healthchek guidelines include Blood Lead Level Screenings for children. Ohio law requires all health care providers to administer blood lead test to children at age 1 and 2, or up to age 6 if no previous test has been completed. PCPs must use a participating lab service for collection of the lead level. The PCP may draw the blood in the office and use the selected lab's courier service if available. The PCP may direct the member to the selected lab's nearest draw site.

Other Available Pediatric Services

At the time of the Healthchek screening, PCPs should identify the need for other medically necessary services. Children under 21 years old are eligible to receive other medically necessary services including speech therapy, occupational therapy, physical therapy, nutritional counseling, specialized nursing care, behavioral health, psychological services and mental health wrap-around services. Requests for these services must be submitted to the Utilization Management department.

Specialist Provider Services

Background

Members may receive services from a Specialist following referral from a member's PCP. The PCP is responsible for the coordination of members' health care needs. By focusing the majority of a member's medical decisions through their PCP, the provider is able to provide comprehensive and high-quality care in a cost-effective manner.

Role of the Specialist

Specialists are expected to deliver care in accordance with the provisions outlined in their UnitedHealthcare Provider Agreement. The specialist may have an extended role in arranging referred diagnostic services and procedures requiring UnitedHealthcare Community Plan prior authorization.

The Specialist's responsibilities include, but are not limited to:

- Notifying the PCP of the treatment plan and estimated duration of specialty care. Specialists should use established means of communicating this information as appropriate.
- Arranging and ordering medically appropriate services as needed.
- Complying with UnitedHealthcare Community Plan administrative prior authorization guidelines.
- Maintaining a member's medical record and documenting all specialty services provided to the member.
- A willingness and ability to make distinctions between treatment methods consistent with the member's cultural background and to maintain consistency in providing quality care across a variety of cultures.
- As agreed upon in the UnitedHealthcare Provider Agreement, the specialist will (a) not discriminate in providing services to members on the basis of race, color, gender, age, national origin, gender orientation, religion, economic status, source of payment, health status or health care needs; (b) observe, protect and promote the rights of members as patients; (c) maintain a written sexual harassment policy and inform employees of the policy; (d) comply with Title VI of the Civil Rights Act of 1964 in providing Covered Services hereunder; and (e) maintain written procedures as to interpretation and translation services for members requiring such services, including members with Limited English proficiency.
- Pursuant to regulations implementing the Americans with Disabilities Act ("ADA"), 28 C.F.R. 35.101 et seq., consulting Provider shall not, on the basis of the disability, exclude any individual with a disability from participation herein or from activities provided for hereunder. Specialists shall comply with the "General Prohibitions Against Discrimination," 28 C.F.R. 35.130, and similar regulations or guidelines that apply to the state of Ohio.
- Specialists must have a process to identify, keep a record of, and report to UnitedHealthcare Community Plan upon request members requiring oral translation, oral interpretation or sign language services and provide the use of TTY or language assistance all free of charge for members. UnitedHealthcare Community Plan may be contacted at 800-895-2017 or TTY 711 for assistance in arranging these services. Please note that UnitedHealthcare Community Plan may conduct periodic audits of consulting Providers' processes to arrange interpreter services.
- Specialists are prohibited from advising or recommending to an eligible individual that they select membership in a particular MCP.
- Notifying UnitedHealthcare Community Plan of any practice related changes, including changes regarding the acceptance of new patients and standard office hours.

Eligibility Verification

Specialists do not receive a monthly member roster. UnitedHealthcare Community Plan recommends that consulting providers verify member eligibility prior to each service. UnitedHealthcare Community Plan offers a number of mechanisms for our providers' use to verify eligibility. Please see the Enrollment and Eligibility section of this manual for details.

Specialist Functioning as a PCP

Specialists may function as a PCP for members with complex illnesses or conditions if approved by a UnitedHealthcare Community Plan Medical Director. All requests for a specialist to serve as a PCP should be directed to Member Services at 800-895-2017.

Obstetrician/Gynecologist (OB/GYN) Services

Background

Members may self-refer to any qualified family planning service provider or any QFP in or out of network. UnitedHealthcare Community Plan also permits PCPs to perform routine gynecological exams, pap smears and provide pregnancy care if they are so trained and equipped in their offices.

Role of the OB/GYN

The OB/GYN is responsible for the following:

- Notifying the PCP of the treatment plan and estimated duration of specialty or prenatal care. The OB/GYN may use established means of communicating this information as appropriate.
- Arranging and ordering medically appropriate services as needed.
- Complying with UnitedHealthcare Community Plan administrative prior authorization guidelines.
- Maintaining a member's medical record and documenting all specialty services provided to the member.
- A willingness and ability to make distinctions between treatment methods consistent with the member's cultural background, and to maintain consistency in providing quality care across a variety of cultures.
- As agreed upon in the UnitedHealthcare Provider Agreement, the OB/GYN will (a) not discriminate in providing services to members on the basis of race, color, sex, age, national origin, religion, economic status, source of payment, health status or health care needs; (b) observe, protect and promote the rights of members as patients; (c) maintain a written sexual harassment policy and inform employees of the policy; (d) comply with Title VI of the Civil Rights Act of 1964 in providing Covered Services hereunder; and (e) maintain written procedures as to interpretation and translation services for members requiring such services, including members with limited English proficiency.
- Pursuant to regulations implementing the Americans with Disabilities Act ("ADA"), 28 C.F.R. 35.101 et seq., OB/GYN shall not, on the basis of the disability, exclude any individual with a disability from participation herein or from activities provided for hereunder. The OB/GYN shall comply with the "General Prohibitions Against Discrimination," 28 C.F.R. 35.130, and similar regulations or guidelines that apply to the state of Ohio.
- OB/GYN must have a process to identify, keep a record of, and report to UnitedHealthcare Community Plan members requiring oral translation, oral interpretation or sign language services and provide the use of TTY or language assistance all free of charge for members. UnitedHealthcare Community Plan's Member Services may be contacted at 800-895-2017 (TTY: 711) for assistance in arranging these services. Please note that UnitedHealthcare Community Plan may conduct periodic audits of OB/GYNs' processes to arrange interpreter services.
- OB/GYNs are prohibited from advising or recommending to an eligible individual that they select membership in a particular MCP.
- Notifying UnitedHealthcare Community Plan of any practice-related changes, including changes regarding the acceptance of new patients and standard office hours.

Eligibility Verification

OB/GYNs do not receive a monthly member roster. UnitedHealthcare Community Plan recommends that OB/GYNs verify member eligibility prior to each service. UnitedHealthcare Community Plan offers a number of mechanisms for our providers' use to verify eligibility. Please see the Enrollment and Eligibility section of this manual for details.

Family Planning Services

A member may self-refer for Family Planning services, including contraceptive care and urine pregnancy tests. There is no limit to the number of Family Planning visits a member may have in a calendar year.

Sterilization

Members must be 21 years of age or older for outpatient sterilization surgery. The Consent to Sterilization Form HHS-687 English exp.10/31/2015 and HHS-687-1 Spanish rev. must be signed and the 30-day waiting period expired; according to State guidelines, members only have 180 days to act from the date of the signature on the Consent Form. The completed Consent Form must be included with any claims.

Hysterectomy

A hysterectomy may not be performed solely for Family Planning purposes. Members undergoing a hysterectomy procedure must sign the Consent to Hysterectomy Form (JFS 03199 (04/11)). A copy of this form must be submitted to UnitedHealthcare Community Plan when submitting any related claims

Gynecological Services

A member may self-refer for annual gynecological exams to any UnitedHealthcare Community Plan participating provider contracted to provide gynecological services. Gynecology providers may order related diagnostic tests such as mammograms and PAP smears. The gynecological provider should refer the member back to the PCP for services unrelated to the gynecologic diagnosis.

In-Office Surgery

Any surgeries performed in the office by the gynecologic provider do not require additional authorization prior to rendering services.

Obstetric Services

A member may self-refer for obstetric services to any UnitedHealthcare Community Plan participating Provider contracted to provide obstetrical services. An OB Needs Assessment Form must be completed and faxed to 877-353-6913 as part of routine prenatal care. UnitedHealthcare Community Plan has developed this form to identify conditions that may place the member at risk for an adverse pregnancy. A copy of this form may be found with this manual and on UHCCommunityPlan.com.

The Obstetrician should evaluate OB needs by using the criteria indicated on the OB Needs Assessment Form. A copy of the form must be faxed or sent to Healthy First Steps. If you have questions, please call 877-353-6913 within 15 days from the initial assessment. Please note that OB needs should be assessed throughout the course of the member's pregnancy. In addition, the form may be submitted to the Pregnancy Care Manager at any time during prenatal care if a member's condition constitutes a change of risk status.

During the course of the pregnancy, the Obstetrician may perform services such as ultrasounds and fetal non-stress tests in the office setting or refer the member to a participating hospital. Routine prenatal care guidelines are outlined in this manual. When ordering specialized services, the Obstetrician must follow UnitedHealthcare Community Plan administrative policies for prior authorizations.

Pregnancy Care Management

Members identified as high-risk, via review of the OB Needs Assessment form, will receive care management services designed to support the prenatal care you provide. Please see the Care Management Program Services section of this manual for additional information

UnitedHealthcare Community Plan Healthy First Steps

The goal of the Healthy First Steps Program is to improve birth outcomes and reduce neonatal intensive care unit admissions. This is accomplished by using early identification to overcome social and psychological barriers to proper prenatal care, increase understanding of the importance of proper prenatal care, building a strong support system around the mother, developing the physician/member relationship before and after delivery, and ensuring appropriate postpartum and newborn care. Providers should notify Healthy First Steps of newly identified pregnant members by submitting an American College of Obstetricians and Gynecologists Risk Assessment Form or an initial prenatal visit form via fax to 877-353-6913.

Coverage Arrangements

PCP On-Call Provider Coverage

PCPs must provide on-call coverage for members 24 hours a day, 7 days a week. In the event of absence that prevents the PCP from providing on-call coverage, the PCP should provide UnitedHealthcare Community Plan with 90 days' notice of his/her unavailability and must arrange for another UnitedHealthcare Community Plan participating provider to be accessible during his/her absence.

Covering providers must adhere to UnitedHealthcare Community Plan administrative policies, regardless of participation status.

Claims for Coverage Services

Reimbursement of provider services is contingent upon proper authorization and member eligibility. On-call providers will be reimbursed at their contracted rate. If the provider is not participating, a prior authorization is necessary.

Referral and Prior Authorization Guidelines

Referral Process

Members obtain the majority of their health care services either directly from or upon referral by their PCP. The PCP serves as the member's "medical home" for health care services. Therefore, the PCP is responsible for the coordination of access to services provided by hospitals, specialty providers and other health care providers. All of the member's care (except for those services designated as self-referred) should be provided or referred by the PCP except in a medical emergency. By focusing the majority of a member's medical decisions through their PCP, the provider is able to provide comprehensive and high-quality care in a cost-effective manner.

PCP Referral Guidelines

When building its provider network, UnitedHealthcare Community Plan's goal is to keep provider referral patterns consistent. Our network is developed through consultation with local providers as well as review of historical Medicaid utilization data. Therefore, we encourage PCPs to refer all services through our participating providers. Please consult the UnitedHealthcare Community Plan Provider Directory for a listing of participating providers. A listing of participating providers may also be found on our website at UHCCommunityPlan.com.

Should it be necessary to refer a member to a non-participating provider, please contact the Utilization Management department for a prior authorization.

Consulting Provider Referral Guidelines

The consulting provider may also refer to participating providers for most diagnostic testing and routine outpatient procedures. The consulting provider should direct a member back to the PCP if the services of another consulting provider are recommended.

Prior Authorization Guidelines

Medical and Behavioral Health Prior Authorization Requests

The UnitedHealthcare Community Plan Utilization Management department reviews prior authorization requests for all medical and behavioral health services. Please see below for further information on processing these requests. Medical policies and coverage determination guidelines can be found at UHCCommunityPlan.com > For Health Care Professionals > Select Your State > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.

Pharmacy Prior Authorization Requests

The UnitedHealthcare Community Plan Pharmacy department reviews prior authorization requests for all pharmacy services. If you need further information or help, please contact the Provider Prior Authorization Help Desk at 800-310-6826 or the Provider Prior Authorization Help Desk fax at 866-940-7328. The PDL and Prior Authorization lists of drugs can be found on the website at UHCCommunityPlan.com.

Dental Prior Authorization Requests

Please note that, although members may self-refer in network for dental services, a limited number of dental services require prior authorization. These requests must be made by the treating dentist and will be submitted to UnitedHealthcare Community Plan's subcontracted dental administrator, DentaQuest. DentaQuest will respond to prior authorization requests via telephone or secure fax within 15 days or less. Prior authorization requests can be made by contacting DentaQuest at 855-398-8411.

Medical and Behavioral Health Prior Authorization Process

The UnitedHealthcare Community Plan Utilization Management department accepts prior authorization requests 24 hours a day, 7 days a week. Prior authorization requests are accepted from a PCP or consulting provider. It is appropriate that the treating Provider forward the clinical information to the UnitedHealthcare Community Plan Utilization Management department. A Provider may phone 800-366-7304 or fax 866-839-6454; the UnitedHealthcare Community Plan Utilization Management department to obtain an authorization. For Behavioral Health Services, they can call 866-261-7692. The provider can also request an authorization online at the UnitedHealthcare Community Plan website.

Requesting providers must have the following information available at the time of the prior authorization request:

- Member name, DOB, and recipient identification number.
- Provider Name and ID Number.
- Caller name, phone/fax number.
- Date(s) service will be performed.
- Name of facility where services will be performed and Provider ID Number.
- Diagnosis by ICD-10 code.
- Procedure by CPT or HCPCS code.
- If clinical information is not provided at the time of the request, the provider's office has 48 hours to submit additional information.

If MCG Guidelines, UnitedHealthcare Policies, or state regulations are not met, the case will be presented to a UnitedHealthcare Community Plan Medical Director. Under these circumstances, the Medical Director may discuss the case with the member's treating provider. The treating provider may contact the Medical Director to discuss the case.

The requesting Provider or appropriate party will be supplied with the medical criteria used in the denial determination upon request. Denial letters are not sent to members if the request is related to being in the hospital as this is not considered prior authorization. The requesting Provider or appropriate party will be supplied with the medical criteria used in the denial determination upon request. A denial may be based on one or more of the following:

- Lack of proper notification (procedural denial).
- Service is not a covered benefit or not medically necessary.
- Place of service not medically necessary.

The Utilization Management department will respond to prior authorization requests via telephone or secure fax within 10 days. If the member's condition requires an expedited response, the provider should notify Intake/Prior Authorization to consider the request as urgent. UnitedHealthcare Community Plan's Utilization Management decisions are made based upon medical necessity. Our Utilization Management decision-making is based solely on appropriateness of care and service. We do not offer any incentive to deny coverage, and we do not offer any incentive to encourage inappropriate utilization.

Providers may appeal medical and procedural denials according to the UnitedHealthcare Community Plan appeal process found in the Provider Dispute Procedures Section of this manual.

Peer to Peer Discussion

Prior authorization requests are reviewed by a physician Medical Director prior to any denial. Review is based on the information sent by the ordering provider. Prior authorization requests are generally reviewed and decided within 72 hours of the request; however, providers may be granted an extension of up to 10 days from the date of the original request in order to provide additional information. Ordering providers who disagree with a denial may contact the prior authorization area

for a peer to peer discussion with the physician Medical Director. We recommend this intervention prior to filing an appeal.

Peer to peer discussions are initiated by calling the UM prior authorization line at 800-366-7304.

New Technology

UnitedHealthcare Community Plan evaluates new technology not covered by the Ohio Medicaid Program on a case-by-case basis. Please contact the UM Department for prior authorization of these services. You may contact the Provider Services department with questions related to services and the need for prior authorization by calling 800-600-9007.

2018 Prior Authorization Requirements

Beginning Jan. 1, 2018, Ohio Medicaid managed care plans are no longer required to enter into a contractual arrangement with a provider that requires the managed care plan to process prior authorization requests that are not submitted electronically. This does not apply to emergency services.

Additional requirements include:

- Ohio Medicaid managed care plans must respond to electronically submitted prior authorizations within 48 hours for urgent services and 10 calendar days for any non-urgent care services. This time period begins once the plan receives the request with all required information.
- Responses to prior authorization requests must indicate whether the request is approved, denied, or incomplete. When the response to a prior authorization is denied, the managed care plan must provide the specific reason.
- If the prior authorization request is incomplete, the department or its designee shall indicate the specific additional information that is required to process the request.

Hospital Services

Role of the Hospital

Hospitals are expected to deliver care in accordance with the provisions outlined in the Provider Network Participation Agreement.

Hospital responsibilities include, but are not limited to:

- Notifying the PCP of the treatment plan and estimated duration of care. Hospitals should use established means of communicating this information as appropriate.
 - Complying with UnitedHealthcare Community Plan administrative prior authorization guidelines.
 - Maintaining a member's medical record and documenting all services provided to the member.
 - A willingness and ability to make distinctions between treatment methods consistent with the member's cultural background and to maintain consistency in providing quality care across a variety of cultures.
 - As agreed upon in the UnitedHealthcare Provider Agreement, the hospital will (a) not discriminate in providing services to members on the basis of race, color, sex, age, national origin, religion, economic status, source of payment, health status or health care needs; (b) observe, protect and promote the rights of members as patients; (c) maintain a written sexual harassment policy and inform employees of the policy; (d) comply with Title VI of the Civil Rights Act of 1964 in providing covered services hereunder; and (e) maintain written procedures as to interpretation and translation services for members requiring such services, including members with Limited English Proficiency.
 - Pursuant to regulations implementing the Americans with Disabilities Act ("ADA"), 28 C.F.R. 35.101 et seq., hospital shall not, on the basis of the disability, exclude any individual with a disability from participation herein or from activities provided for hereunder. Hospital shall comply with the "General Prohibitions Against Discrimination," 28 C.F.R. 35.130, and similar regulations or guidelines that apply to the state of Ohio.
- Hospital must have a process to identify, keep a record of, and report to UnitedHealthcare Community Plan upon request members requiring oral translation, oral interpretation or sign language services and provide the use of TTY or language assistance all free of charge for members. UnitedHealthcare Community Plan's Member Services may be contacted at 800-895-2017 for assistance in arranging these services. Please note that UnitedHealthcare Community Plan may conduct periodic audits of hospitals' processes to arrange interpreter services.
 - Hospitals are prohibited from advising or recommending to an eligible individual that they select membership in a particular MCP.

Emergency Medical Condition Defined

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or,
3. Serious dysfunction to any bodily organ or part.

Medical Emergency

A member may self-refer for an emergency as defined above. PCP authorization is not required prior to medical emergency treatment. However, UnitedHealthcare Community Plan recommends that the facility or member notify the PCP of the incident within 24 hours.

Emergency Room Services

Emergent Inpatient Admissions

In order for UnitedHealthcare Community Plan to monitor the quality of care and utilization of services by our members, all UnitedHealthcare Community Plan providers are required to notify the Utilization Management department within 48 hours or the next business day of a hospital admission arising from an emergency medical condition.

Post-Stabilization Services

UnitedHealthcare Community Plan will cover post-stabilization services as defined in Federal Medicaid managed care regulation at 42 CFR 438.114(e) and 42 CFR 422.113(c) and OAC rule 5160-26-03(G) without requiring prior authorization, if any of the following situations exist:

- The post-stabilization services were pre-approved by UnitedHealthcare Community Plan.
- The post-stabilization services were not pre-approved by UnitedHealthcare Community Plan because UnitedHealthcare Community Plan did not respond to the provider's request for the services within 1 hour of the request.
- The post-stabilization services were not pre-approved by UnitedHealthcare Community Plan because UnitedHealthcare Community Plan could not be reached by the provider to request pre-approval for these post-stabilization services
- Authorization for hospital admissions can be obtained by calling Utilization Management at 800-366-7304. Inpatient admissions for behavioral health can be authorized by calling 866-261-7692.
- The post-stabilization services are not pre-approved by a UnitedHealthcare Community Plan Utilization Management representative and a UnitedHealthcare Community Plan Medical Director was not available for consultation; the treating provider may continue with the proposed plan of care until a plan Medical Director can be reached.

- The attending or treating provider shall determine when the member is stable for transfer or discharge. UnitedHealthcare Community Plan shall defer to the treating provider regarding the point of stabilization.

Non-emergent Inpatient Admissions

In order for UnitedHealthcare Community Plan to monitor the quality of care and utilization of services by our members, all UnitedHealthcare Community Plan providers are required to obtain prior authorization by contacting the Utilization Management department for all hospital admissions.

UnitedHealthcare Community Plan will accept prior authorization requests for non-emergent services from the PCP, ordering Provider, attending provider or Hospital Utilization Review department. No party should assume the other has obtained prior authorization.

The requesting Provider should make every attempt to request the above prior authorization at least 72 hours prior to admission unless contract guidelines stipulate otherwise.

- Authorization for hospital admissions can be obtained by calling Utilization Management at 800-366-7304. Inpatient admissions for behavioral health can be authorized by calling 866-261-7692.

Inpatient Concurrent Review

The UnitedHealthcare Community Plan Utilization Management department must monitor a member's progress throughout the inpatient stay. This is accomplished by a review of clinical information provided by the hospital detailing the member's progress to date. The Utilization Management department monitors appropriateness of continued inpatient stay, according to established criteria under the direction of the UnitedHealthcare Community Plan Medical Director. If medical necessity dictates a continued stay, the plan representative will provide the next review date. As part of the concurrent review

process, the Utilization Management department coordinates the discharge plan and assists in arranging additional services, special diagnostics, home care, and DME. Medical Directors are always available to discuss the case with the attending physician.

Any denials of ongoing hospital stays are based on the information provided by the hospital. A physician Medical Director with previous medical practice experience reviews all potential denials and makes a final decision. Physicians may request reconsideration of the denial by calling and requesting a peer to peer discussion with the denying physician Medical Director. We recommend this intervention prior to filing a provider dispute. Peer to peer discussions can be requested for up to 14 days after the denial is issued or 2 days after the patient is discharged. Peer to peer discussions are initiated by calling the UM prior authorization line at 800-366-7304.

Inpatient Concurrent Review: Clinical Information

Your cooperation is required with all UnitedHealthcare 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 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 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.

Hospital Transfers

In the event of a transfer admission to or from the hospital, the sending and receiving hospital or the attending provider must contact the Utilization Management department. No party should assume the other has obtained prior authorization.

Outpatient Surgical Services

Prior authorization may be required for the procedure or surgery. The ordering Provider must make the request for such prior authorization.

The requesting Provider should make every attempt to request the above prior authorization at least 72 hours prior to admission unless contract guidelines stipulate otherwise.

In the event that a member's condition requires an immediate admission, prior authorization must be obtained for the admission. The ordering Provider or the facility may make the request for such prior authorization. Please be sure that all claims include your appropriate Provider ID numbers and appropriate authorization information for each place of service.

Discharge Planning

Discharge planning begins at the time a member is admitted to the hospital and continues through the concurrent review process. The Utilization Management nurse will use approved medical criteria as discharge

indicators. In addition to the member's clinical status, the psychosocial situation and home environment are also taken into consideration when evaluating the member's discharge status. Post-hospitalization services may include, but are not limited to, home health visits, DME, rehabilitation and pharmacy services. The Utilization Management nurse will refer pre-identified patients to a dedicated discharge team. This discharge team will assume responsibility for the finalization of the discharge plan and will serve as a resource to the attending provider, hospital team and the member. The discharge team will perform the following discharge planning tasks:

- Confirm benefit levels.
- Assist with the identification of participating providers.
- Facilitate the certification process of post-hospitalization services.
- Refer members to Care Management for continuity of care.
- Identify high-risk patients for post-discharge follow-up contact to confirm the discharge plan was executed.
- Assist provider with identification and resolution of unanticipated issues identified immediately post-discharge.

The Utilization Management discharge team's focus is to assist the hospital staff and attending provider with the coordination of the member's discharge plan. In addition, during the discharge planning process, the discharge team will identify those members who may be considered high-risk and will outreach to the member post-discharge to verify the discharge plan was executed as the treating provider intended.

Home Health Services

Upon discharge, specific Home Health Care services and related DME must be prior authorized through the UnitedHealthcare Community Plan Utilization Management department as necessary.

Skilled Nursing Units

UnitedHealthcare Community Plan providers may use a skilled nursing unit only when prior authorized by the Utilization Management department. The ordering Provider or the facility may make the request for such prior authorization.

The requesting Provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission, unless contract guidelines stipulate otherwise.

Inpatient Rehabilitation Unit/Long Term Acute Care Facility

UnitedHealthcare Community Plan providers may use an Inpatient Rehabilitation Unit only when prior authorized by the Utilization Management department. The ordering Provider of the facility may make the request for such prior authorization.

The requesting Provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission, unless contract guidelines stipulate otherwise.

Care Management Services

Background

UnitedHealthcare Community Plan strongly believes in the utilization of care management services to promote comprehensive coordinated care for identified populations.

Our Care Management program serves as an individualized service delivery based on comprehensive assessment tools that are used to develop a care plan. The care plan is developed in collaboration with the member, family (if applicable), and the treating provider. The goal is to empower the member and involve them in all aspects of the planning and service arrangements.

The UnitedHealthcare Community Plan philosophy expands on this premise as we believe that psychosocial issues, especially in the Medicaid population, directly impact upon the members' ability to manage their disease or condition. To this end, our care management team employs a multidisciplinary approach where the clinical care management (RN) activities are complemented or assisted by social work-based care managers, health coaches and behavioral health advocates.

Provider Involvement

Providers can be actively involved in the care management programs in several ways. The plan recognizes the importance of not only including the treating provider on a member-by-member basis but also to use the expertise of practicing providers in the ongoing refinement of the care management program. The various processes for provider involvement are described below:

- Each treating provider is notified in writing at the time of their patient's enrollment in the care management program and is invited at that time to participate in the initial and ongoing development of the care plan.

The care manager may contact the primary treating provider in order to design specific interventions in conjunction with the practitioner's treatment plan. This is also considered as an opportunity by the care manager to develop a relationship with the treating provider and his office staff.

- The care managers contact the treating provider with any serious changes in member's condition to update/redirect the plan.
- Providers are strongly encouraged to refer patients to care management on an as-needed basis.

Providers can refer their patients for care management by calling 800-508-2581.

Health Management Programs

The **Adult Care Management** portion of the program identifies and risk-stratifies the adult medically complex population with consideration to co-morbid conditions and social environment. Activities are designed to address members within the continuum of their disease, including educational outreach, ongoing-targeted short and long-term care management, as well as collaboration with the member's provider and other health care team members to effectively educate and develop an optimal treatment plan to help the member manage their disease.

The **Pediatric Care Management** portion of the program was intentionally designed to have a very broad diagnoses base to allow referrals for reasons other than catastrophic type illnesses or conditions.

Disease management programs offered through UnitedHealthcare Community Plan:

Asthma Care Management

Each patient is assessed, stratified and the care plan intensity can range from basic education mailings for those members who require limited assistance to comprehensive care plans with frequent outreach, including face-to-face visits for high-risk members and their treating providers.

All children under 21 years of age with a diagnosis of asthma, regardless of severity, should be referred to care management services for screening/assessment.

High-Risk Pregnancy Care Management

The High-Risk Pregnancy program is through the Healthy First Steps program, which offers coaching for all pregnant members to encourage pre-natal care. Members are identified as high-risk, primarily through the OB/GYN physician's submission of the Prenatal Risk Assessment Form that is completed during the first prenatal visit. The assessment form is designed to clearly identify members who are at risk of pre-term labor or a poor outcome of the pregnancy.

High-risk pregnancy indicators are as follows:

- Teen pregnancy – age 17 and under (CSHCN indicator).
- Pre-term labor.
- Premature rupture of membranes/cervical dilation.
- Uncontrolled insulin dependent diabetes.
- Fetal anomalies.
- Placental/uterine abnormalities.
- Hyper-emesis.
- Incompetent cervix.
- Uncontrolled asthma.
- Uncontrolled or chronic hypertension/pregnancy induced.
- Hypertension.
- Pre-eclampsia.
- Multiple gestation.
- History of 3 or more previous miscarriages after first trimester.
- Bleeding after first trimester.
- Current drug or alcohol abuse.

Neonatal Intensive Care Unit (NICU) Care Management

The **NICU Care Management** program is designed to assign a care manager as soon as possible after the infant's birth. The NICU care manager performs all of the Utilization Management activities for the admission, which include continued stay and discharge planning. Contact with the parent(s) is established while the infant is hospitalized so that if the infant is identified, through risk stratification methodology, for care management services post discharge, the critical relationship with the parent(s) has already been established.

If a **High-Risk Pregnancy** care manager identifies a patient where premature delivery of a high-risk infant is imminent or predicted, the care manager will consult with the NICU care managers and discuss the mother's clinical and social history, allowing a smooth transition of the high-risk mother and infant to the NICU care manager.

Diabetes Care Management

Diabetes care management focus is education and improved compliance with the provider's treatment plan. Patients are primarily identified through claims and pharmacy activity but as with all of the programs, members, treating providers and the plan's Utilization Management department are also a strong referral source. Each member is assessed, stratified and the care plan is customized to meet each member's needs. Members that require limited assistance will receive educational mailings and members who require a more intense approach, a comprehensive care plan will be developed that includes frequent outreach to both the member and the treating provider.

Transplant Care Management

The Transplant Care Management program monitors the member from initial evaluation throughout the transplant hospitalization. After the transplantation has occurred, the member is followed by the health plan's care managers. Activities are designed to address members within the continuum of care, provide ongoing-targeted care management, which includes collaboration with the member's provider(s) and the facility transplant team.

The transplant care managers are assigned as the member enters the transplant evaluation process. The care manager performs the Utilization Management activities associated with the transplant evaluation, all inpatient admissions and related outpatient services. The care manager develops a relationship with the patient, family and the hospital transplant team, which allows the care manager to support the patient and family through a very difficult and stressful time of their lives.

Provider Dispute Procedures

Overview

It is UnitedHealthcare Community Plan's goal to identify, eliminate, and prevent dissatisfaction of providers by making every effort to maintain open lines of communication with providers. To ensure that provider disputes are resolved in a consistent manner, UnitedHealthcare Community Plan operates internal provider dispute procedures.

If a Provider has a complaint or other problem regarding any aspect of UnitedHealthcare Community Plan's operations, the provider may contact the Provider Services department at 800-600-9007 to register a complaint and seek resolution.

If a matter cannot be resolved to the provider's satisfaction, the provider can exercise his/her dispute rights in writing within the time frames specified below. Requests should include all details relevant to the dispute and attempts at resolution prior to filing.

Provider Disputes

UnitedHealthcare Community Plan's various dispute processes. Providers may obtain further information regarding specific situations by contacting our Provider Services department.

Providers may dispute the following decisions by UnitedHealthcare Community Plan:

Step 1: Claim Reconsideration/Dispute. You must submit your Claim Reconsideration/Dispute within 45 days from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). If you believe we underpaid you, the first step in addressing your concern is to submit a Claim Reconsideration/Dispute.

The quickest way to submit a Claim Reconsideration request is online.

Go to UHCprovider.com > Claims & Payments > Claim Reconsideration. Please identify the specific claims in "paid" or "denied" status which you believe should be adjusted and give a description of the requested adjustment.

If written documentation is needed, such as proof of timely filing or medical notes, you must use the form that is found on UHCprovider.com > Claims & Payments > Claim Reconsideration > Claim Reconsideration Request Form.

The form should be mailed to the claim address on the back of the Customer's health care ID card.

If you are submitting a Claim Reconsideration/Dispute Request Form for a claim which was denied because filing was not timely:

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

Note: All proof of timely filing requests must also include documentation that the claim is for the correct patient.

If you are submitting a Claim Reconsideration/Dispute Request Form for a claim which was denied requesting medical documentation:

1. Complete the Claim Reconsideration Request Form and check "Previously denied/closed for Additional Information" as your reason for request.
2. Provide a description of the documentation being submitted along with all pertinent documentation.

Note: It is extremely important to include the Customer name and health care ID number as well as the provider name, address and TIN on the Claim Reconsideration form to prevent processing delays.

Alternatively, you can call 800-600-9007 to request an adjustment for a claim that does not require written documentation.

If you have a request involving 20 or more paid or denied claims, aggregate these claims on the Claim Project online form and submit the form for research and review. Go to UHCprovider.com > Claims & Payments > Claim Research Project.

Dispute of Denied Claims and Payment Authorization

Claims and requests for payment authorization may be denied for failure to follow required procedures or UnitedHealthcare Community Plan's UM/QI Plan, e.g., failure to obtain required prior authorization, or submit claims on time. While UnitedHealthcare Community Plan encourages providers to seek informal resolution of claim disputes through our Provider Services department, the formal dispute process must be initiated within 45 days of UnitedHealthcare Community Plan's remittance advice or as stated in your contract. Disputes of denied claims must be submitted in writing to:

UnitedHealthcare Community Plan
Grievance/Appeal Coordinator
P.O. Box 31364
Salt Lake City, UT 84131

Providers should not re-submit denied claims or send disputes to the Claims department.

Disputes must include all supporting documentation and specify all reasons why the provider believes UnitedHealthcare Community Plan's original decision is in error. Disputes over payment will generally be decided within 30 days of receipt thereof, the provider must submit an original copy of the disputed claim along with a copy of UnitedHealthcare Community Plan's remittance advice.

Contract Termination Decisions

Contract termination disputes are appealable. If you have received a notice of contract termination and have a question, please contact the Provider Services Department at 800-600-9007.

Arbitration

If you have a concern or a complaint about your relationship with us, send a letter containing the details to the address listed in your agreement with us. A representative will look into your complaint and try to resolve it through an informal discussion.

If you disagree with the outcome of this discussion, an arbitration proceeding may be filed as described in your agreement with us. If your concern or complaint relates to a matter involving UnitedHealthcare administrative procedures, such as the notification or claim appeal processes described in this Guide, we both will follow the dispute procedures set forth in those plans to resolve the concern or complaint. After following these procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described in your agreement with us. For disputes regarding payment of claims, you must timely complete the claim reconsideration and appeal process as set forth in this Guide prior to initiating arbitration.

If we have a concern or complaint about your compliance with your agreement with us, we will send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us.

Provider Dispute Process Revisions

The provider dispute process described herein is subject to change, without notice, to accommodate revisions in applicable federal and state law. If you have any questions, contact our Provider Services department at 800-600-9007.

Member Appeals, Grievances and State Hearings

The Provider may reference the member handbook at UHCCommunityPlan.com or contact UnitedHealthcare Community Plan to request UnitedHealthcare Community Plan's policies and procedures for more detailed information regarding the member dispute process.

Member Appeal Process

The member, or authorized representative with the written consent of the member, may file an appeal regarding a UnitedHealthcare Community Plan action within 60 days of the date of the action. An action is any reduction, suspension, termination, denial, or untimely delivery of a service or denial of payment for a service. The member may request that the authorized representative assist or represent them during the process and be present during the review. Member appeals are reviewed and resolved within 15 calendar days of receipt per OAC 5160-26-08.4(C)(6).

UnitedHealthcare Community Plan will review the member's appeal in an expedited manner if the member's treating provider certifies that the member's health will be harmed by deciding the appeal in the regular appeal time frames. The certification must include the clinical rationale and member-specific facts to support the provider's opinion. The appeal will be reviewed and decided within 48 hours of its receipt of the expedited appeal request per OAC 5160-26-08.4(D)(2)(e).

Members' Rights and Responsibilities

As a Member of UnitedHealthcare Community Plan, You Have the Following Rights:

- To receive all services that UnitedHealthcare Community Plan must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/ corrected if needed.
- To be able to say yes or no to having any information about you given out unless UnitedHealthcare Community Plan has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or MCP must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See the section called "How to Let UnitedHealthcare Community Plan Know if You Are Unhappy or Do Not Agree With a Decision We Made" in this Member Handbook for information.
- To be able to get all UnitedHealthcare Community Plan written member information from the plan:
- At no cost to you.
- In the prevalent non-English languages of members in the MCP's service area.
- In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To get information about UnitedHealthcare Community Plan services, our practitioners and providers, and member rights and responsibilities.
- To be able to get help free of charge from UnitedHealthcare Community Plan and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See pages 46-50 of the Member Handbook, which explains about advance directives.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your Primary Care Provider (PCP) to another PCP on UnitedHealthcare Community Plan's panel at least monthly. UnitedHealthcare Community Plan must send you something in writing that says who the new PCP is and the date the change began.
- To be free to carry out your rights and know that the MCP, the MCP's providers, or ODJFS will not hold this against you.
- To know that the MCP must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.

- If you are a female, to be able to go to a woman's health provider on UnitedHealthcare Community Plan's panel for covered woman's health services.
- To be able to get a second opinion from a qualified provider on UnitedHealthcare Community Plan's panel. If a qualified provider is not able to see you, UnitedHealthcare Community Plan must set up a visit with a provider not on our panel.
- To get information about UnitedHealthcare Community Plan from us.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights:

United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601
312-886-2359 (TTY: 312-353-5693)

Bureau of Civil Rights Ohio:

Department of Job and Family Services 30 E. Broad St.,
30th Floor Columbus, Ohio 43215
614-644-2703; 866-227-6353
(TTY: 866-221-6700)

- To share ideas to make UnitedHealthcare Community Plan better; including recommendations regarding your rights and responsibilities.
- To talk openly about all appropriate and needed medical treatment options no matter what the cost or benefit coverage.

As a Member of UnitedHealthcare Community Plan, You Have the Responsibility:

- To understand how UnitedHealthcare Community Plan works by reading this book.
- To choose your Primary Care Provider.
- To carry your UnitedHealthcare Community Plan card; (You must show your card when receiving services and to report a stolen or lost card as soon as possible. You also must inform UnitedHealthcare Community Plan of any other insurance you may have, and to present current insurance information to your Primary Care Provider).
- To seek medical attention as needed.
- To be on time for all appointments.
- To tell your PCP's office or any medical office if you need to change an appointment.
- To respect the rights and property of your PCP, other healthcare workers, and other patients.
- To know when to take your medicine, how to take your medicine and to follow your doctor's instructions.
- To give the right medical information about yourself.
- To take full responsibility, think about the consequences of your decision if you refuse care (say no) to treatment, and ask questions if you don't understand.
- To understand as best you can your health problems and take part in developing mutually agreed upon treatments.
- To be sure that your Primary Care Provider has all your medical records; (This includes all medical records from other doctors.)
- To let UnitedHealthcare Community Plan know if you are in the hospital: (Do this in 24 hours or as soon as possible.)
- To consent to the proper use of your health information.
- To keep your Medicaid eligibility current so you do not lose your UnitedHealthcare Community Plan membership.

Quality Improvement Program

Overview

The UnitedHealthcare Community Plan Quality Improvement Program is designed to continually monitor, evaluate and improve the quality of care and services UnitedHealthcare Community Plan provides. The program identifies and recommends ways to improve health care and related services delivered to UnitedHealthcare Community Plan members through the use of continuous quality improvement concepts and methods, including:

- Evaluating clinical and administrative aspects of care and services provided to members to determine areas for improvement;
- Recommending corrective plans of action to improve the quality of care and service;
- Implementing the plans of action; and
- Measuring the effectiveness of interventions to improve the quality of care, customer service and the health status for the members it serves.

Provider Participation in Quality Management

All providers and practitioners are required to participate in and cooperate with the UnitedHealthcare Quality Management program. The UnitedHealthcare Quality Management program is allowed to use practitioner and provider performance data to conduct quality activities.

UnitedHealthcare Community Plan has a Provider Advisory Committee (PAC) through which participating providers give UnitedHealthcare Community Plan advice and expert counsel in medical policy, quality management and quality improvement. A medical director chairs the PAC, which meets on a regular basis and has oversight responsibility for issues affecting health services delivery. The PAC is composed of participating providers and UnitedHealthcare Community Plan management staff and reports its recommendations and actions to the UnitedHealthcare Community Plan Board of Directors.

Monitoring and Improving Quality of Care

The Quality Improvement Program tracks certain indicators of plan performance to assess the quality, adequacy and appropriateness of health care resources used. Performance indicators are based upon:

- The accessibility of practitioners, which is evaluated by analysis of complaint data, on-site and investigative reviews;
 - The availability of practitioners and providers, which is monitored by GEOAccess reports and subsequent analysis of standards;
 - Member and provider satisfaction with the plan services and Utilization Management process, which is monitored by Consumer Assessment Health Plan Survey (CAHPS) and provider satisfaction survey results, respectively, as well as complaints;
 - Credentialing and recredentialing standards, which are monitored by adherence to standards and time frames;
 - Practitioner adherence to published clinical practice guidelines that is measured by annual guideline measures;
 - Preventive health services, which are evaluated by Healthplan Effectiveness Data and Information Set (HEDIS) measures and chart audits;
 - Continuity and coordination of care processes that are evaluated by survey and chart audits;
 - Access to Member Services team members that are evaluated by telephone statistics;
 - Quality of care issues evaluated by member complaints and sentinel events; and
 - Health promotion services for children and adults, which are measured by HEDIS performance measures and chart audits.
- Physicians and providers must allow the plan to use physician and provider performance data.

Development of Clinical Practice Guidelines

UnitedHealthcare Community Plan develops and distributes clinical practice guidelines associated with acute and chronic conditions prevalent in the membership population in an effort to assist practitioners and members with health care decisions based on disease or condition. UnitedHealthcare Community Plan's Quality Improvement team in conjunction with the PAC reviews these guidelines annually.

Ongoing Evaluation Activities

Throughout the year, potential risk management cases and quality of care problems will be evaluated through a formal program, which will identify those cases that require investigation and follow up and establish the data collection mechanism for trending purposes. This process shall be conducted as part of UnitedHealthcare Community Plan's peer review activities. Each potential risk management or potential quality of care problem is reported to the UnitedHealthcare Community Plan Quality Management & Performance Department (QMP), and is investigated to determine the assignment of a quality concern level and initiation of an action plan. The QMP department will refer all necessary issues to the Medical Director for review.

Information used for tracking and trending purposes includes:

- Date of incident or identification.
- Member identification number.
- PCP name.
- Involved participating provider, if other than PCP.
- Problem description.
- Quality concern level.
- Facility (site) where problem occurred.
- Action steps.
- Outcome/follow-up.

The UnitedHealthcare Community Plan QMP department prepares a summary of tracking activities for review by the PAC.

The PAC acts as a peer review forum to review trends in quality of care issues and monitoring for system-wide problems. Focused studies/audits or multi-disciplinary teams may be recommended for pursuing QMP initiatives for system-wide problems

Monitoring Member and Provider Satisfaction and Feedback

UnitedHealthcare Community Plan monitors member satisfaction of care and services to ensure all areas of member interactions are working effectively and to identify opportunities to improve on these processes whenever possible for the full range of its operations, including:

- Availability and accessibility of health practitioners and services;
- Utilization Management procedures;
- Quality and service provided in practice settings; and
- Quality of member services.

UnitedHealthcare Community Plan analyzes member satisfaction data from all sources including member satisfaction survey data, member complaints and grievances, and provides for interval analysis as well as an annual aggregate report. The report includes the assessment of member satisfaction data and the monitoring methodology, a quantitative and qualitative analysis, year-to-year trending, comparisons to goals and benchmarks, barrier analysis, opportunities for improvement, and evaluation of the effectiveness of past interventions.

UnitedHealthcare Community Plan utilizes Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, member complaints and member grievances from an integrated set of carefully tested and standardized questions to collect and report meaningful

and reliable information about the experiences of the members.

UnitedHealthcare Community Plan evaluates practitioner satisfaction using an annual satisfaction survey. On an annual basis, the survey data is reviewed and analyzed to ensure providers' needs are acknowledged and addressed.

Peer Review Procedures

The UnitedHealthcare Community Plan Medical Director will contact a provider if there is a question about services delivered or in response to a complaint, the credentialing process, quality of care or sentinel events. If the Medical Director and individual provider or practice cannot resolve the issues adequately and pursuant to state and federal regulations, the issues will then be sent to the PAC.

Delegated Medical Management

Delegation Oversight

We may assign medical management to a medical group/Independent Practice Association (IPA) with established medical management standards. We refer to the medical group/IPA as a "delegate". Care providers associated with these delegates may use the delegate's office and protocols for authorizations. The delegate's medical management protocols and procedures must comply with UnitedHealthcare Community Plan as well as all applicable state and federal regulatory requirements.

Before assigning medical management functions, we assess the delegate. Within 90 calendar days of the contract effective date, we assess it again to measure compliance with UnitedHealthcare Community Plan standards. We assess the delegate annually thereafter. We may also conduct an off-cycle assessment if needed.

Based on the assessment findings, we may have the delegate develop and implement a corrective action plan to bring the medical group/IPA back into compliance. Delegates who do not achieve compliance

within the established timeframes may undergo further corrective action. If the action is not successful, the medical management function will be withdrawn.

Appeals

When we review a member or care provider's adverse determination appeal from a delegate, we use MCG (formerly Milliman Care Guidelines) as the externally licensed medical management guidelines. This happens even if the delegate used different externally licensed medical management guidelines to make the determination.

Semi-Annual Reporting

The delegate provides UnitedHealthcare Community Plan with semi-annual reports as outlined in the delegation agreement. Reports must meet applicable requirements and accreditation standards.

Purpose of Medical Management Program

The Medical Management Program helps determine if medical services are:

- Medically necessary.
- Covered under the UnitedHealthcare Community Plan benefit.
- Performed at both the appropriate place and level of care.

Determining Medical Necessity

Delegates review nationally recognized criteria to determine medical necessity and appropriate level of care for services. This includes Medicaid coverage guidelines. For services not addressed in Medicaid coverage guidelines, delegates use UnitedHealthcare Community Plan's medical policies. If other nationally recognized criteria disagree with Medicaid coverage guidelines, delegates follow Medicaid coverage guidelines.

Members may call the delegate's general number (or the number listed in the denial letters) to request individual eligibility and benefit criteria. They may also call our Member Services department.

NCQA Accreditation standards require all health care organizations, health plans and delegates distribute a statement to members, care providers and employees who make utilization management (UM) decisions. The statement must note the following:

- UM decision-making is based only on appropriateness of care, service and coverage.
- You or others are not rewarded for issuing denials or encouraging decisions that result in under-utilization

Care Provider Requirements

Render covered services at the most appropriate level of care based on nationally recognized criteria. With few exceptions, we do not reimburse for non-covered services and those not medically necessary. We do not reimburse for the wrong procedures (e.g., notification requirements, preauthorization, verification guarantee process). Authorization receipts do not affect how payment policies determine reimbursement.

We nor the member are responsible for reimbursing medical services, admissions, inappropriate facility days, and/or medically necessary services if you did not obtain required prior authorization. Regardless of the Medical Management Program determination, the decision to render medical services lies with the member and you, as the attending care provider. If you and the member decide to go forward with the medical services after UnitedHealthcare Community Plan or the delegate deny preauthorization, no care provider, facility or ancillary services will be reimbursed. The delegate's medical director can discuss the decisions and criteria with the member. The delegate also makes the medical policy decisions available upon request.

Medical Management Denials/Adverse Determinations

UnitedHealthcare Community Plan or a delegate may issue a denial when a non-covered benefit is requested but deemed not medically necessary. This may also happen when we receive insufficient information.

Denials, Delays or Modifications

UnitedHealthcare Community Plan or the delegate must make and communicate timely approvals, modifications or denials. We or the delegate must also state the decision to delay a service based on medical necessity or benefit coverage appropriate to the member's medical condition, in accordance with the applicable state and federal law. We base all authorization decisions on sound clinical evidence, including medical record review, consultation with the treating care providers, and review of nationally recognized criteria. You must clearly document the medical appropriateness with your authorization request. State and federal law applies to criteria disclosure.

The medical director, Utilization Management Committee (UMC) or you must review referral requests not meeting the authorization criteria. Otherwise, you must present the information to UMC or the subcommittee for discussion and a determination. Only a care provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist, as appropriate) may delay, modify or deny services for medical necessity reasons. Board-certified, licensed care providers from appropriate specialties must help make medical necessity decisions, as appropriate. Determination rules include:

- You may not review your own referrals.
- Care providers qualified to make an appropriate determination will review referral requests considered for denial.
- Any referral request where the medical necessity or the proposed treatment is not clear will be discussed with the care provider. Complex cases may be brought to the UMC/medical director for further discussion.
- Individual(s) who can hold financial ownership interest in the organization may not influence the clinical or payment decisions.

Possible request for authorization determinations include:

- Approved as requested – No changes.
- Approved as modified – Referral approved, but changed the requested care provider or treatment

plan. (e.g., requested chiropractic, approved physical therapy).

- Extension – Delay of decision (e.g., need additional information, require consultation). CMS allows an extension when a Medicaid member requests one.
- Delay in Delivery – Postpone access to an approved service until a certain date. This is not the same as a modification. A written notification in the denial letter format is required.
- Denied – Non-authorization request for health care services.

Reasons for denials of requests for services include:

- Not a covered benefit – The requested service(s) is excluded under the member's benefit plan.
- Not medically necessary or benefit coverage limitation – Specify criteria or guidelines used to make the determination.
- Member not eligible at the time of service.
- Benefit exhausted - Include what benefit was exhausted and when.
- Not a participating care provider – A participating care provider/service is available within the medical group/ IPA in-network.
- Experimental or investigational procedure/treatment.
- Self-referred/no prior authorization (for non-emergent post-service).
- PCP can provide requested services.

Written Denial Notice

The written denial is an important part of the member's chart and the delegate's records. Regardless of the form used, the denial letter documents member and care provider notification of:

- The denial, delay, partial approval or modification of requested services.
- The reason for the decision, including medical necessity, benefits limitation or benefit exclusion.
- Member-specific information about how the member did not meet criteria.

- Appeal rights.
- An alternative treatment plan, if applicable.
- Benefit exhaustion or planned discharge date.

CMS requires the use of the CMS Integrated Denial Notice/Notice of Denial of Medical Coverage (IDN/ NDMC) for Medicaid plan members. Do not alter this template except to add text to the requested areas. Most states require approved standardized templates for member notices, such as denial of services. UnitedHealthcare Community Plan will provide appropriate and approved templates to the delegates.

Minimum Content of Written or Electronic Notification

Written or electronic notices to deny, delay or modify a health care services authorization request must include the following:

- The requested service(s)
- A reference to the benefit plan provisions to support the decision
- The reason for denial, delay, modification, or partial approval, including:
 - Clear, understandable explanation of the decision
 - Name and description of the criteria used
 - How those criteria were applied to the member's condition
- Notification the member can get a free copy of the benefit provision, guideline, protocol or other criterion used to make the denial decision
- Contractual rationale for benefit denials
- Alternative treatments offered, if applicable
- A description of additional information needed to complete that request and why it is necessary
- Appeal and grievance processes, including:
 - When, how and where to submit a standard or expedited appeal
 - The member's right to appoint a representative to file the appeal

- The right to submit written comments, documents or other additional relevant information
- The right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable
- The name and phone number of the health care professional responsible for the decision.

Medical Group/IPA's Responsibilities Related to Member Grievance and Appeals

Occasionally, a member may contact the delegate instead of the plan. In such cases, delegates must:

- Within one hour of receipt, forward all member grievances and appeals to UnitedHealthcare Community Plan for processing.
- Respond to UnitedHealthcare Community Plan requests for appeal or grievance information within the designated timeframe. (Standard appeals with 24 hours, expedited appeals within two hours. Timeframes apply to every calendar day.)
- Comply with all final UnitedHealthcare Community Plan determinations.
- Cooperate with UnitedHealthcare Community Plan and the external independent medical review organization or State Fair Hearing. This includes promptly forwarding all medical records and information related to the disputed health care service.
- Provide UnitedHealthcare Community Plan with the authorization (pre-service) within the requested timeframes on adverse determinations reversals.
- Respond to requests for proof of overturned appeals.

Referrals

Referral authorization procedure

The delegate may initiate a member referral. (Refer to the delegated group's pre-authorization list, as applicable). The following capitated medical services are examples of when a referral authorization may be needed:

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA's facility)
- Specialty consultation/treatment

The delegate, PCP and/or other referring care provider must verify the care provider participates in UnitedHealthcare Community Plan.

You must also comply with the following procedures:

- Review the service request for medical necessity.
- If the treatment is not medically necessary, discuss an alternative treatment plan with the member.
- If the treatment requires referral or prior authorization, submit the request to the delegate UMC for determination.

If the request is not approved, the delegate must issue the member a denial letter.

Referral Authorization Form

The delegate may design its own authorization form, without approval from UnitedHealthcare Community Plan. The form should include all the following:

- Member identification (e.g., Member ID number and birth date)
- Services requested (including appropriate ICD-10-CM and/or CPT codes)
- Authorized services (including appropriate ICD-10-CM and/or CPT codes)
- Proper billing procedures (including the medical group/IPA address)
- Verification of member eligibility

The delegate provides this form to the following:

- Referral care provider
- Member
- Member's medical record
- Managed care administrative office

The delegate does so within 36 hours of receipt of information necessary to make a decision. This includes one working day and does not exceed 14 calendar days. If UnitedHealthcare Community Plan is financially responsible for the services, the delegate submits the authorization information to the plan.

Continuity of Care

Continuity of care lets members temporarily continue receiving services from a non-participating care provider. It is intended to last a short period.

The delegate facilitates continuity of care for medically necessary covered services. If a member entering the health plan is receiving medically necessary services (in addition to or other than prenatal services) the day before enrollment, the health plan covers the continued costs of such services without prior approval. This is regardless of whether in-network or out-of-network care providers grant these services.

- The health plan provides continuation of such services for the lesser of (1) 60 calendar days or (2) until the member has transferred without disruption of care to an in-network care provider.
- For members eligible for care management, the new health plan provides service continuation authorized by the prior health plan for up to 60 calendar days after the member's enrollment in the new health plan. Services will not be reduced until the new health plan assesses the situation.

Members in their third trimester of pregnancy may receive services from their prenatal care provider (whether in-network or out-of-network) without any form of prior authorization through the postpartum period (defined as 60 calendar days from date of birth).

A member should not continue care with a non-participating care provider without formal approval by UnitedHealthcare Community Plan or the delegate. Except for emergent or urgent out-of-area (OOA) care, payment for services performed by a non-participating medical group/IPA become the member's responsibility.

UnitedHealthcare Community Plan (or the delegate) reviews all requests for continuity of care. We consider the member's condition and the potential effect on the member's treatment. We also consider how changing the care provider can affect the health outcome.

A member may request to continue covered services with a care provider who has terminated from UnitedHealthcare Community Plan for reasons other than cause or disciplinary action. As the care provider, you must agree in writing:

- To agree to the same contractual terms and conditions imposed on participating care providers, including credentialing, facility privileging, utilization review, peer review and quality assurance requirements; and
- To be compensated at rates and payment methods similar to those used by UnitedHealthcare Community Plan and participating care providers granting similar services who are not capitated and are practicing in the same geographic area.

Second Opinion

Members have the right to second opinions. The delegate will provide a second opinion when either the member or a qualified health care professional requests it. Qualified health care professionals must provide the member with second opinions at no cost. A third opinion is allowed as well.

Notification Requirements for Facility Admissions when UnitedHealthcare pays claims

Contracted facilities are accountable to provide timely notification to both the delegate and UnitedHealthcare Community Plan within 24 hours of admission for all inpatient and observation status cases. This information is needed to verify eligibility, authorize care, and initiate concurrent review and discharge planning.

In maternity cases, notify vaginal delivery or C-section delivery on or before the end of the mandated period 48 hours or 96 hours, respectively. We require notification if the baby stays longer than the mother. In all cases, separate notification is required immediately when a baby is admitted to the neonatal intensive care unit.

For emergency admissions, notification occurs once the member has been stabilized in the emergency department.

Authorization Log and Denial Log Submission

Authorization logs for all inpatient acute, observation status and skilled nursing facility cases must be accurately submitted to clinicaloperations@uhc.com. When no inpatient acute, observation statuses or skilled nursing facility cases are active, the delegate must submit its weekly authorization log indicating either “no activity” or “no admissions” for each designated admission service type specified in this section and for the applicable reporting time.

Authorization logs covering facility and skilled nursing facility daily information includes the following:

- Member ID
- Member name
- Member date of birth
- Attending care provider: (Name and address, with TIN if available)
- Facility care provider: (Name and address, with TIN if available)
- Admitting diagnosis (ICD-10-CM or its successor code)
- Planned and actual admission dates
- Planned and actual discharge dates
- Level of care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/surgery (CPT Code)
- Discharge disposition
- Service type
- Authorization number (if available)

The delegate must clearly define medical necessity and authorizing outpatient services paid as either shared risk or plan risk per the medical group/IPA contract. It must submit authorization or denials for services the group authorized or denied care on behalf of UnitedHealthcare Community Plan.

For more information, please contact your Provider Advocate.

Claim Guidelines

Code Sets/Claim Forms

Claims must be submitted to UnitedHealthcare Community Plan using HIPAA compliant CPT-4 or HCPCS codes. UnitedHealthcare Community Plan follows Ingenix Clinical Editing System (ICES) edits in the processing of provider claims. Hospitals should bill on a UB-04 or CMS 1500 form. Other providers, including Ancillary providers, should bill using the CMS 1500 form. All paper claims must be billed on red and white claim forms. Black and white claim forms will not be accepted.

Clean Claims

Please allow 30 days for the processing of clean claims. A “clean claim” is a claim for payment for a health care service which has no defect or impropriety, such as a lack of required documentation or a particular circumstance requiring special treatment that prevents timely adjudication of the claim, and in compliance with applicable law

Payment in Full

In accordance with OAC Rule: 5101:3-1-60, Payment by UnitedHealthcare Community Plan is considered payment in full. Participating and Non-Participating providers may not bill a UnitedHealthcare Community Plan member unless all of the following conditions are met:

1. The member was notified by the provider of the financial liability in advance of the service delivery;
2. The notification by the provider was in writing, specific to the service being rendered, and clearly states that the recipient is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose;
3. The notification is dated and signed by the member; and
4. The reason the service is not covered by UnitedHealthcare Community Plan is specified and is one of the following reasons;

- a. The service is a benefit exclusion;
- b. The provider is not contracted with UnitedHealthcare Community Plan and UnitedHealthcare Community Plan has denied approval for the provider to provide the service because the service is available from a contracted provider; or
- c. The provider is not contracted with UnitedHealthcare Community Plan and has not requested approval to provide the service.

Electronic Claims (EDI)

Why Submit Electronically?

UnitedHealthcare Community Plan has the capability of accepting claims electronically through various vendors. UnitedHealthcare Community Plan prefers and encourages providers to take advantage of electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster Claims Submission.
- Expedited Payment.
- Detailed Submission Reports.
- Increased Claims Accuracy.
- Reduced Paperwork.
- Time and Cost Savings.

Claim Reconsiderations

A Claim Reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration request, we review whether a claim was paid correctly, including if your provider information and/or contract are set up incorrectly in our system, which could result in the original claim being denied or reduced.

UnitedHealthcare Community Plan acknowledges that providers remain eligible to file claims reconsiderations, resubmissions, disputes or appeals as permitted under

the terms of their participation agreement or provider manual. A request for claims reconsideration is intended solely for convenience and administrative ease. In the event this claims reconsideration process conflicts in any way with your participation agreement or provider manual, the terms and conditions of the participation agreement or provider manual shall govern. Providers are encouraged to review their participation agreement and provider manual to understand all other available claims reconsideration, resubmission or appeals remedies.

Below are the methods for submitting Claim Reconsideration Requests.

Electronic Claim Reconsideration Request (Preferred method)

- UHCprovider.com/claims
 - [Claim Submission](#)

Paper Claim Reconsideration Request

The paper Claim Reconsideration Request form can be downloaded from:

- [UHCprovider.com Claim Reconsideration](https://UHCprovider.com/ClaimReconsideration)
 - Paper Claim Reconsideration instructions

Where to Send Claim Reconsideration Requests:

UnitedHealthcare Community Plan
P.O. Box 8207
Kingston, NY 12402

Claim Dispute/Formal Appeal

If after the conclusion of the Claim Reconsideration process, you still are not satisfied with the outcome, you may submit a Claim Dispute/Formal appeal using the process outlined in your participating agreement or provider manual.

Overpayments

If you identify a claim for which you were overpaid by us, or if we inform you in writing or electronically of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. We may also apply the overpayment against future claim payments unless precluded by your agreement with us and applicable law.

All refunds of overpayments in response to overpayment refund requests received from UnitedHealthcare, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter. Refunds of any credit balances existing on your records should be sent to:

UnitedHealth Group Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0804

Please include appropriate documentation that outlines the overpayment, including member's name, member ID number, date of service and amount paid. If possible, please also include a copy of the remittance advice that corresponds with the payment from UnitedHealthcare. If the refund is due as a result of coordination of benefits with another carrier, please provide a copy of the other carrier's EOB with the refund.

When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician, healthcare professional, facility or ancillary provider. In the case of an over-payment, we will implement a claim reconsideration and request a refund at least 30 days prior to implementing a claim adjustment, or as provided by applicable law or your agreement with us. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it.

If you disagree with the claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you can appeal the determination.

To submit claims online at UHCprovider.com or use another electronic option:

- a. Connectivity Director is a direct connection for those who can create a claim file in the HIPAA 837 format. This web-based application enables real-time and batch submissions direct to UnitedHealthcare at no cost to you. Connectivity Director provides immediate response back to all transaction submissions (claims, eligibility, and more). Additional information can be found at UnitedHealthcareCD.com, including a comprehensive User Guide and information on how to get started.
- b. UnitedHealthcare Online All-Payer Gateway™ is a web-based connectivity solution which links UnitedHealthcare Online users to UnitedHealthcare group's clearinghouse vendor (OptumInsight™, formerly Ingenix) that offers multi-payer health transactions and services at preferred pricing. Using your current UnitedHealthcare Online User ID and password, you can register with OptumInsight to submit batch claims to many government and Commercial payers. For more information: UHCprovider.com/edi.
- c. Electronic Data Interchange (EDI) Gateway and Clearinghouse Connections –UnitedHealthcare's preferred clearinghouse is OptumInsight, but you can use any clearinghouse you prefer to submit claims to UnitedHealthcare. Both participating and non-participating physicians, health care professional, facility and ancillary provider claims are accepted electronically, using UnitedHealthcare's primary Payer ID (87726).

A complete list of Payer IDs for UnitedHealthcare, Affiliates, and Strategic Alliances can be found on UHCprovider.com > Menu > Resource Library > Electronic Data Interchange > Payer List for Claims.

How to Submit Electronically

If you currently submit claims electronically to other insurance carriers, please contact your software vendor for further instructions. Please notify your vendor that UnitedHealthcare Community Plan's Payer ID number is 87726. When submitting claims to UnitedHealthcare Community Plan, it is particularly important that your UnitedHealthcare Community Plan provider ID number and the member's UnitedHealthcare Community Plan ID number be present and accurate for each claim. If you are not presently submitting claims electronically, please contact the EDI Support Line at 800-842-1109.

What Can and Cannot Be Submitted Electronically?

All services submitted on a standard CMS 1500 Form or UB-04 Form will be accepted for electronic submission. Encounter Data must also be submitted using one of the aforementioned form types. There are a few types of claims and attachments which cannot be submitted electronically to UnitedHealthcare Community Plan, such as:

- Medicaid attachments.
- Claims for which UnitedHealthcare Community Plan is the secondary insurance.
- Claims for non-payable Medicaid codes which were negotiated for payment.

To avoid having one of the previously mentioned claims denied, a paper copy of the claim form and the attachment must be sent to the appropriate UnitedHealthcare Community Plan claims address.

Received Dates

The "received date" of the claim will be dependent on when the claim is received by UnitedHealthcare Community Plan. Any claim submitted to UnitedHealthcare Community Plan and received by 7 p.m. Monday through Friday will have a "received date" of that business day. Claims received after 7 p.m. will have a "received date" of the following business day.

Required Fields

Along with the standard fields required, the following fields must be completed for a claim to be accepted by UnitedHealthcare Community Plan for processing:

Field Numbers		
Field Description	CMS 1500 Form	UB-04 Form
Provider NPI Number	Box 33a & 24J	Box 51
Member ID Number	Box 1a	Box 60
Date of Service	Box 24A	Box 6 and 45*
DRG Number	N/A	Box 56 (I/P only)
Place of Service **	Box 24B	N/A

* Date of Service must be listed in box 6 on the UB04. For Outpatient claims, the Date of Service must also be listed on each line in box 45 on the UB04.

** Medicare Place of Service codes should be used.

Paper Claims

Providers that do not yet have the ability to submit electronic claims should submit their claims in the traditional paper format. All paper claims must be billed on red and white claim forms. Handwritten claim forms will not be accepted. Paper claims may be mailed to the following address:

UnitedHealthcare Community Plan
P.O. Box 8207
Kingston, NY 12402

Submission Requirements

Reimbursement of services is contingent upon proper authorization and member eligibility. Please be sure to submit every claim with a complete and accurate provider number.

Claims

All encounters and services provided to members must be submitted on a CMS 1500 or UB 04 as appropriate. All paper claims must be billed on red and white claim forms. Black and white claim forms will not be accepted. The submission must include HIPAA compliant codes and valid diagnosis codes. Depending on the service(s), the provider may possess an authorization number, obtained from UnitedHealthcare Community Plan's Utilization Management department respective to the service. In cases where prior authorization is required, the authorization number should be indicated on the claim in the prior authorization field (Box 23 on CMS-1500).

Time Frames

UnitedHealthcare Community Plan must receive a properly submitted claim within 90 days from the date of service. In cases where UnitedHealthcare Community Plan is not the primary payer, the Provider has 365 days to submit a claim after the payment/denial of the primary carrier. UnitedHealthcare Community Plan will forward a remittance advice and reimbursement within 30 days from receipt of a claim.

However, reimbursement is contingent upon proper authorization and member eligibility. Timely filing and re-submission guidelines are based upon your contractual agreement with UnitedHealthcare Community Plan of Ohio, please see OAC rule 5160-1-19 for reference. For non-participating providers, timely filing for original claims submission is 365 days and 180 days for claim re-submissions.

Inpatient Readmissions

For hospitals paid under the prospective payment system, a readmission is defined as an admission to the same institution within 30 days of the previous discharge. If any UnitedHealthcare Community Plan member is readmitted to the same facility within 30 days of discharge, please submit medical records with the second admission for review.

If a UnitedHealthcare Community Plan member is readmitted to the same facility within 24 hours of a previous discharge, this is automatically reconsidered a readmission. In this case, a combination claim will be needed for consideration of payment.

Reporting Birth Weight on Newborn Claims

Please note that providers are required to report newborn weight to UnitedHealthcare Community Plan. To report this data, the appropriate value code must be used:

UB-04: Report in block 39, 40 or 41 using value code "54" and the newborn's weight grams.

If billing electronically, please report birth weight in loop 2300, segment HI, with the qualifier BE and the value code "54" in HI01-2 and the newborn's weight in grams in HI01-5.

UnitedHealthcare Community Plan references the following codes to identify newborn claims. Therefore, please be sure to include birth weight on all claims containing these codes:

ICD-10 Procedure Codes:

- 72.x Forceps, vacuum, and breech delivery.
- 73.51 Manually assisted delivery; Manual rotation of fetal head.
- 73.59 Manually assisted delivery; Other.
- 74.0 Cesarean section and removal of fetus; Classical cesarean section.
- 74.1 Cesarean section and removal of fetus; Low cervical cesarean section.
- 74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section.
- 74.4 Cesarean section and removal of fetus; Cesarean section of other specified type.
- 74.99 Cesarean section of unspecified type.

ICD-10 Diagnosis Codes:

- 080 Normal Delivery.
- V27.x Outcome of Delivery.

The following codes must have a 5th digit equal to 1 or 2:

- 640-648 Complications mainly related to pregnancy.
- 651-659 Normal delivery and other indications for care in pregnancy, labor, and delivery.
- 660-669 Complications occurring mainly during the course of labor and delivery.
- 670-676 Complications of the puerperium.

CPT Codes:

- 59409 Vaginal delivery (with or without episiotomy or forceps).
- 59514 Cesarean delivery only.
- 59612 Vaginal delivery only, after previous cesarean delivery (with or with our episiotomy or forceps).
- 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.

Diagnosis Codes

Please make sure all diagnosis codes on any claim are billed to the highest level of specificity. This direction applies not just to the primary diagnosis but all diagnosis claims listed on the claim.

Reporting Date of Last Menstrual Period

Please note that providers are required to report the date of a member's last menstrual period to UnitedHealthcare Community Plan. If billing on paper, please report the date of the last menstrual period as follows:

UB-04: Report anywhere in blocks 32-36 using occurrence code "10" in one block with the date of the last menstrual period in the next block.

CMS-1500: Report in block 14 using the date of the last menstrual period.

If billing electronically, please report the date of the last menstrual period as follows:

837I: Report using occurrence code “10” and the date of the last menstrual period in loop 2300, segment HI, qualifier BH.

837P: Report the date of the last menstrual period in loop 2300, segment DTP, qualifier 484.

Why Accept Payment Electronically?

UnitedHealthcare Community Plan has the capability of paying providers electronically through electronic funds transfer (EFT). UnitedHealthcare Community Plan prefers and encourages providers to take advantage of our EFT capabilities. Accepting payment electronically offers the following benefits:

- Lower administrative costs or bank fees – no paper checks to process and deposits to be taken to the bank.
- Receive funds more quickly – payment hits your account the same day the check would otherwise be dropped in the mail.
- Reduced risk of lost checks, checks cashed by the wrong person, or other check related fraud.
- By making one single payment per Tax ID, the sum of all payments reconciles easily to your 1099 at the end of the year.

How to Enroll in UnitedHealthcare Community Plan’s EFT Program

Simply complete and return the “Authorization to Initiate Electronic Funds Transfer (EFT)” form included with this manual, or visit our website at UHCprovider.com or call 866-842-3278 and select option 5.

Corrected Claims Policy

Effective 3/1/2010, corrected claims need to be billed in the following format:

- CMS 1500
 - box 22, enter the appropriate claim frequency code.
- 7 – replacement of prior claim.
- 8 – void/cancel of prior claim.
- UB 04
 - box 4, enter the appropriate claim frequency code.
- 7 – replacement of prior claim.
- 8 – void/cancel of prior claim.

For professional, institutional and dental EDI claims, the only mechanism excepted to indicate the claim is a correction or a void of a previous processed claim will be the following:

- Loop 2300.
- Segment CLM05-3.
- Name Claim Frequency Type Code.
- Instructions: when resubmitting, enter the appropriate claim frequency code which is 7 or 8.

Please make sure corrected claims are resubmitted within your contractual time frames with UnitedHealthcare Community Plan.

Coordination of Benefits (COB)

If the Medicaid managed care consumer does not provide adequate information about other insurance coverage or denies having it, health care providers may submit their health care claims to UnitedHealthcare Community Plan for reimbursement. In order for UnitedHealthcare Community Plan to pay these claims, the provider must demonstrate that they have already taken “reasonable measures” to obtain third-party payments. “Reasonable measures” are defined as any (emphasis added) of the following:

1. The provider has first submitted a claim to the third-party carrier and received (a) remittance advice citing a valid reason for not paying the claim;
2. The provider has submitted the claim (to) the third-party payer at least once within a 90-day period and has not received (a) remittance advice or other communication within 90 days of the last submission. (Providers must be able to document each claim submission and its date.)
3. The provider has not submitted a claim, but has obtained written documentation from the third-party payer that the service is not eligible for coverage.

UnitedHealthcare Community Plan will pay provider claims submitted that meet the above listed criteria of “reasonable measures”. It is important that providers may not bill Medicaid consumers for unpaid medical claims.

Health Plan Standards

Access Standards

UnitedHealthcare Community Plan confirms that practitioners are accessible to our members. Compliance with accessibility standards are monitored by reviewing data collected from various sources, including: member complaints, office reviews, member satisfaction surveys, monthly random availability phone checks, and calls to the Member Services department. This data is presented to the PAC for barrier analysis and development of interventions when the results suggest that it is required. Follow-up is provided by the Provider Relations department, which educates offices that are not in compliance with the standards.

UnitedHealthcare Community Plan has established the following standards relative to accessibility:

- PCPs:
 1. Emergency cases must be triaged and treated immediately on presentation at the PCP site.
 2. Urgent cases must be scheduled within 24 hours.
 3. Routine Asymptomatic Appointments must be scheduled within 6 weeks.
 4. Routine care-persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP site.
 5. Preventive/General physical appointments must be scheduled within 6 weeks.
- Obstetrician/Gynecologist and Certified Nurse Midwife (CNM) standards:
 1. Initial prenatal care appointments are accessible within 2 weeks.
 2. First trimester: within 10 business days of request.
 3. Second trimester: within 5 business days of request.
 4. Third trimester: within 4 business days of request.
 5. High-risk pregnancies: within 1 week, unless urgent need exists, then within 24 hours.
- Orthopedic surgeon, allergist, dermatologist, otolaryngologist and neurologist accessibility standards:
 1. Urgent care appointments are seen within 48 hours of referral.
 2. Routine appointments for new patients are accessible within 6 weeks.
 3. Routine appointments for established patients within 4 weeks.
- Accessibility standards for all other specialty provider types:
 1. Urgent care appointments are seen within 24 hours of referral.
 2. Routine appointments for new patients are accessible within 4 weeks.
 3. Routine appointments for new patients are accessible within 3 weeks.
- Office Wait Times: The member's wait time should be no more than 45 minutes or up to 1 hour when the provider encounters an unanticipated urgent visit or is treating a member with a difficult medical need. Emergency cases should be seen immediately.
- Provider Coverage: All PCPs are contractually required to be available to their members 24 hours a day, 7 days a week to make certain the members have timely access to necessary care, for emergency care, and to allow the PCP continues to act as the "medical home." Offices must have a phone message or answering service available to members after office hours that instruct the member on how to contact the provider for urgent or emergency conditions.

Medical Record Documentation Standards

The UnitedHealthcare Community Plan Quality Management Program (QMP) confirms that medically necessary services are provided to members in both a timely and confidential manner. Medical records must be maintained in a manner that is current, detailed and

organized, and that permits effective and confidential patient care and quality review. The UnitedHealthcare Community Plan Medical Record Documentation Standards follow National Committee for Quality Assurance (NCQA) guidelines.

Per the UnitedHealthcare Community Plan provider agreements, all records, including medical records and financial documents, shall be maintained and available for review, audit or evaluation by authorized state personnel or their representatives. Providers shall retain the source records for operational data reports for a minimum of 8 years and have written policies and procedures for storing such information.

Standards:

Demographics

- Each page of a medical record should contain a name or medical record number as an identifier.
- An address where patient can be reached by mailings should be noted as well as the home phone number. If there is no phone, a neighbor, family member or friend should be listed.
- Birth date should be documented in the medical record. Emergency contact and phone number should be listed in the medical record.
- Each entry needs to contain the author's identification. Signature can be electronic, hand written or initialed.
- All entries in the medical record should be dated.
- The medical record should be legible to someone other than the writer. If questionable UnitedHealthcare Community Plan reserves the right for medical records to be released to our medical director for review.

Patient History

- Each medical record should contain a problem list. This area, where significant illnesses or medical conditions can be documented, should be updated frequently to show both active and inactive conditions.

- A medication list should be incorporated into the charting system. This section should be a current list of maintenance type medications.
- Allergies need to be noted in a prominent place in the chart. Such prominent areas could be the covers of the chart or an area easily identified when the chart is opened. If the patient has no allergies then NKA needs to be documented.
- There should be a detailed past medical history including illnesses, operations, injuries, disabilities, family history and any information pertinent to patient's health.
- A medical record should contain documentation that smoking, alcohol and substance abuse have been addressed. If patient is under 12 years old, documentation should be related to smoking in the home, if 12 years and older documentation should be patient-specific.

Diagnosis and Treatment Plan

- Lab and other studies ordered are appropriate to patient symptoms and physical findings.
- Working diagnosis should be consistent with physical, X-ray, lab and consult findings.
- Action and treatment plans should be consistent with diagnosis.
- Follow-up visits should be documented
- in days, weeks or months when clinically appropriate. Follow-up visits can be noted in chart, appointments scheduled at time of visit, reminder card system or super billing system.
- Unresolved problems from previous visits should be documented in the subsequent visit.

Continuity

- There should be evidence to support the use of consultations.
- If referred to by the primary doctor, documentation of consulting provider's findings, inpatient discharge summaries, skilled nursing facility progress notes or discharge summaries and home health care notes and discharge summaries should be noted in the medical record.

- All consults, summaries, lab and imaging studies need to be initialed or have explicit notation of review in the medical record.
- Abnormal labs, consults, imaging studies and summaries should have explicit notations of a follow-up treatment plan.

Prevention

- A completed immunization record should be present in all children's medical records.
- Height, weight and BMI should be noted
- An appropriate immunization record should be present in adult medical records.
- Preventive health issues should be appropriately addressed in the medical record and are audited using the applicable Preventive Health audit tools. These preventive health guidelines by age appropriateness are located in the provider service manual.
- Documentation of the presence or absence of an advance directive should be present on the chart of patients' 65 years and older.

Credentialing and Recredentialing

We are dedicated to providing our Customers with access to effective health care and, as such, we credential physicians and other health care professionals who seek to participate in our network and get listed in our provider directory, and then recredential them at least every 36 months thereafter in order to maintain and improve the quality of care and services delivered to our Customers. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee for Quality Assurance (NCQA) and Center for Medicare and Medicaid Services (CMS) requirements.

We are a member of the Council for Affordable Quality Healthcare (CAQH), and we use the CAQH Universal Provider DataSource (UPD) for gathering credentialing data for physicians and other health care professionals. The CAQH process is available to physicians and other

health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All physicians and other health care professionals applying to begin participating in our network and those scheduled for recredentialing are instructed on the proper method for accessing the CAQH UPD.

Physicians and other health care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or recredentialing application, upon request. You can check on the status of your application by calling the United Voice Portal at 877-842-3210.

While current board certification is not a requirement for network participation, it is a requirement for designation in the UnitedHealth Premium designation program. Providing updated board certification is part of the credentialing application. Physicians and other health care providers can view the current UnitedHealthcare Credentialing Plan at: UHCprovider.com > Menu > Resource Library > Join Our Network and Credentialing.

Adverse Credentialing

Providers that do not meet the criteria set forth by the Credentialing Committee will be notified in writing via certified mail. The letter will define the Committee's determination, along with the right to appeal and a copy of the Appeals Process. Possible factors that would prohibit a provider from meeting

the Committee's criteria include: Lack of Admitting Privileges to a UnitedHealthcare Community Plan Participating Hospital(s), Non-Compliance to providers' Medical Standards and members' Benefits and criteria included in the Better Health Quality Improvement Program.

We ask that you notify us of changes to the following demographic information 30 calendar days prior to the effective date of the change: TIN changes, address changes, additions or departures of health care providers from your practice, and new service locations.

Demographic Changes

To update your practice or facility information:

You can make all other demographic updates to your practice information by submitting the change directly through UHCprovider.com by using the Practice/Facility profile function found on the global navigation at the top of any web page. You can also submit your change by: (a) completing the Provider demographic update fax form and faxing the form to the appropriate fax number listed on the bottom of the form; or (b) calling our United Voice Portal at 877-842-3210.

To change an existing TIN or to add a physician or health care provider:

You must include your W-9 form to make a TIN change or to add a physician or other health care provider to your practice. To submit the change, please complete and fax the Provider demographic update fax form and the W-9 form to the appropriate fax number listed on the bottom of the fax form.

The W-9 form and the Provider demographic update fax form are available at UHCprovider.com > Menu > Find a Provider > Care Provider Demographic Information Update Form.

Changes can also be made by submitting the detailed information about the change, the effective date of the change, and a W-9 on your office letterhead. This information can be faxed to the fax number on the bottom of the demographic change request form.

Compliance

Regulatory Compliance

Introduction

As a business segment of UnitedHealth Group, UnitedHealthcare Community Plan implements and is governed by the UnitedHealth Group Ethics and Integrity Program. UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with members, 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.

The Ethics and Integrity Program promotes compliance with applicable legal requirements, fosters ethical conduct within UnitedHealthcare and provides guidance to its employees and contractors. Additionally, the Ethics and Integrity Program focuses on increasing the likelihood of preventing, detecting, and correcting violations of law or UnitedHealthcare policy. The implementation of such a program, however, cannot guarantee the total elimination of improper employee or agent conduct. If misconduct occurs, UnitedHealthcare will investigate the matter, take disciplinary action, if necessary, and implement corrective measures to prevent future violations. Preventing, detecting and correcting misconduct safeguards UnitedHealthcare's reputation, assets and the reputation of its employees.

Ethics and Integrity Program

The Ethics and Integrity Program incorporates recommended compliance program guidance from the Department of Health and Human Services Office of the Inspector General ("OIG"), the Centers for Medicare and Medicaid Services ("CMS"), and the Federal Sentencing Guidelines for Organizations (revised and amended, 2010). The purpose of the Ethics and Integrity Program is to ensure operational accountability and to provide standards of conduct for compliance with the obligations that govern our federal and state programs. Ethics and Integrity Program activities support the

following seven key elements that facilitate prevention, early detection and remediation of violations of law and UnitedHealthcare policies.

1. Written Standards, Policies and Procedures
2. High Level Oversight – Governance
3. Effective Training and Education
4. Effective Lines of Communication/Reporting Mechanisms
5. Enforcement and Disciplinary Guidelines
6. Auditing and Monitoring
7. Response to Identified Issues

Examples of applicable regulations and requirements include but are not limited to:

- Medicaid: Title 42 CFR Part 438 Managed Care, and executed state contracts.
- Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and state health information privacy laws; Federal and state False Claims Acts.

UnitedHealthcare Community Plan has compliance program staff, led by the Chief Medicaid Compliance Officer, which is responsible for oversight and management of the Ethics and Integrity Program. A Compliance Committee, consisting of senior managers from each of our key organizational functions provides direction and oversight for the Program. UnitedHealthcare Community Plan also has Compliance Officers or Compliance Contacts located in each health plan or business unit who report to the senior management of their assigned entity.

Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare employee which comes to the attention of a provider should be reported to a UnitedHealthcare senior manager in the health plan or directly to the Ethics and Compliance Help Center at 800-455-4521.

An important aspect of the Ethics and Integrity Program is assessing high-risk areas of UnitedHealthcare operations and implementing periodic reviews and audits to ensure compliance with law, regulations, and contracts. When informed of potentially, irregular, inappropriate or potentially fraudulent practices within the plan or by our providers, UnitedHealthcare will conduct an appropriate investigation. 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 provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised.

If a provider becomes the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to the provider's operations (other than a routine request for documentation from a regulatory agency), the provider must advise UnitedHealthcare of the details of this and of the factual situation which gave rise to the inquiry.

Fraud, Waste and Abuse

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by providers and plan members. A toll-free Fraud, Waste and Abuse Hotline 877-401-9430 has been set up to facilitate the reporting process of any questionable incidents involving plan members or providers.

Through the Anti-Fraud, Waste and Abuse Program, UnitedHealthcare's mission is to prevent paying fraudulent, wasteful and abusive health care claims, as well as identify, investigate and recover money it has paid for fraudulent, wasteful or abusive claims through evolving policies and initiatives to detect, prevent and combat fraud, waste and abuse. UnitedHealthcare will also appropriately refer suspected fraud, waste and abuse (FWA) cases to law enforcement, regulatory, and administrative agencies pursuant to state and federal law. UnitedHealthcare seeks to protect the ethical and fiscal integrity of the company and its employees,

members, providers, government programs, and the public, as well as safeguard the health and well-being of its members.

UnitedHealthcare is committed to compliance with its Anti-Fraud, Waste and Abuse Program and all applicable federal and state regulatory requirements governing its Anti-Fraud, Waste and Abuse Program. UnitedHealthcare recognizes that state and federal health plans are particularly vulnerable to fraud, waste and abuse and strives to tailor its efforts to the unique needs of its members and Medicaid, Medicare and other government partners.

All suspected instances of Fraud, Waste and Abuse in any way and in any form is thoroughly investigated. In appropriate cases, the matter is reported to law enforcement and/or regulatory authorities, in accordance with federal and state requirements. UnitedHealthcare cooperates with law enforcement and regulatory agencies in the investigation or prevention of Fraud, Waste and Abuse.

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are aimed at reducing fraud within the health care programs funded by the Federal government. 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 contractor 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 provider 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 [UHCCommunityplan.com](https://www.uhc.com/uhccommunityplan). 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.

HIPAA

UnitedHealthcare Community Plan is proud of its success in implementing the required Health Insurance Portability and Accountability Act (HIPAA) standards. UnitedHealthcare Community Plan is Clear Data Interchange (Clearinghouse for Electronic Data Interchange) certified as to the administrative simplification standards for transactions and code sets. We are capable of interacting directly with providers through HIPAA-compliant EDI transactions. UnitedHealthcare Community Plan also contracts with a clearinghouse which providers can use to submit and receive non-compliant EDI transactions. If you are interested in communicating with us via EDI, please contact the Provider Services department at 800-600-9007.

The UnitedHealthcare Community Plan companies adopted 'affiliated entity' status for purposes of the HIPAA privacy standards. We use and disclose our members' protected health information (PHI) only for purposes of treatment, payment and health care operations. Copies of the notices that describe our privacy practices for each UnitedHealthcare Community Plan managed care product can be accessed at UHCCommunityPlan.com or can be provided as a hard-copy upon request. The UnitedHealthcare Community Plan ID card reminds our members that, by enrolling in UnitedHealthcare Community Plan's managed care product, they agreed to our limited use of their PHI for appropriate purposes. UnitedHealthcare Community Plan reminds providers that they are obligated, both by applicable law and the standard provider participation agreement, to obtain the consent of our member, who is their patient, as it relates to the use of PHI for any purposes other than those permitted by law. Providers are also required to timely inform UnitedHealthcare Community Plan about any breach of the HIPAA privacy rules and cooperate with reasonable actions designed to remediate the adverse effects of such a breach.

Like all members of the health care industry, UnitedHealthcare Community Plan is aware of the significant HIPAA security challenges we all face.

UnitedHealthcare Community Plan is committed to adopting and updating its physical, electronic and administrative safeguards to protect our member's PHI. We encourage our network participating providers to adopt similar safeguards that are suitable to the associated risks and their individual environments to further secure PHI. The Omnibus Rule made final and clarified many of the amendments to the HIPAA Privacy and Security Rules originally promulgated under ARRA/HITECH in 2009. With certain exceptions, compliance with the new provisions is required by September 23, 2013. We will update our manual as appropriate to reflect the changes to HIPAA.

False Claims Acts

UnitedHealthcare Community Plan complies with federal and state law to prevent and detect fraud, waste, and abuse in government health care programs. UnitedHealthcare Community Plan complies with Section 6032 of the federal Deficit Reduction Act of 2005 (DRA).

UnitedHealthcare Community Plan is required to comply with Section 6032 of the DRA. UnitedHealthcare Community Plan provides the following information in accordance with the DRA.

Federal False Claims Act

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

The term "knowingly" is defined to mean that a person, with respect to information: has actual knowledge of the falsity of information in the claim; acts in deliberate ignorance of the truth or falsity of the information in a claim; or acts in reckless disregard of the truth or falsity of the information in a claim.

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

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

Qui Tam “Whistle-blower” Provisions

To encourage individuals to come forward and report misconduct involving false claims, the Act includes a “qui tam” or whistle-blower provision.

This provision essentially allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government. Individuals seeking whistle-blower status must meet several criteria to prevail as outlined below.

Original Source

The whistle-blower must be the “original source” of the information reported to the U.S. government. Specifically, the whistle-blower must have direct and independent knowledge of the false claims activities, must voluntarily provide this information to the government, and the matter disclosed cannot already be the subject of a federal investigation.

Rights of Parties to Qui Tam Actions

If the government determines that the lawsuit has merit and decides to join, the lawsuit will be directed by the U.S. Department of Justice. At this point, the government will be the “plaintiff,” or party suing. If the government decides not to intervene, the whistle-blower can continue with the lawsuit on his or her own.

Award to Qui Tam Whistle-blowers

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

No Retaliation Protection for Whistle-blowers

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

State Laws

States where UnitedHealthcare Community Plan does business have laws that contain civil or criminal penalties for false claims and statements that are in addition to the penalties provided in the Act. Certain states also have whistle-blower protections similar to the Act. In Ohio the applicable laws are ORC Sections 5164.35, 5162.15, 2913.40, 124.341, 4113.52, and 3901.44. For more information on a specific state law, please contact the UnitedHealthcare Community Plan compliance officer or legal department.

Glossary of Terms in Managed Care

6/3/2013

Pages 55-56 Glossary of Terms in Managed Care

www.cms.gov/apps/glossary.

Authorization

MCO (Managed Care Organization) approval necessary prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MCO whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)

Benefits Description (Plan)

The scope, terms and/or condition(s) of coverage including any limitation(s) associated with the plan provision of the service.

Case Management

A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.

Centers For Disease Control and Prevention

An organization that maintains several code sets included in the HIPAA standards, including the ICD-10-CM codes.

Centers For Medicare and Medicaid Services

The HHS agency responsible for Medicare and parts of Medicaid Centers for Medicare and Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Coordination of Benefits

A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicaid health plan, Federal law may decide who pays first.

Coordination of Benefits

Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim. Also called cross-over.

Copayment

The requirement that the health plan member pay some portion of medical expenses. Includes, copayments, deductibles, and coinsurance (paying a portion of the premium).

Fee-for-Services

A plan or PCCM (Primary Care Management) is paid for providing services to enrollees solely through fee-for-service payments plus in most cases, a case management fee.

Healthcare Effectiveness and Data Information Set

A set of standard performance measures that can give you information about the quality of a health plan. You can find out about the quality of care, access, cost, and other measures to compare managed care plans. The Centers for Medicare & Medicaid Services (CMS) collects HEDIS data for Medicaid and Medicare plans.

National Committee for Quality Assurance

An organization that accredits managed care plans, or Health Maintenance Organizations (HMOs). In the future, the NCQA may play a role in certifying these organizations' compliance with the HIPAA A/S requirements. The NCQA also maintains the Health Employer Data and Information Set (HEDIS).

Participating Physician or Supplier

A doctor or supplier who agrees to accept assignment on all Medicaid claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts.

Primary Care

A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.

Primary Care Case Management Provider

A PCCM provider is a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants) who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category includes any PCCMs and those PHPs which act as PCCMs.

Primary Care Doctor

A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicaid managed care plans, you must see your primary care doctor before you see any other health care provider.

TTY

A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

