

2018 Virginia Community Plan Provider Manual

**For Physicians, Health Care Professionals, Facilities,
and Ancillary Care**

**Includes: Commonwealth Coordinated Care Plus,
Medicaid and Family Access to Medical Insurance
Security Community Plans**

Welcome to the CCC Plus, Medicaid and Family Access to Medical Insurance Security (FAMIS) Provider Manual

This up-to-date Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 reference PDF manual allows you and your staff to find important information such as how to process a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic tools on our website at UHCprovider.com.



If you have a question related to a Medallion 3 member, policy or date of service, please contact the VA Department of Medicaid Services at their Contact Link at dmas.virginia.gov or go to the [Medallion 3.0 Resource guide](#).

CLICK THE FOLLOWING LINKS TO ACCESS DIFFERENT MANUALS:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com/guides. Select Community Plan Care Provider Manuals, select state.

EASILY FIND INFORMATION IN THIS MANUAL USING THE FOLLOWING STEPS:

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

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. We greatly appreciate your participation in our program and the care you offer our members.



If you have questions about the information or material in this manual, or about our policies, please call [Provider Services](#).

Important Information about the use of this manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

PARTICIPATION AGREEMENT

In this manual, we refer to your Participation Agreement as “Agreement”.

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Chapter 1: Introduction

UnitedHealthcare Community Plan of Virginia provides benefits to:

- **COMMUNITY PLAN COMMONWEALTH COORDINATED CARE PLUS PLAN** (CCC Plus) members, which include ABD- Aged, Blind, and Disabled
- Medallion 4.0 members, serving Medicaid and **FAMIS** - Family Access to Medical Insurance Security which include:
 - **LIFC**: Low Income Families with Children
 - **CHIP**: Children's Health Insurance Program



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

877-843-4366 – CCC Plus Provider Services

844-284-0146 – Medallion Provider Services

CCC Plus Overview

WHAT IS UNITEDHEALTHCARE COMMUNITY PLAN COMMONWEALTH COORDINATED CARE PLUS AND MEDALLION 4.0 PLAN?

Managed care is when health care organizations manage how members receive health care services. Managed Care Organizations work with different care providers to offer quality health care services.

The goals of UnitedHealthcare Community Plan CCC Plus plan are to provide:

- Coordinated long-term care across different health care settings
- A choice of the best long-term care plan for their needs
- Long-term care plans with the ability to offer more services
- Access to cost-effective community-based long-term care services

Members in CCC Plus plan have their services/care managed through the Managed Care Health Plan. We work with you to offer quality health care services and to help ensure members have access to covered services.

The CCC Plus plan's goals are to provide coordinated long term care services across different health care settings and to provide access to cost- effective community-based long-term care services.

Enrollment in the CCC Plus plan will not change a member's Medicare benefits.

These benefits allow at-risk individuals to remain at home and improve their quality of life.

HOW THE CCC PLUS PLAN WORKS

We have a contract with the Commonwealth of Virginia's Department of Medical Assistance Services (DMAS).

We support and coordinate all CCC Plus-covered benefits for members. It helps members remain in the community. The managed care plan also helps to provide the member with every opportunity to improve quality of life and, when or if possible, allow for a successful transition back into the community from a facility.

The plan uses covered benefits, enhanced benefits, community resources, caregiver/family support systems and primary care providers (PCPs) to meet the member's overall care needs. We are required to comply with any new Medicaid coverage decisions.

CCC PLUS PLAN CARE PROVIDER RELATIONSHIP

The success of our plan depends on strong relationships with you. Each member has an assigned care manager, and we encourage members to work with their care manager to coordinate care and help them access covered benefits. If the member uses a non-contracted care provider, **the services are not covered** unless authorized by the care manager.

THE MEMBER AND UNITEDHEALTHCARE COMMUNITY PLAN

Only CCC Plus plan members who meet eligibility requirements and are living in a region with authorized

Managed Care Plans are eligible to be in the CCC Plus Plan. Each member has a choice of Managed Care Plans. They may select any authorized Managed Care Plan unless the Managed Care Plan is restricted to a specific population that does not include the member.

The Department of Medical Assistance Services, or its agent, is responsible for enrollment, including enrollment into the CCC Plus Plan, disenrollment and outreach and education.

We accept Medicaid recipients without restriction in the order they enroll. We do not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services.

CARE COORDINATOR PROVISIONS

Each member has an assigned care manager. They work with the care providers, and authorized representatives, to develop and coordinate the care plan. **A Medicare beneficiary can access any Medicare-approved care provider without authorization.**

Medallion Overview

The Medallion 4.0 plan serves Medicaid & FAMIS members throughout Virginia. The program goals are to increase member and provider engagement, support integration and innovation, and improve healthcare quality and outcomes.

Who is Eligible?

Medallion 4.0 adds new populations and services:

- Pregnant Women
- Infants
- Children/Teens
- Children in foster care or adoption assistance
- Early Intervention Services
- Community Mental Health and Rehabilitative Services (CMHRS)
- Third Party Liability

Medallion 4.0 Covered Benefits for eligible individuals include comprehensive health care and prevention services including:

- Prenatal, delivery and postpartum care
- Newborn, pediatric (through age 19), preventive and acute treatment, including immunizations, health screening and Early, Periodic Screening Diagnostic and Treatment (EPSDT) through age 21
- Foster Care and Adoption Assistance
- Addiction and Recovery Treatment Services (ARTS)
- Telemedicine
- Care Management
- Mental Health and Rehabilitation Services

Our Approach to Health care

WHOLE PERSON CARE MODEL

The Whole Person Care (WPC) program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community partners to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. WPC examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

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

Community Plan serves. WPC provides:

- Market-specific care management encompassing medical, behavioral and social care.
- Extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist.

- Field-based interventions engage members, connecting them to needed resources, care and services.
- Individualized and multidisciplinary care plan.
- Assistance with appointments with PCP and coordinating appointments. The WPC Program refers members to an RN, BHA or other specialists as required for complex needs.
- Education and support with complex conditions.
- Tools for helping members engage with providers, such as appointment reminders and help with transportation.
- Foundation to build trust and relationships with hard-to-engage members.

The goals of the WPC program are to:

- Lower avoidable admissions and unnecessary ER visits, measured outcomes by inpatient (IP) admission and emergency room (ER) rates.
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames.
- Identify and discuss behavioral health needs, measured by number of BH care provider visits within identified time frames.
- Improve access to pharmacy.
- Identify and remove social and environmental barriers to care.
- Improve health outcomes, measured by improved Health Plan Employer Data and Information Set (HEDIS) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics.
- Empower the member to manage their complex/chronic illness or problem and care transitions.
- Improve coordination of care through dedicated staff resources and to meet unique needs.
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services.

Care Provider Resources

UnitedHealthcare Community Plan manages a comprehensive care provider network of independent practitioners and facilities. The network includes health

care professionals such as PCPs, specialists, medical facilities, allied health professionals and ancillary service care providers. UnitedHealthcare Community Plan offers several options to support care providers who need assistance.

Referring Your Patient

To refer your patient who is a UnitedHealthcare Community Plan member to WPC, call Member Services at **866-622-7982** CCC Plus, **844-752-9434** Medallion 4.0, TTY 711. You may also call Provider Services at **877-843-4366** – CCC Plus Provider Services, **844-284-0146** – Medallion Provider Services.

SECURE CARE PROVIDER WEBSITE

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



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

The secure care provider website lets you:

- Verify member eligibility including secondary coverage.
- Review benefits and coverage limit.
- Check prior authorization status.
- Access remittance advice and review recoveries.
- Review your preventive health measure report.
- Access the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) toolset.
- Search for CPT codes. Type the CPT code in the header search box on UHCprovider.com, and the search results will display all documents and/or web pages containing that code.
- Find certain web pages more quickly using vanity URLs. You'll see changes in the way we

direct you to specific web pages on our UHCprovider.com provider portal. You can now use certain vanity URLs, which helps you find and remember specific webpages easily and quickly. You can access our most used and popular web pages on UHCprovider.com by typing in that page's vanity URL identified by a forward slash in the web address, e.g. UHCprovider.com/claims. When you see that forward slash in our web links, you can copy the vanity URL into your web page address bar to quickly access that page.

PROVIDER SERVICES

Provider Services is the primary contact for care providers who require assistance. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.



[Provider Services](#) can assist you with questions on Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

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

NETWORK MANAGEMENT DEPARTMENT

Within UnitedHealthcare Community Plan, the Network Management Department can help you with your contract, credentialing and in-network services. The department has network account managers and provider advocates who are available for visits, contracting, credentialing and other related issues.



If you need to speak with a network contract manager about credentialing status or contracting, call our [Network Management Phone Team](#) or go to UHCprovider.com/join for instructions on joining our network.

ENROLLMENT BROKER

DMAS contracts with an enrollment broker to help members with enrollment using a toll free member service helpline and website. Members may call Cover Virginia at 855-242-8282 Monday through Friday from 8 am to 7 pm and Saturday 9 am to 12 pm Eastern Time or go to the Cover Virginia website at www.coverva.org to apply or make changes to Medicaid enrollment. If members do not have coverage, they click on "Apply". If they want to make a change, they select "Already Enrolled".

An enrollment broker is an independent broker (third party vendor) who enrolls members in the health plan and who is responsible for the operation and documentation of a toll-free member service helpline. The responsibilities of the enrollment broker include, but are not limited to, member education and enrollment, assistance with and tracking of member's grievance resolution, and may include member marketing and outreach.

CULTURAL COMPETENCY RESOURCES

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

UnitedHealthcare Community Plan offers the following support services:

- **Language Interpretation Line:** If members do not speak English and need to call us or go to a doctor's appointment, the member's care/service coordinator orders an interpreter by calling Provider Services.
- **Cultural member materials:** We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

CARE PROVIDER PRIVILEGES

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

DIRECT CONNECT

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

- Manage overpayments in a controlled process.
- Create a transparent view between care provider and payer.
- Avoid duplicate recoupment and returned checks.

- Decrease resolution timeframes.
- Real-time reporting to track statuses of inventories in resolution process.
- Provide control over financial resolution methods.

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



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

COMPLIANCE

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

EVIDENCE-BASED CLINICAL REVIEW CRITERIA AND GUIDELINES

UnitedHealthcare Community Plan uses MCG Care Guidelines (formally Milliman Care Guidelines) for care determinations.

How to Contact Us

Topic	Website/Address	CCC Plus Phone/Fax	Medicaid/FAMIS Phone/Fax	Information
Benefits	UHCprovider.com/benefits	877-843-4366	844-284-0146	Confirm a member's benefits and/or prior authorization.
Cardiology Prior Authorization/Evicore	UHCprovider.com/cardiology	866-889-8054 Fax: 866-889-8061	866-889-8054	Phone line is available from 7 a.m. to 7 p.m., Eastern Time (ET), Monday through Friday. Prior authorization numbers represent the specific procedure requested and are valid for 45 calendar days from the date they are issued.
Chiropractor Care	myoptumhealth.physicalhealth.com	Not a covered benefit.	844-284-0146 Fax: 844-882-7133	We provide members older than 21 with up to six visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.
Claims	Use the Link Provider Portal at UHCprovider.com/claims Mailing address: UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402 For FedEx (use for large packages/more than 500 pages): UnitedHealthcare Community Plan 1355 S 4700 West, Suite 100 Salt Lake City, UT 84104	877-843-4366	844-284-0146	Ask about a claim status or about proper completion or submission of claims.

Topic	Website/Address	CCC Plus Phone/Fax	Medicaid/FAMIS Phone/Fax	Information
Claim Overpayments	See the Overpayment section for requirements before sending your request. Sign in to UHCprovider.com/claims to access Link, then select the UnitedHealthcare Online app Mailing address: UnitedHealthcare Community Plan ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800"	877-843-4366	844-284-0146	Ask about claim overpayments.
Dental Services	coverva.org/programs/smiles.cfm	855-586-1419	888-912-3456	Dental services are provided by Smiles for Children. Available Monday through Friday, 8 a.m. to 6 p.m., ET.
Electronic Data Intake Claim Issues	ac_edi_ops@uhc.com	800-210-8315	800-210-8315	Ask about claims issues or questions.
Electronic Data Intake Log-on Issues		800-842-1109	800-842-1109	Information is also available at UHCprovider.com .
Eligibility	To access the app, sign in to UHCprovider.com/eligibility to access Link, then select the UnitedHealthcare Online app	877-843-4366	844-284-0146	Confirm member eligibility.
Enterprise Voice Portal		877-842-3210	877-842-3210	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Ethics and Compliance Help Center		800-455-4521	800-455-4521	Report unethical, unlawful or inappropriate behavior by a UnitedHealthcare Community Plan employee.

Topic	Website/Address	CCC Plus Phone/Fax	Medicaid/FAMIS Phone/Fax	Information
Fraud and Abuse	MFCU_mail@oag.state.va.us	800-455-4521 or 800-286-3932	800-455-4521 or 800-286-3932	Notify us anonymously of suspected fraud or abuse on the part of a provider or member. The Medicaid Fraud and Abuse Complaint Form is available online at: oag.state.va.us > Programs & Initiatives > Medicaid Fraud
Healthy First Steps/ Obstetrics (OB) Referral		800-599-5985	800-599-5985	Refer high-risk OB members.
LabCorp for Providers		800-833-3984	800-833-3984	LabCorp is the preferred lab provider.
Medicaid	dmas.virginia.gov	855-242-8282	855-242-8282	Contact VA Medicaid directly.
Medical Claim Disputes	<p>Sign in to UHCprovider.com/claims to access Link, then select the UnitedHealthcare Online app</p> <p>Reconsiderations mailing address: UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402</p> <p>Appeals mailing address: Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364</p> <p>In-Person Delivery Address: 9020 Stony Point Parkway, Suite 400 Richmond, VA 23235</p>	877-236-0826 Fax: 801-994-1082	844-752-9434 Fax: 801-994-1082	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.

Topic	Website/Address	CCC Plus Phone/Fax	Medicaid/FAMIS Phone/Fax	Information
Member Services		866-622-7982	844-752-9434	Assist members with issues or concerns. Available 8 a.m. – 8 p.m. ET, Monday through Friday.
Mental Health & Substance Abuse (including Community Mental Health Rehabilitation Services & Addiction Recovery Treatment Services)	providerexpress.com	877-843-4366	844-284-0146	
Multilingual/ Telecommunication Device for the Deaf (TDD) Services		TDD 711	TDD 711	Available 8 a.m. – 5 p.m. Central Time, Monday through Friday, except state-designated holidays.
National Credentialing Center (VETTS line)		877-842-3210	877-842-3210	Self-service functionality to update or check credentialing information.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	800-465-3203	800-465-3203	Apply for a National Provider Identifier (NPI).
NurseLine		800-842-3014	800-842-3014	Available 24 hours a day, seven days a week.
Obstetrics and Baby Care	UHCBabyBlocks.com	800-599-5985 Fax: 877-353-6913	800-599-5985 Fax: 877-353-6913	Resources for pregnant moms and newborn babies.
Optum Support Center	LinkSupport@optum.com	855-819-5909	855-819-5909	Available 7 a.m. – 9 p.m. CT, Monday through Friday; 6 a.m. – 6 p.m. CT, Saturday; and 9 a.m. – 6 p.m. CT, Sunday.
Pharmacy Prior Authorization	UHCprovider.com/priorauth	800-310-6826 Fax: 866-940-7328	800-310-6826 Fax: 866-940-7328	Request authorization for medications that go through the pharmacy benefit and require a prior authorization per the Virginia Preferred Drug List (PDL).

Topic	Website/Address	CCC Plus Phone/Fax	Medicaid/FAMIS Phone/Fax	Information
Pharmacy Services and Help Desk	professionals.optumrx.com	855-873-3493 877-305-8952 (OptumRx)	844-284-0146	OptumRx oversees and manages the pharmacy network. Pharmacy Help Desk is available 24 hrs a day, seven days a week.
Prior Authorization/Notification of Health Services	UHCprovider.com/priorauth	877-843-4366 Fax: 844-882-7133	844-284-0146 Fax: 844-882-7133	Request authorization/notify of the procedures and services outline in the prior authorization/notification requirements section of this manual. Complete and current list of prior authorizations. Do not use this prior authorization information for prescriptions.
Provider Advocate	<ul style="list-style-type: none"> Hospital/Medical Providers: VA PR Team@uhc.com Skilled Nursing Facilities: virginia_snf_pra@optum.com Home and Community-Based Services hcbs_northeast_pr@uhc.com 			Advocates are assigned by territory.
Provider Grievance	After exhausting appeals/grievances to the Virginia Health Plan, submit appeal/grievance to DMAS at: Office of Appeals Hearings, Department of Medical Assistance Services (DMAS) Appeals Division 600 E Broad Street Richmond, VA 23219	804-371-8488	804-371-8488	Ask for an appeal hearing in writing at this address. You must exhaust appeals with us before appealing to the Department of Medical Assistance Services (DMAS).
Provider Services	UHCprovider.com/vacommunityplan	877-843-4366 Fax: 844-882-7133	844-284-0146 Fax: 844-882-7133	Available 8 a.m. – 6 p.m. ET, Monday through Friday.

Topic	Website/Address	CCC Plus Phone/Fax	Medicaid/FAMIS Phone/Fax	Information
Radiology Prior Authorization	UHCprovider.com/priorauth	866-889-8054 Fax: 866-889-8061	866-889-8054	Available 7 a.m. to 7 p.m., ET, Monday through Friday.
Referrals	UHCprovider.com/referrals	877-843-4366 Fax: 866-622-1428	844-284-0146 Fax: 844-882-7133	
Tobacco Free Quit Line		866-QUIT-4-LIFE (866-784-8454)	866-QUIT-4-LIFE (866-784-8454)	Ask about services for quitting tobacco/smoking.
Transportation (National MedTrans)	natmedtrans.com/index.php/va-providers/	844-604-2078 TTY 844-488-9724	833-215-3884	Call to schedule transportation. To arrange non-urgent transportation, please call two days in advance. Please make reservations at least three days in advance.
Utilization Management		877-843-4366	844-284-0146	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. Request a copy of our UM guidelines or information about the program."
Vaccines for Children (VFC) Program		800-219-3224 Fax: 573-526-5220	800-219-3224 Fax: 573-526-5220	Care providers must participate in the VFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as VFC providers with DHSS to bill for the administration of the vaccine. FAMIS eligible members do not qualify for VFC.

Topic	Website/Address	CCC Plus Phone/Fax	Medicaid/ FAMIS Phone/Fax	Information
Vision Services	Marchvisioncare.com	855-476-2724	855-476-2724	<p>Contact MARCH Vision Care's provider relations department for education on benefits, lab order submissions, and demographic changes. This includes changes to addresses, phone numbers, office hours, network providers, and federal tax identification numbers.</p> <p>Attend a training session on eyeSynergy.® This web portal gives you 24/7 access to eligibility, benefit, claim and lab order information.</p>
Website for Virginia Community Plan	UHCprovider.com/vacommunityplan			Access your state specific community plan information on this website.

Chapter 2: Care Provider Standards & Policies

General Care Provider Responsibilities

NON-DISCRIMINATION

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

COMMUNICATION BETWEEN CARE PROVIDERS AND MEMBERS

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

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

1. Educate members, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.

4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.

PROVIDE OFFICIAL NOTICE

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

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

You may use the care provider demographic information update form for demographic changes or update NPI information for care providers in your office. This form is located at UHCprovider.com > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

TRANSITION MEMBER CARE FOLLOWING TERMINATION OF YOUR PARTICIPATION

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

ARRANGE SUBSTITUTE COVERAGE

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



For the most current listing of network care providers and health care professionals, review our care provider and health care professional directory at UHCprovider.com > Find Dr.

ADMINISTRATIVE TERMINATIONS FOR INACTIVITY

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

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

CHANGING AN EXISTING TIN OR ADDING A HEALTH CARE PROVIDER

Please complete and email the Care Provider Demographic Information Update Form and your W-9 form to the address listed on the bottom of the form. The W-9 form and the Care Provider Demographic Information Update Form are available at UHCprovider.com > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form.

Otherwise, complete detailed information about the change, the effective date of the change and a W-9 on your office letterhead. Email this information to the number on the bottom of the demographic change request form.

UPDATING YOUR PRACTICE OR FACILITY INFORMATION

You can update your practice information through the Provider Data Management application on UHCprovider.com. Go to UHCprovider.com > Menu > Find a Care Provider > Care Provider Paper Demographic Information Update Form. Or submit your change by:

- Completing the Provider Demographic Change Form and faxing it to the appropriate number listed on the bottom of the form.
- Calling our Enterprise Voice Portal.

AFTER-HOURS CARE

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

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

PARTICIPATE IN QUALITY INITIATIVES

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

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

PROVIDE ACCESS TO YOUR RECORDS

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 10 years or longer if required by applicable statutes or regulations.

PERFORMANCE DATA

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

COMPLY WITH PROTOCOLS

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



You may view protocols at UHCprovider.com.

OFFICE HOURS

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

PROTECT CONFIDENTIALITY OF MEMBER DATA

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

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

FOLLOW MEDICAL RECORD STANDARDS

Please reference Chapter 9 for Medical Record Standards.

INFORM MEMBERS OF ADVANCE DIRECTIVES

The federal Patient Self-determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state law about advance treatment directives, about members' right to accept or refuse treatment, and about your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through Member Handbooks and other communications.

DISPUTE RESOLUTION

If you have a concern about your Agreement with us, send a letter with the details to the address in your

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

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

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member's Handbook at UHCCommunityPlan.com.

Also reference Chapter 12 of this manual for information on Provider Claim Disputes, Appeals and Grievances.

Appointment Standards (VA DMAS Access and Availability Standards)

Comply with the following appointment availability standards:

PRIMARY CARE

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 30 calendar days
- Physical exam: within 180 calendar days
- EPSDT appointments: within 6 weeks
- New member appointment: within 30 calendar days
- In-office waiting for appointments: not to exceed one hour of the scheduled appointment time

SPECIALTY CARE

Specialists should arrange appointments for:

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

PRENATAL CARE

Prenatal care providers should arrange OB/GYN appointments for:

- First and second trimester: within seven calendar days of request
- Third trimester: within three business days of request
- High-risk: within three business days of identification of high risk

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

Care Provider Directory

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

We are required to contact all participating care providers annually and independent physicians every six months. We require you to confirm your information is accurate or provide us with applicable changes.

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

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

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

To help ensure we have your most current provider directory information, submit applicable changes to:

For Delegated providers, email your changes to delprov@uhc.com.

For Non-delegated providers, visit UHCprovider.com for the Provider Demographic Change Submission Form and further instructions.

PROVIDER ATTESTATION

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

Prior Authorization Request

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

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

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

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

If you have questions or problems connecting to Link, please call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 3, 7 a.m. – 9 p.m. Central Time, Monday through Friday.

Timeliness Standards for Notifying Members of Test Results

After receiving results, notify members within:

- Urgent: 24 hours
- Non-urgent: 10 business days

Sentinel Event Requirements

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

Report sentinel events to the health plan immediately upon identification.

Requirements for PCP and Specialists Serving in PCP Role

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

PCPs are an important partner in the delivery of care, and VA Department of Medical Assistance Services (DMAS) members may seek services from any participating care provider. The VA DMAS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

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

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

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

Nurse practitioners may enroll with the state as solo providers, but physician assistants must be part of a group practice.



Members may change their assigned PCP by contacting [Member Services](#) at any time during the month. Customer Service is available 8 a.m. - 8 p.m., Monday through Friday.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

You may print a monthly Primary Care Provider Panel Roster by visiting [UHCprovider.com](#).

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

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

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners for women's health care services and any non-women's health care issues discovered and treated in the course of receiving

women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

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

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

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing.
- Submit all accurately coded claims or encounters timely.
- Provide all well baby/well-child services.
- Coordinate each UnitedHealthcare Community Plan member's overall course of care.
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice.
- Be available to members by telephone any time.
- Tell members about appropriate use of emergency services.
- Discuss available treatment options with members.

Responsibilities of PCPs and Specialists Serving in PCP Role

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

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

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide.
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment.
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines.
- Refer services requiring prior authorization to the Prior Authorization Department, UnitedHealthcare Community Plan Clinical, or Pharmacy Department as appropriate.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
 - Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
 - Transfer medical records upon request. Provide copies of medical records to members upon request at no charge.
 - Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
 - Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards.
 - Complying with the VA DMAS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Risk Arrangements

We are required to disclose care provider incentive arrangements when requested. The purpose of this is to allow the Commonwealth of VA to monitor us since we hold care providers at “substantial financial risk.” In addition, we are required to give this information to current and potential members, if requested.

The information we give describes the plan’s general arrangement, not specific to any care provider. Please respond promptly to our requests for information.

Rural Health Clinic, Federally Qualified Health Center or Primary Care Clinic as PCP

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

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
 - Preventative (wellness) health services from a care provider, physician assistant, nurse practitioner and/or social worker.
 - Mental health services.
 - Immunizations (shots).
 - Home nurse visits.
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Primary Care Provider Checklist

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

- Verify eligibility using Link at UHCprovider.com/eligibility or by calling Provider Services at 844-284-0146 for Medallion or 877-843-4366 for CCC Plus.
- Verify member identity with photo identification, if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth to locate and view the current prior authorization information and notification requirements.
- Refer to UnitedHealthcare Community Plan participating specialists unless we authorize otherwise.
- Identify and bill other insurance carriers when appropriate.
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form. See Chapter 11 for more information on submitting forms.

Specialist Care Providers Responsibilities

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services.
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer.
- Verify the eligibility of the member before providing covered specialty care services.
- Provide only those covered specialty care services, unless otherwise authorized.
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist’s care.
- Note all findings and recommendations in the

member's medical record. Share this information in writing with the PCP.

- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws.
- Comply with the VA DMAS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, seven days a week. Or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Ancillary Care Provider Responsibilities

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

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

Ancillary Care Provider Checklist

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

- Verify the member's enrollment before rendering services. Go to Link at UHCprovider.com or contact [Provider Services](#). Failure to verify member enrollment and assignment may result in claim denial.
- Check the member's ID card each time the member has services. Verify against photo ID if this is your office practice.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit UHCprovider.com/priorauth.
- Identify and bill other insurance carriers, when appropriate.

Prenatal Care Responsibilities for Medicaid and FAMIS Members

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

An obstetrician does not need approval from the member's care provider for prenatal care, testing or obstetrical procedures. Advise and test pregnant members for HIV unless the member refuses. Include refusal documentation in the member's medical record. Obstetricians may give the pregnant member a written prescription at any UnitedHealthcare Community Plan participating radiology and imaging facility listed in the care provider directory.

Chapter 3: Care Provider Office Procedures and Member Benefits

Assignment to PCP Panel Roster

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

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, it is removed from auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

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

Choosing a Primary Care Provider

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

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of

practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Deductibles/Copayments

Please verify member co-payment if applicable. FAMIS members will be subject to cost sharing provisions that include nominal copayments for services. Go to pg 81 of the DMAS website for cost sharing details: dmas.virginia.gov

Medically Necessary Service

UnitedHealthcare Community Plan only pays for medically necessary services.

MEDICALLY NECESSARY DEFINITION

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

- Necessary to meet members' basic health needs.
- Cost-efficient and appropriate for the covered services.

Member Assignment

ASSIGNMENT TO UNITEDHEALTHCARE COMMUNITY PLAN

VA DMAS assigns eligible members to UnitedHealthcare

Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. VA DMAS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

At enrollment time, each member receives a welcome packet that includes information on how to access the [UnitedHealthcare Community Plan Member Handbook](#). The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.



Obtain copies of the [Member Handbook](#) online at [UHCCommunityPlan.com](#) or contact [UnitedHealthcare Provider Services](#).

IMMEDIATE ENROLLMENT CHANGES:

Immediate enrollment into managed care means the responsible payer for members, including newborns, may change from Fee for Service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, have the payer assignment of newborns checked daily.



Get eligibility information by calling the [Medicaid Inquiry line](#).

Member Eligibility

UnitedHealthcare Community Plan serves members enrolled with VA DMAS, VA's Medicaid program. The VA DMAS determines program eligibility. An individual who becomes eligible for the VA DMAS program either chooses or is assigned to one of the VA DMAS-contracted health plans.

Virginia Medicaid Expansion

Effective Jan. 1, 2019, Virginia will expand Medicaid eligibility guidelines. These new eligibility guidelines apply to Virginia residents age 19-64. Members will receive services through Medallion 4.0 (excluding FAMIS) and CCC Plus health plans. Coverage will include all Medicaid covered services. Find additional information at [coverva.org](#).

Member ID Card

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



If a fraud, waste and abuse event arises from a care provider or a member, notify UnitedHealthcare Community Plan in writing, as discussed in Chapter 12 of this manual. Or you may call the [Fraud, Waste, and Abuse Hotline](#).

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

MEMBER IDENTIFICATION NUMBERS

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The VA DMAS Medicaid Number is also on the member ID card.

PCP-Initiated Transfers

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

1. To transfer the member, contact UnitedHealthcare Community Plan by fax at CCCP: **866-622-1428**, Medallion: **844-882-7133**, or mail with the specific event(s) documentation. Documentation includes the date(s) of failed appointments or a detailed account of reasons for termination request, member name, date of birth, Medicaid number, current address, current phone number and the care provider's name

Mailing address:


UnitedHealthcare Community Plan

Attn: Health Services

P.O. Box 5270
Kingston, NY 12402

2. UnitedHealthcare Community Plan prepares a summary within 10 business days of the request. We try to contact the member and resolve the issue to develop a satisfactory PCP-member relationship.
3. If the member and UnitedHealthcare Community Plan cannot resolve the PCP member issue, we work with the member to find another PCP. We refer the member to care management, if necessary.
4. If UnitedHealthcare Community Plan cannot reach the member by phone, the health plan sends a letter (and a copy to the PCP) stating they have five business days to contact us to select a new PCP. If they do not choose a PCP, we will choose one for them. A new ID card will be sent to the member with the new PCP information.

Sample Health Member ID Card

	
Health Plan (80840)	911-87726-04
Member ID: 001500005	Group Number: VAMDN
Member:	Payer ID: 87726
Member Name	
Medicaid ID: 9999999999	
PCP Name:	
Provider Name	
PCP Phone: (000)000-000	
Date of Birth: 06/15/2013	Effective Date: 08/26/2013
No Copays	
0501	UnitedHealthcare Community Plan of Virginia - Medicaid Administered by UnitedHealthcare of the Mid-Atlantic, Inc.

In an emergency go to nearest emergency room or call 911.		Printed: 05/21/18
Carry card at all times and before you get non-emergency services. Call Member Services with questions or if you suspect fraud or abuse. Hospitals: Preadmission certification required for non-emergency admissions.		
Member Services/Behavioral:	844-752-9434	TTY 711
Smiles for Children:	888-912-3456	TTY 711
NurseLine:	800-842-3014	TTY 711
Transportation:	833-215-3884	TTY 711
For Providers:	UHCprovider.com	844-284-0146
Claims:	PO Box 5270, Kingston, NY 12402-5270	
Preauthorization:	844-284-0146	
Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903		
For Pharmacists: 855-873-3493		

Verifying Member Enrollment


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

- Provider Portal: access the Link portal through UHCprovider.com/eligibility.
- [UnitedHealthcare Provider Service](#) is available from 8 a.m. – 6 p.m. Eastern Time, Monday through Friday.
- Virginia Medicaid Management Information System (VAMMIS).

PREGNANT WOMEN USING MEDICAID/FAMIS:

Encourage your members to notify the VA DMAS when they know they are expecting. VA DMAS notifies Managed Care Organizations (MCOs) daily when VA Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the VA website to report the baby's birth. With that information, VA DMAS verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify VA DMAS when the baby is born.


Please advise members to enroll the newborn as soon as possible using the Cover Virginia website at coverva.org or by calling 855-242-8282.

 Members may call Virginia's Medicaid Managed Care at **800-643-2273**.

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

PCP SELECTION FOR MEDICAID/FAMIS MEMBERS:

Ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

 UnitedHealthcare Community Plan Members can go to myuhc.com/communityplan to look up a care provider.

Benefit Information

Available online – Link at UHCprovider.com > UHC Community Application > Health Care Professional > Virginia > Provider Resources.

UnitedHealthcare Dual Complete (HMO SNP)

For information regarding UnitedHealthcare Dual Complete, please see the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products at UHCprovider.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Administrative Guide.

Covered Level of Benefits

Covered benefits only if services are rendered by a participating care provider. If the member has services from a non-contracted provider, we provide an opportunity for the non-contracted provider to become contracted. If the care provider chooses to remain non-contracted, the care manager works with the member and our participating care providers to transition services. All services require case management authorization. Medicare members may access any Medicare-approved care provider without authorization.

Chapter 4: Medical Management

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

FAMIS

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization. Coverage is applicable to FAMIS and in some instances, CCC Plus.

HOME HOSPICE

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice and not receiving continuous home care. We cover care provider hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

RESPITE HOSPICE

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to five days per month. This includes the day of admission but not the day of discharge.

INPATIENT HOSPICE

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. VA DMAS covers residential inpatient hospice services. VA DMAS will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

CCC Plus:

If a member enters a hospice program while enrolled in the CCC Plus program, the member will remain enrolled in CCC Plus for those services.

MEDICAID AND FAMIS MEMBERS

Family Planning

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

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services

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

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
 - GIFT (Gamete intrafallopian transfer)
 - ZIFT (zygote intrafallopian transfer)
 - Embryo transport
- Infertility services, if given to achieve pregnancy
Note: Diagnosis of infertility is covered. Treatment is not.
 - Morning-after pill. Contact the state of VA to verify state coverage.

PARENTING/CHILD BIRTH EDUCATION PROGRAMS

- Child birth education is covered.
- Parenting education is not covered.

VOLUNTARY STERILIZATION

In-network treatment with consent is covered. The member needs to give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent for:

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the VA DMAS Regulations for more information on sterilization.

STERILIZATION AND HYSTERECTOMY PROCEDURES FOR MEDICAID/FAMIS MEMBERS

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

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

STERILIZATION INFORMED CONSENT

A member has only given informed consent if the VA Department of Social Services Medical Assistance Consent Form for sterilization is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

STERILIZATION CONSENT FORM

Use the consent form for sterilization:

- **Complete all applicable sections of the form.**
Complete all applicable sections of the consent

MEDICAID AND FAMIS MEMBERS (CONTINUED)

form before submitting it with the billing form. The VA Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.

- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state’s definition of “shortly before” is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.



You may also find the form on the VA Department of Social Services website virginiamedicaid.dmas.virginia.gov/.

Have three copies of the consent form:

1. For the member.
2. To submit with the Request for Payment form.
3. For your records.

Maternity/Pregnancy/Well-Child Care

PREGNANCY/MATERNITY

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



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

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

1. the woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and

2. if she has an established relationship with a non-participating obstetrician.

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

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

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

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

MATERNITY ADMISSIONS

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



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

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

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

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

- Date of delivery.
- Gender.
- Birth weight.

MEDICAID AND FAMIS MEMBERS (CONTINUED)

- Gestational age.
- Baby name.

Hospitals are encouraged to facilitate newborn enrollment through the Medicaid provider web portal at virginiamedicaid.dmas.virginia.gov/.

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

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

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

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

POST MATERNITY CARE FOR MEDICAID/FAMIS MEMBERS

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of two visits, at least one in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is required for home health care visits for post-partum follow-up. The attending care provider decides the location and post-discharge visit schedule. We also cover lactation consultation and breast pumps as part of post-discharge care.

NEWBORN ENROLLMENT

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members (provided the mother was admitted using her ID card).

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

The hospital provides significant support to the enrollment process by providing required birth data at the time of admission. Please advise members to enroll the newborn as soon as possible using the Cover Virginia website at coverva.org or by calling **855-242-8282**.

HOME CARE AND ALL PRIOR AUTHORIZATION SERVICES

The discharge planner ordering home care should call the [Prior Authorization Department](#) to arrange for home care.

HYSTERECTOMIES

Hysterectomies cannot be reimbursed if performed for sterilization. Members who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The member should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility.



Find the form on the VA Department of Social Services virginiamedicaid.dmas.virginia.gov/.

Exception: VA DMAS does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgment was not possible. Include a description of the emergency.

MEDICAID AND FAMIS MEMBERS (CONTINUED)

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member's ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

PREGNANCY TERMINATION SERVICES

Pregnancy termination services are not covered, except in cases to preserve the woman's life. In this case, follow the VA consent procedures for abortion.

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

Neonatal Resource Services (NICU Case Management)

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

NEONATAL RESOURCE SERVICES

The Neonatal Resource Services (NRS) program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns in a NICU level of care are eligible upon birth (including babies who are transferred from PICU and/or any infants readmitted within their first 30 days of life and previously managed in the NICU). All babies admitted to the NICU are followed by NRS.

NRS neonatologists and NICU nurses manage NICU members through evidence-based medicine and care plan use.

The NRS nurse case manager will:

- Work with the family, the care providers, and the facility discharge planner to help ensure timely discharge and service delivery.

- Develop care management strategies and interventions based on infant and family needs.
- Coordinate services prior to discharge and after discharge if the member is under NRS case management.

The NRS nurse case manager's role includes:

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

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

CCC PLUS, MEDICAID AND FAMIS MEMBERS

Ambulance Services

AIR AMBULANCE

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:

- Great distances or other obstacles keep members from reaching the destination.
- Immediate admission is essential or
- The pickup point is inaccessible by land.

EMERGENCY AMBULANCE TRANSPORTATION

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:

- Injury to their overall health.
- Impairment to bodily functions. Or
- Dysfunction of a bodily organ or part.

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

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

NON-EMERGENT TRANSPORTATION

UnitedHealthcare Community Plan members may get non-emergent transportation services through National MedTrans for covered services. Covered transportation includes sedan, taxi, wheelchair-equipped vehicle, public transit, mileage repayment and shared rides.

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



For non-urgent appointments, members must call for transportation at least two days before their appointment. Online requests can be made online anytime at natmedtrans.com or by phone at **National MedTrans: 844-604-2078**.

UHC Virginia Medallion Reservations – Toll Free Number **833-215-3884**.

UHC Virginia Medallion Where's My Ride – Toll Free Number **833-215-3885**.

Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. They must be billed by the ambulance provider. This includes transporting the member to another facility for services (e.g., diagnostic testing) and returning them to the first hospital for more inpatient care.

Urgent non-emergency trips, such as when a member is sent home from the hospital, may be made through our Member Call Center after 7 p.m. Eastern Time. Rides may be scheduled up to 30 days in advance.



Members using MedTrans must call between 7 a.m. - 7 p.m. Eastern Time, Monday through Friday, to schedule transportation. If they have questions about their order, they may call MedTrans.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop.
- Has an appointment less than half a mile from the bus stop.

Cardiology

We use a Cardiology Prior Authorization Program to improve compliance with evidence-based and professional society guidance for cardiology procedures.

The following require prior authorization:

- Diagnostic catheterization
- Electrophysiology implants
- Echocardiogram
- Stress echocardiogram

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

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

PLACE OF SERVICE WHERE PRIOR AUTHORIZATION IS REQUIRED

Office Auth required:

- Diagnostic catheterization
- Electrophysiology implants
- Echocardiogram
- Stress echocardiogram

Inpatient Auth required: Electrophysiology implants

To get or verify prior authorization:

- Online: UHCprovider.com/priorauth > Cardiology > Online Portal link.
- Phone: **866-889-8054** from 7 a.m. – 7 p.m. Eastern Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code. Each authorization number is CPT-code specific.

Care Coordination Program

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

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with

providers to improve member outcomes

- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

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

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

Commonwealth Coordinated Care Plus Waiver

The CCC Plus Waiver covers a range of community support services offered to:

- Older adults
- Disabled individuals
- Chronically ill or severely impaired individuals who have lost a vital body function and who need substantial and ongoing skilled nursing care.

The individuals would require admission to a nursing facility or a prolonged stay in a hospital or specialized care nursing facility. Individuals in this waiver are eligible to participate in the CCC Plus program.

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

The waiver covers the following services:

- Adult day health care
- Assistive technology
- Environmental modifications
- Personal care
- Personal emergency response system and medication monitoring
- Respite care
- Services facilitation
- Private duty nursing
- Transition services

Emergency Care Resulting in Admissions

Prior authorization is not required for emergency services.



Emergency care should be delivered without delay. Notify UnitedHealthcare Community Plan about admission. Call the [Prior Authorization Department](#) or fax your Prior Authorization Form by 5 p.m. the next business day. (The form is located at UHCprovider.com/priorauth.)

Nurses in the Health Services Department review emergency admissions within one business day of notification.

UnitedHealthcare Community Plan makes utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization.

Care determination criteria is available upon request by contacting the Prior Authorization Department (UM Department, etc.)



The criteria are available in writing upon request or by calling the [Prior Authorization Department](#).

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

Emergency/Urgent Care Services

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate emergency room use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fever, cough and colds, and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and care provider service by in and out-of-network care providers.
- Medical examination.
- Stabilization services.
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services.
- Emergency ground, air and water transportation.
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal.

We pay out-of-network care providers for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Prior notification is not required for emergency services.

EMERGENCY ROOM CARE

For an emergency, the member should seek immediate care at the closest emergency room (ER). If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an emergency room are screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable. If UnitedHealthcare Community Plan does not respond within one hour or cannot be reached, or if the health plan and attending care provider do not agree on the member's care, UnitedHealthcare Community Plan lets the treating care provider talk with the health plan's medical director. The treating care provider may continue with care until the health plan's medical care provider is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. An MCO representative and the treating care provider reach an agreement about the member's care.
4. The member is released.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services. Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area.

URGENT CARE (NON-EMERGENT)

Urgent care services are covered.



For a list of urgent care centers, contact [Provider Services](#).

Laboratory, X-rays, Imaging Procedures

ADVANCED OUTPATIENT IMAGING PROCEDURES

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



[UHCprovider.com](#) > Select Prior Authorization and Notification > select the Radiology tab on the left side of the menu Call **866-889-8054** from 7 a.m. to 7 p.m., EST, Monday through Friday.

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

LAB SERVICES



LabCorp is the preferred lab provider. Contact [LabCorp](#) directly.

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

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

See the Billing and Encounters chapter for more information.

Prescription Drug Coverage

We have an extensive pharmacy program, including a Prescription Drug List (PDL) and pharmaceutical management procedures. Some require prior authorization.



For details on drugs covered under the pharmacy benefit and list of drugs that require prior authorization, go to [UHCprovider.com/priorauth](#) > Clinical Pharmacy and Specialty Drugs > Community Plan Prior Authorization Forms > Virginia Community Plan Prior Authorization Forms.

PRESCRIPTIONS REQUIRING PRIOR AUTHORIZATION

To request a pharmacy prior authorization, including injectable drugs, call 800-310-6826 or fax the prior authorization request form to 866-940-7328. Prior authorization forms are located on our website at [UHCprovider.com/priorauth](#) > Clinical Pharmacy and Specialty Drugs > Community Plan Prior Authorization Forms > Virginia Community Plan Prior Authorization Forms.

Review the UnitedHealthcare Community Plan Prescription Drug Lists, to to [UHCprovider.com/VA](#) > Pharmacy Resources and Physician Administered Drugs to verify if prior authorization is necessary. You should request a prior

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

authorization before giving our member a prescription that requires prior authorization. We make prior authorization determinations within 24 hours of receiving all the necessary information.

GENERIC DRUGS

Generic drugs are given, when available, as required by state mandatory generic substitution regulations. Generic drugs are approved by the Food and Drug Administration (FDA) as equivalent to their brand name counterparts. If a generic drug is available, a brand-name drug will not be provided to the member. In some cases, the brand-name drug may be preferred over its generic equivalent.

BRAND-NAME DRUGS

If a brand name is needed based on medical necessity, prior authorization is required.

PHARMACY BENEFIT EXCLUSION

Certain drugs are not covered by the pharmacy benefit.

Existing UnitedHealthcare Community Plan members may continue taking a medication not on the formulary if:

- Member is enrolled in UnitedHealthcare Community Plan (unless the medication has been deemed unsafe).
- You provide medical rationale to support continued use.
- You have consulted with and received approval from the member.

A member may change to a medication on the UnitedHealthcare Community Plan formulary only if you and the member agree on the change. Members new to therapy are required to use a medication on the formulary, unless otherwise authorized.

DAY SUPPLY DISPENSING LIMITATIONS

Members may receive up to a one-month supply (31 days) of medication per prescription order or refill. Members may reorder or refill a medication after using 90 percent for controlled substance medications or 85 percent for all other medications. If submitting a refill before then, the claim will reject with a “refill too soon” message.

QUANTITY LIMITATIONS

We have quantity limitations on medications indicated with “QL” next to the medication name on the Prescription

Drug List. Per state and Plan regulations, certain quantity limits may apply. These include:

- Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request.

We recognize a number of patient-specific variables must be taken into consideration when drug therapy is prescribed. Overrides are available through the medical exception (prior authorization) process.

EMERGENCY PRESCRIPTIONS

We allow for a three-day emergency medication supply when a medication is needed without delay and prior authorization (PA) cannot be resolved within 24 hours. This applies to all drugs requiring a PA, either because they are non-preferred drugs on the PDL or because they are subject to clinical edits.

If you cannot be reached, or are unable to request a PA, the pharmacy may submit an emergency 72-hour prescription.

A pharmacy may dispense a product packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply. You will receive a response by fax within 24 hours of a request for PA.

Prescription Monitoring Program (PMP)

The Prescription Monitoring Program (PMP) is an electronic system to monitor the dispensing of Schedule II, III, IV and V controlled substance prescription drugs. It is established, maintained, and administered by the Department of Health Professions. More information on the Virginia PMP is available on the Department of Health Professions website at dhp.virginia.gov/.

Use information from the PMP about specific members to determine eligibility, when completing prior authorization forms and to manage the care of the specific member participating in the PUMS.

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

Radiology Prior Authorization Program

We use a Radiology Prior Authorization Program to improve compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain a prior authorization before ordering CT scans, MRIs, MRAs, PET scans, nuclear medicine and nuclear cardiology studies in an office or outpatient setting.

Radiology Procedures Requiring Prior Authorization

Certain procedures are subject to prior authorization requirements (“Advanced Outpatient Imaging Procedures”):

- CT scans
- MRI/MRA
- Positron- Emission Tomography (PET)
- Nuclear Medicine
- Nuclear Cardiology services

For the most current listing of prior authorization CPT® codes, go to UHCprovider.com/radiology.

The following images do not require prior authorization:

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

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

To get or verify prior authorization:

- Online: UHCprovider.com/priorauth > Radiology > Online Portal link.
- Phone: **866-889-8054** from 7 a.m. - 7 p.m. Central Time, Monday through Friday. Make sure the medical record is available. An authorization number is required for each CPT code. Each authorization number is CPT-code specific.

Specialty Pharmacy Medications

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

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

Specialty pharmacy medications are available through our preferred specialty pharmacy network.

Drugs on the Preferred Drug List (PDL) that are part of this program are identified by a “SP” in superscript next to the drug name on the Preferred Drug List.

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

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

RESPONSIBILITIES:

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

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

of TB to the LHD TB Control Program within one day of identification.

Medical Management Guidelines

ADMISSION AUTHORIZATION AND PRIOR AUTHORIZATION GUIDELINES

All prior authorizations must have the following:

- Patient name and ID number.
- Ordering care provider or health care professional name and TIN/NPI.
- Rendering care provider or health care professional and TIN/NPI.
- ICD CM.
- Anticipated date(s) of service.

- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable.
- Service setting.
- Facility name and TIN/NPI, when applicable.



For behavioral health and substance use disorder authorizations, please contact UnitedHealthcare Community Plan.



Locate the Prior Authorization Fax Request Form at UHCprovider.com/priorauth > Clinical Pharmacy and Specialty Drugs > Community Plan Prior Authorization Forms > Virginia Community Plan Prior Authorization Forms. If you have questions, please call [Prior Authorization Intake](#).

Type of Request	Decision TAT CCC Plus	Decision TAT Medallion	Practitioner notification of approval	Written practitioner/member notification of denial
Inpatient (Concurrent Review)	One business day	One business day	One business day	One business day
Non-urgent Pre-Service	Three business days	14 Calendar Days	14 Calendar Days	14 Calendar Days
Urgent Pre-Service	72 Hours	72 Hours	Within 72 hours	Within 72 hours
Retrospective Review	30 Calendar Days	30 Calendar Days	30 Calendar Days	30 Calendar Days
Long Term Services and Supports (Non-urgent)	Five Business Days	N/A	Five Business Days	Five Business Days
Long Term Services and Supports (Urgent)	72 Hours	N/A	72 Hours	Within 24 hours

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

See Mental Health chapter for behavioral health prior authorization.

*Timeframes begin after receipt of clinical information

* *Urgent: A medical (physical, mental, or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected by a prudent layperson that possesses an average knowledge of health and medicine to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily function;
- (3) Serious dysfunction of any bodily organ or part; or
- (4) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

Concurrent Review Guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. We perform an on-site facility review or phone review for each day's stay using MCG, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

CONCURRENT REVIEW DETAILS

Concurrent Review is notification within 24 hours or one business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or on-site.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. local time, or make best efforts to

provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day).

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

Determination of Medical Necessity

Medically necessary services or supplies are those necessary to:

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

Determination Process

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

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

Evidence-Based Clinical Guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to [UHCprovider.com](https://www.uhcprovider.com).

Medical and Drug Policies and Coverage Determination Guidelines

Find medical policies and coverage determination guidelines at [UHCprovider.com](https://www.uhcprovider.com) > Policies and Protocols > Community Plan Policies > Medical and Drug Policies and Coverage Determination Guidelines for Community Plan.

Referral Guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization of all out-of-network referrals. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for, but not limited to, the following:

- Continuity of care issues
- Necessary services are not available within network

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using LINK on [UHCprovider.com](https://www.uhcprovider.com), contacting UnitedHealthcare Community Plan's Provider Services Department, or the VA Medicaid Eligibility System.
- Submit documentation needed to support the medical necessity of the requested procedure.
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized.
- Determine if the member has other insurance that should be billed first.

UnitedHealthcare Community Plan will not reimburse:

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

Second Opinion Benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the VA DMAS. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating provider. The participating provider should contact UnitedHealthcare Community Plan at:

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

- **877-843-4366** – CCC Plus Provider Services
- **844-284-0146** – Medallion Provider Services.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations.
- If follow-up care is recommended, the member meets with the PCP before receiving treatment.

Services Requiring Prior Authorization



For a list of services that require prior authorization, go to UHCprovider.com/priorauth.

DIRECT ACCESS SERVICES – NATIVE AMERICANS

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization.

SEEK PRIOR AUTHORIZATION WITHIN THE FOLLOWING TIME FRAMES

- **Emergency or Urgent Facility Admission:** one business day.
- **Inpatient Admissions; After Ambulatory Surgery:** one business day.
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than five business days in advance, use the scheduled admission time.

Utilization Management Guidelines



Call **844-284-0146 (877-843-4366 CCC Plus)** to discuss the guidelines and utilization management.

Utilization Management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community

Plan network on a fee-for-service basis. The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

UTILIZATION MANAGEMENT (UM) APPEALS

These appeals contest UnitedHealthcare Community Plan's UM decisions. They are appeals of UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. Adverse determination decisions may include UnitedHealthcare Community Plan's decision to deny a service authorization request or to authorize a service in an amount, duration, or scope less than requested. See Appeals in [Chapter 12](#) for more details.

Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Prevention

The **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid.

Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. EPSDT screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

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

Early Intervention Services

Early Intervention Services provide early intervention services to infants and toddlers with disabilities and their families.

Referral – refer children who are identified as potentially requiring developmental intervention services to the appropriate agency for evaluation once you identified the need for services. Provide information as requested to complete the referral process. If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these impairments, contact the local lead agency for evaluation and early intervention services. After contacting the local lead agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility.

Continuity of Care – support the development of the Individualized Family Service Plan (IFSP) developed by the local lead agency and its providers. The assigned coordinator will help the local lead agency and you to ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP. UnitedHealthcare Community Plan provides member case management and care coordination to help ensure all medically necessary covered diagnostic, preventive and treatment services are identified in the IFSP developed by the Early Intervention Program, with your participation.

Contact your local lead agency at infantva.org or Infant & Toddler Connection of Virginia at **800-234-1448**.

Full Screening

Perform a full screen. Include:

- Interval history
- Unclothed physical examination
- Anticipatory guidance
- Lab/immunizations (Lab and administration of immunizations is reimbursed separately.)
- Lead assessment
- Personal-social and language skills
- Fine motor/gross motor skills
- Hearing
- Vision
- Dental

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

Interperiodic Screens

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

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

Lead Screening/Treatment

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

Case Management

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

Case Management is a voluntary program and members may choose to opt out. Your support of the member and care manager during the process is valued and necessary for successful outcomes. Current focused programs under our Case Management include:

- Complex Case Management for members with emerging risk, high utilization or catastrophic event
Chronic Condition Management
- Asthma
- Diabetes

- CHF/CAD
- COPD
- Cancer
- Childhood obesity
- Maternity Case Management
- NICU
- Children and Youth with Special Health Care Needs
- Behavioral Health Case Management

You, on behalf of a member, may request participation in any of the programs. The care manager will work with you, the member and/or the hospital to identify the necessary:

- Intensity level of care management services and education needed
- Healthcare services required including equipment and/or supplies
- Community-based services available
- Communication required between member and PCP/specialist

If you have identified a member who could benefit from any of our case management programs,

Medallion: Refer members for case management by calling Member Services at **844-752-9434**.

CCC Plus: Refer members for case management by calling Member Services at **866-622-7982**.

All of our Case Management programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with high-risk or complex health coordination needs. The program includes a holistic, member-centric care management approach that allows care managers to focus on multiple needs of member.

Program features:

- Proactive population identification processes and risk stratification
- Evidence-based national practice guidelines
- Collaborative practice models to include physician and support-service providers in treatment planning for members
- Continuous patient self-management education, including primary prevention, and compliance/surveillance

- Community or home visits and case/care management for high-risk members
- Ongoing process and outcomes measurement, evaluation, and management
- Ongoing communication with providers regarding patient status as needed

Vaccines for Children program (VFC)

The Vaccines for Children program provides immunizations. Immunizations offered in the state VFC program must be ordered by your office. We do not reimburse for the vaccine ordered by the VFC program, but we reimburse for administering the vaccine.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. We cannot reimburse for private stock vaccines when they are available through VFC.



Contact [VFC](#) with questions.
Phone: 800-219-3224
Fax: 573-526-5220

Any child through 18 years of age who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for Medicaid; FAMIS excluded.
- American Indian or Alaska Native, as defined by the Indian Health Services Act.
- Uninsured.
- Underinsured (these children have health insurance but the benefit plan does not cover immunizations).

Children in this category may not only receive vaccinations from a federally qualified health center or rural health clinic; they cannot receive vaccinations from a private health care provider using a VFC-supplied vaccine).

Chapter 6: Value-Added Services

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call Provider Services at **877-843-4366** – CCC Plus Provider Services and **844-284-0146** – Medallion Provider Services unless otherwise noted.

CCC PLUS MEMBERS

Acute Home-delivered Meals

This program is available for members who are discharged from an acute inpatient hospital stay or from a nursing facility back into the community setting. They can receive nutritious prepared meals chosen from menus that support the management of many chronic conditions such as diabetes. After discharge, 14 meals are delivered to the member's home, enough to provide two meals per day for seven days. Requests are coordinated through the member's care coordinator and reviewed by the medical director.

Adult Vision

We provide adult vision coverage to eligible members older than the age of 21. Our vision coverage includes an annual eye exam and frames/lenses every two years, if necessary. The benefit is limited to in-network providers.

Consumer-Directed Services

Consumer-Directed Services are available for members who are eligible under the CCC Plus HCBS Waiver.

Eligible personal care and respite services may be provided by a health agency (known as agency-directed or AD services) or by a personal attendant hired by the consumer (known as consumer directed or CD services).

CD services allow members to act as the employer in the self-direction of their personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants.

Members selecting the CD services option work with their UnitedHealthcare Community Plan Care Manager to select a Service Facilitator. The selected Service Facilitator helps ensure the development and monitoring of the CD services Plan of Care, provides employee management training, and completes ongoing review activities as required by DMAS for CD personal care and respite services. The Service Facilitator works with the member's assigned Care Manager to help ensure alignment and compliance with the member's Plan of Care.

The selected Service Facilitator works with a Financial Management Service that manages the budgeted number of service hours established for members, processes timesheets submitted by personal care/respite workers, and pays these workers on the member's behalf. Members are able to change their selected Service Facilitator at any time.

Dental Services

COVERED

A Dental Provider Manual is available for detailed coverage information.

CCC PLUS MEMBERS (CONTINUED)

UnitedHealthcare Community Plan covers the facility and anesthesia for medically necessary outpatient dental services for adults ages 21 and older. If older than 21, we do not provide coverage without the presence of trauma or cases where treatment is needed for serious medical conditions.

Facility services require a prior authorization.

The following services are covered for children younger than 20 years, pregnant women, the blind and nursing facility residents:

- Diagnostic
- Periodontics
- Preventive
- Prosthodontics (limited)
- Restorative
- Oral and maxillofacial surgery
- Endodontics

For more details, go to: dbp.com.

NON-COVERED

UnitedHealthcare Community Plan does not cover routine dental services for anyone 21 years and older. Refer to the Dental Provider Manual for applicable exclusions and limitations and covered services. Standard ADA coding guidelines apply to all claims.

For more details, go to UHCprovider.com.

Environmental Home Modifications

Environmental home modifications such as ramps and grab bars in members' homes can help them live safely in the least restrictive environment. We provide environmental and home modifications to all members who are not currently eligible for coverage through a waiver. Limits include \$5,000 each calendar year or \$10,000 per lifetime. Request for the modifications is coordinated through the individual's care coordinator and reviewed by our medical director.

Home and Community- Based Services (HCBS) Program

This program combines traditional physical health, behavioral health and nursing facility based services. All HCBS require prior authorization through the plan of care (POC) process.

Goals of this program include:

- Having integrated, whole-person care
- Preserving paths to Independence
- Creating access models with emphasizing home and community-based services



More information on HCBS services, including benefit limitations, unit definitions and billing codes is available on the DMAS web portal at viriniamedicaid.dmas.virginia.gov > Provider Resources > Provider Manuals.

My HealthLine

MyHealthLine Free Cellphone Program: Being able to connect directly with our members is essential to supporting their health improvement goals. To support open communication, we will provide our free cellphone program, MyHealthLine, to all eligible members. MyHealthLine provides 350 minutes per month and unlimited texting. By providing a cellphone pre-programmed with UnitedHealthcare contacts, members can quickly and easily reach us to discuss benefit questions or for NurseLine support.

Quit for Life®

Since 1985, the Quit For Life® Program has helped millions of people, and it can help your patients, too. When you refer your patient, our trained Quit Coach® staff will help them create a personalized plan to give them all the resources and support needed to quit and make it stick. Our coaches understand why people smoke, why they want to quit, and the triggers that keep them hooked. They'll work with your patient one-on-one, to make sure

CCC PLUS MEMBERS (CONTINUED)

they have the knowledge and positive encouragement they need. Plus, they'll provide tried-and-true strategies to help your patient fend off cravings, handle tricky social situations, and avoid triggers that make them want to pick up the tobacco.

Transitional Support Funds

We know that there are individuals who are deemed ready for discharge from state psychiatric hospitals for more than 30 days, but remain institutionalized due to a lack of resources or supports in the community. Transitional support funds are made available when other resources prevent eligible members from being discharged. On an annual basis, we establish a funding pool to use for eligible members. Requests are coordinated through the member's care coordinator. They require approval from our project manager, medical director and behavioral health lead.

Weight Watchers

This program enrollment is offered to qualifying members so they may learn valuable skills about healthy eating and weight loss. Upon referral by your PCP, members will receive meeting vouchers to attend up to 10 meetings. Limited to members age 10 and older.

You Can Live Well Program

Our care coordinators refer eligible members to attend the six-week program. We will support and collaborate with the Department of Aging and Rehabilitative Services. We also work with them to develop any additional programs to help members with chronic disease management programs.

MEDICAID AND FAMIS MEMBERS

Adult Pain Management/ Chiropractic Services

Evidence-based medicine supports chiropractic care to help lower back pain. In some cases, a visit to the chiropractor can reduce or eliminate the need for pain medication. It can even help combat opioid addiction and overuse.

We provide members older than 21 with up to six visits per calendar year with an in-network chiropractor. This benefit does not need prior authorization.

Use the following steps to access the fee schedules online:

1. Go to myoptumhealthphysicalhealth.com.
2. Enter your provider ID & password.
3. Click “Tools & Resources.”
4. Click “Plan Summaries” or “Fee Schedules.”
5. The two covered CPT codes are 98940 and 98941.

For more information on chiropractic care, go to myoptumhealthphysicalhealth.com.

Assistance for Asthmatics

We offer hypoallergenic mattress covers and pillowcases that help reduce or eliminate dust mites. This benefit has a maximum value of \$150 per calendar year. It requires a diagnosis of asthma and authorization of benefit qualification.

Please have the member call our member services number to begin the process: **CCC Plus Member Services at 866-622-7982** or **Medallion Member Services at 844-752-9434**.

Community Care Package

This provides home-delivered meals to members at risk of poor health. It is limited to members who are discharged from an acute inpatient hospital stay (postpartum or other acute stay) and are identified as high risk by case management. This benefit requires prior authorization. It is limited to up to four discharges per year, per member.

Extracurricular Sports Physical

Healthy activities contribute to higher self-esteem, improved health and lower likelihood of childhood obesity.

Extracurricular sports physical value add includes Athletic Training Evaluation, Athletic Training Reevaluation, and examination for participation in sports.

Fotonovelas

Fotonovelas are an engaging, culturally competent way to educate the Latino population about subjects such as asthma, depression, diabetes, immunizations and obesity. Fotonovelas are Spanish “comic book”-like printed booklets. They can be understood by anyone with limited health literacy. This benefit has no service limits or authorization required.

On My Way (OMW)

OMW is an interactive website that informs and supports young adults on many real-world situations. OMW teaches practical skills, such as managing money, securing housing, creating a resume, finding job training and applying for college. This benefit is limited to young adults transitioning into independence. No service limits or prior authorization required.

Vision Enhanced Benefit

We provide members with vision services that include:

- Exams for members younger than the age of 21 every 12 months
- Exams for members 21 and older every 24 months;
- Glasses (or medically necessary contact lenses) — one pair every 24 months; Replacement of glasses once per 12 months if there is a change in vision of +/- 0.5.

MEDICAID AND FAMIS MEMBERS (CONTINUED)

Women, Infants and Children Supplemental Nutrition Program (WIC)

This program provides Federal grants for supplemental foods, health care referrals, transportation and nutrition education for low-income pregnant, postpartum women. It also covers infants and children up to age five who are at nutritional risk.

Eligibility –

- Pregnant women- as soon as there is a positive pregnancy test
- Women who have been pregnant within the previous six months
- Breastfeeding women
- Children younger than five

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

A current hemoglobin or hematocrit is required:

- Hemoglobin or hematocrit within 90 days of enrollment
- Hemoglobin or hematocrit within 90 days of each succeeding six month certification except for a child whose blood value was within normal limits at the previous certification. For these children, the lab tests are required every 12 months
- For infants younger than nine months of age, height/length and weight dated within 60 days of enrollment and with each six-month recertification

Contact Information:

877-835-5942

vdh.virginia.gov/wic

CCC PLUS, MEDICAID AND FAMIS MEMBERS

Baby Blocks™ Program

Baby Blocks™ is a web-based, mobile tool that reminds and rewards pregnant women and new mothers to get prenatal, postpartum and well-child care. Baby Blocks™ is available to pregnant UnitedHealthcare Community Plan members or their newborns.

BABY BLOCKS™ BENEFIT

Baby Blocks engages members with text and email appointment reminders. Members who enroll early in their pregnancy can earn up to eight rewards by following prenatal and postpartum recommendations.

How it Works

1. Care providers and UnitedHealthcare Community Plan reach out to members to enroll them in Baby Blocks.
2. Members enter information about their pregnancy and upcoming appointments at UHCBabyBlocks.com.
3. Members get reminders of upcoming appointments and record completed visits at UHCBabyBlocks.com.
4. At milestones throughout the program, members choose a reward for themselves or their baby.

How You Can Help

1. Identify UnitedHealthcare Community Plan members during prenatal visits.
2. Share a Baby Blocks brochure with the member and talk about the program.
3. Encourage the member to enroll at UHCBabyBlocks.com.



Members self-enroll on a smartphone or computer. They can go to UHCBabyBlocks.com and click on “Sign Up Here.”

Non-Emergency Transportation

Some members require non-emergency transportation (NEMT) to and from services beyond what the state agency covers. NEMT provides crucial support in helping improve our members’ access to care. All members eligible for state-approved transportation services are qualified for this additional health benefit.

NEMT includes trips to and from WIC, food banks, methadone clinics, inpatient behavioral health and to the pharmacy immediately following a covered service appointment.

FAMIS members may receive 10 round trips (20 one way trips) per calendar year; additional trips require prior authorization. To request and schedule rides, members call Medical Transportation Management (MTM) directly. If members need assistance in scheduling rides, the service coordinators, Member Services Advocates (MSAs) and the mobility manager can assist. Services may be scheduled up to 14 days in advance. Hotel stays will be paid for trips that require an overnight stay with prior approval for eligible members.

Urgent non-emergency trips, such as when a member is discharged from the hospital, may be made through the call center after 8 p.m. Eastern Time. Urgent calls are the ONLY calls taken in person by a reservation specialist after 8 p.m. Eastern Time. Schedule rides up to 30 days in advance.



For non-urgent appointments, members must call for transportation with a 48 hour notice before their appointment.

Bus transportation will also be available if the member:

- Lives less than half a mile from a bus stop.
- Has an appointment less than half a mile from the bus stop.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, seven days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the emergency room or to schedule an appointment with their

CCC PLUS, MEDICAID AND FAMIS MEMBERS (CONTINUED)

PCP. Our nurses also help educate members about staying healthy. Call **800-842-3014** to reach a nurse.

UHC Latino



uhclatino.com, our award-winning Spanish-language site, provides more than 600 pages of health and wellness information and reminders on important health topics.

Chapter 7: Mental Health and Substance Use

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with mental health and substance use disorder (SUD) benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law. The National Optum Behavioral Health manual is located on providerexpress.com.

This chapter does not replace the national Optum network manual. Rather, it supplements the national manual by focusing on Medicaid's specific services and procedures.

You must have a National Provider Identification (NPI) number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To request an ID number, contact DMAS at dmas-info@DMAS.Virginia.gov or **804-786-7933**.

UnitedHealthcare Community Plan provides Mental Health Inpatient and starting April 2019, Residential managed care services and Addiction Recovery Treatment Services (ARTS). The ARTS program expands access to all levels of American Society of Addiction Medicine (ASAM) evidence-based addiction treatment for Medicaid enrollees in the Commonwealth of Virginia.

Credentialing

Credentialing information is available at providerexpress.com > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum

Covered Services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders. We offer care management to

help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in one place.

liveandworkwell.com, accessed through a link on myuhc.com, includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.



For member resources, go to providerexpress.com. Go to the Live and Work Well (LAWW) clinician center. Locate Health Condition Centers at the Clinical Resources tab. The Provider Express Recovery and Resiliency page includes tools to help members addressing mental health and substance use issues.

Standard BH Services:

- Acute Inpatient Hospitalization
- Electroconvulsive Therapy (ECT)
- Psychological Testing
- Individual and Group Outpatient Therapy

Community Mental Health Rehabilitation Services (CMHRS):

- Mental Health Case Management
- Therapeutic Day Treatment for Children (TDT)
- Day Treatment/Partial Hospitalization for Adults
- Crisis Intervention
- Intensive Community Treatment
- Mental Health Skill Building Services (MHSS)
- Intensive In-Home
- Psychosocial Rehab
- Crisis Stabilization
- EPSDT Behavioral Therapy/ABA

- Peer Support Services for Adults
- Family Support Partners for Youth

Addiction Recovery Treatment Services (ARTS):

- Peer Support Services
- Substance Abuse Case Management Services
- Intensive Outpatient
- Partial Hospitalization
- ASAM Level 3 Residential Services
- ASAM Level 4 Inpatient Hospital Services

Family Access to Medical Insurance Security (FAMIS):

A limited set of services are available for Mental Health and Substance Abuse for FAMIS enrollees.

Eligibility

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



Evidence-based clinical guidelines are available on UHCprovider.com/vacommunityplan > Policies and Clinical Guidelines.

Authorizations

BEHAVIORAL HEALTH AUTHORIZATIONS

Type of Request	Decision TAT CCC Plus	Decision TAT Medallion	Practitioner notification of approval (verbal)	Written practitioner/member notification of denial
Standard Outpatient	Three business days or up to five business days if additional information is needed			
Non-urgent Pre-Service	N/A	Inpatient: One calendar day Outpatient: Three calendar days	Inpatient: One calendar day Outpatient: Three calendar days	Three calendar days
Urgent Pre-Service	Inpatient: Three hours	Inpatient: One calendar day Outpatient: Three calendar days	Inpatient: One calendar day Outpatient: Three calendar days	Three calendar days
Urgent (Not pre-service inpatient)	24 hours			
Initial/ Concurrent Inpatient	One business day or up to three business days if additional information is needed			
Concurrent Review	N/A	Inpatient: One calendar day Outpatient: Three calendar days	Inpatient: One calendar day Outpatient: Three calendar days	Three calendar days
Retrospective Review	N/A	30 calendar days	30 calendar days	30 calendar days

Members may access all behavioral health outpatient services (mental health and substance use) without a referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care. All ARTS and CMHRS services require registration or authorization using a DMAS service-specific form. Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to UHCprovider.com/priorauth, calling **844-284-0146**, or faxing **855-368-1542**.

Coordination of Care

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

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

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

Portal Access

Website: UHCprovider.com

Access Link, the gateway to UnitedHealthcare Community Plan's online tools, on this site. Use the tools to verify eligibility, review electronic claim submission, view claim status, and submit notifications/ prior authorizations.

View the Prior Authorization list, find forms and access the care provider manual. Or call [Provider Services](#) to verify eligibility and benefit information (available 8 a.m. - 5 p.m. Central Time, Monday through Friday).

Website: providerexpress.com

Update provider practice information, review guidelines and policies, and view the national Optum Network Manual. Or call Provider Services at **877-843-4366** – CCC Plus Provider Services, **844-284-0146** – Medallion Provider Services.

Claims

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

Monitoring Audits

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

Addressing the Opioid Epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community partnerships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

BRIEF SUMMARY OF FRAMEWORK

- Prevention:
 - Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.
- Treatment:
 - Access and reduce barriers to evidence-based and integrated treatment.
- Recovery:
 - Support case management and referral to person-centered recovery resources.
- Harm Reduction:
 - Access to Naloxone and facilitating safe use, storage, and disposal of opioids.
- Strategic community partnerships and approaches:
 - Tailor solutions to local needs.
- Enhanced solutions for pregnant mom and child:
 - Prevent neonatal abstinence syndrome and supporting moms in recovery.
- Enhanced data infrastructure and analytics:
 - Identify needs early and measure progress.

INCREASING EDUCATION & AWARENESS OF OPIOIDS

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/ OUD assessments and screening resources, and

other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

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

PREVENTION

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

PATIENT UTILIZATION MANAGEMENT & SAFETY (PUMS) PROGRAM FOR MEMBERS

UnitedHealthcare Community Plan of Virginia has established a Patient Utilization Management & Safety (PUMS) program to coordinate care and help ensure members are accessing and using services with all applicable rules and regulations. The PUMS program is a utilization control and case management program designed to promote proper medical management of essential healthcare. This program is intended to:

- Improve the quality of care for members.
- Curb the abuse or misuse of controlled substance medications.
- Reduce unnecessary physician utilization.

Members enrolled in the PUMS program will be restricted to one or more of the following:

- The use of a single pharmacy
- Use of a specific PCP
- Use of a specific controlled substances prescriber

- Use of a specific hospital (for non-emergency hospital services only)
- On a case-by-case basis, other qualified provider type and the circumstances of the member

Once enrolled, members remain in the PUMS Program for a period of 12 months. At the end of the 12-month period, the member is re-evaluated to determine if the member continues to display behavior or patterns that indicate the member should remain in the PUMS Program.

Placement into the PUMS program may occur with any of the following trigger events:

- The specific utilization review of the member’s past 12 months of medical and/or billing histories indicates the member may be accessing or using health care services inappropriately, or in excess of what is normally medically necessary,

Minimum specifications include:

- Buprenorphine Containing Product: Therapy in the past 30 days – AUTOMATIC ENROLLMENT
- High Average Daily Dose: > 120 cumulative morphine milligram equivalents per day over the past 90 days
- Opioid and Benzodiazepines concurrent use: at least one opioid claim and 14-day supply of benzodiazepine (in any order)
- Doctor and/or Pharmacy Shopping: > three prescriptions OR > three pharmacies writing/filling claims for any controlled substance in the past 60 days
- Use of a controlled substance with a history of dependence, abuse, or poisoning/overdose: Any use of a controlled substance in the past 60 days with at least two medical claims for controlled substance abuse or dependence in the past 365 days
- History of substance use, abuse or dependence or poisoning/overdose: Any member with a diagnosis of substance use, substance abuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past 60 days. *No prior claims in the previous two months or 60-day time frame
- Medical care providers or social service agencies provide direct referrals to the Department or INTotal Health If the member changes from another health plan to INTotal

PHARMACY LOCK-IN

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

Chapter 8: Member Rights and Responsibilities

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

Privacy Regulations

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

ACCESS TO PROTECTED HEALTH INFORMATION

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

AMENDMENT OF PHI

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

ACCOUNTING OF DISCLOSURES

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

- For treatment, payment and health care operations purposes

- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not need us to give an accounting

RIGHT TO REQUEST RESTRICTIONS

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

Member Rights and Responsibilities

The following information is in the Member Handbook at the following link under the Member Information tab: [UHCCommunityPlan.com](https://www.uhc.com/MemberHandbook).

NATIVE AMERICAN ACCESS TO CARE

Native American members can access care to tribal clinics and Indian hospitals without approval.

MEMBER RIGHTS

Members may:

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

- Make suggestions about our member rights and responsibilities policies.
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply.

MEMBER RESPONSIBILITIES

Members should:

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

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

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

- Participate in decisions regarding their health care, including the right to refuse treatment directly or through an advance directive.
- Be free from any restraint or seclusion.
- Free exercise of rights if they do not adversely affect the way UnitedHealthcare Community Plan or our care providers treat the member.

Surveys

VA DMAS requires an annual member satisfaction survey. Members are polled to determine satisfaction with:

- The care manager
- Customer service
- Network availability/service provision
- Member materials

A survey or focus group may be conducted with members who are non-English speaking, or have physical disabilities, or are part of a minority ethnic group.

Chapter 9: Medical Records

Medical Record Charting Standards

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

Topic	Contact
Confidentiality of Record	Office policies and procedures exist for: <ul style="list-style-type: none"> • Privacy of the member medical record. • Initial and periodic training of office staff about medical record privacy. • Release of information. • Record retention. • Availability of medical record if housed in a different office location.
Record Organization	<ul style="list-style-type: none"> • Have a policy that provides medical records upon request. Urgent situations require copies be provided within 48 hours. • Maintain medical records in a current, detailed, organized and comprehensive manner. The records should be: <ul style="list-style-type: none"> - In order. - Fastened, if loose. - Separate for each member. - Filed in a manner for easy retrieval. - Readily available to the treating care provider where the member generally receives care. - Promptly sent to specialists upon request. • Medical records are: <ul style="list-style-type: none"> - Stored in a manner that helps ensure privacy. - Released only to entities as designated consistent with federal requirements. - Kept in a secure area accessible only to authorized personnel.

Topic	Contact
Procedural Elements	<p>Medical records are readable*</p> <ul style="list-style-type: none"> • Sign and date all entries. • Member name/identification number is on each page of the record. • Document language or cultural needs. • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the member’s first language is something other than English. • Procedure for monitoring and handling missed appointments is in place. • An advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information about advance directives. • Include a list of significant illnesses and active medical conditions. • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions.*
History	<p>An initial history (for members seen three or more times) and physical is performed. It should include:</p> <ul style="list-style-type: none"> • Medical and surgical history* • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, and/or substance abuse use/ history beginning at age 11 • Current and history of immunizations of children, adolescents and adults • Screenings of/for: <ul style="list-style-type: none"> - Recommended preventive health screenings/tests - Depression - High-risk behaviors such as drug, alcohol and tobacco use; if present, advise to quit - Medicare members for functional status assessment and pain - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Topic	Contact
<p>Problem Evaluation and Management</p>	<p>Documentation for each visit includes:</p> <ul style="list-style-type: none"> • Appropriate vital signs (Measurement of height, weight, and BMI annually) <ul style="list-style-type: none"> - Chief complaint* - Physical assessment* - Diagnosis* - Treatment plan* • Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines. • Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT). • Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets. • Treatment plans are consistent with evidence-based care and with findings/diagnosis: <ul style="list-style-type: none"> - Timeframe for follow-up visit as appropriate - Appropriate use of referrals/consults, studies, tests • X-rays, labs consultation reports are included in the medical record with evidence of care provider review. • There is evidence of care provider follow-up of abnormal results. • Unresolved issues from a previous visit are followed up on the subsequent visit. • There is evidence of coordination with behavioral health care provider. • Education, including lifestyle counseling, is documented. • Member input and/or understanding of treatment plan and options is documented. • Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented.

*Critical element

SCREENING AND DOCUMENTATION TOOLS

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

Medical Record Review

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

- Problem list with:
 - Biographical data with family history.
 - Past and present medical and surgical intervention.
 - Significant medical conditions with date of onset and resolution.
 - Documentation of education/counseling regarding HIV pre- and post-test, including results.
 - Entries dated and the author identified.
 - Legible entries.
 - Medication allergies and adverse reactions (or note if none are known).
 - Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen three or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
 - Medication record, including names of medication, dosage, amount dispensed and dispensing instructions.
 - Immunization record.
 - Tobacco habits, alcohol use and substance abuse (12 years and older).
 - Copy of advance directive, or other document as allowed by state law, or notate member does not want one.
 - History of physical examination (including subjective and objective findings).
 - Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding.
- Lab and other studies as appropriate.
 - Member education, counseling and/or coordination of care with other care providers.
 - Notes regarding the date of return visit or other follow-up.
 - Consultations, lab, imaging and special studies initialed by primary care provider to indicate review.
 - Consultation and abnormal studies including follow-up plans.

Member hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9, etc.)

Chapter 10: Quality Management (QM) Program and Compliance Information

What is the Quality Improvement Program?

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

The program consists of:

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

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

COOPERATION WITH QUALITY-IMPROVEMENT ACTIVITIES

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

- Providing requested timely medical records.
- Cooperation with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participation in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, secure email or secure fax.
- Practitioner appointment access and availability surveys.

Quality Improvement Program

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

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

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

Care Provider Satisfaction

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

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

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

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

Credentialing Standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable VA statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and Recredentialing Process

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

CARE PROVIDERS SUBJECT TO CREDENTIALING AND RE-CREDENTIALING

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or
- Nurse practitioners and physician assistants who practice under a credentialed UnitedHealthcare Community Plan care provider.

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/ national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. You can find applications on the Council for Affordable Quality Healthcare (CAQH) website.



First-time applicants must call the [National Credentialing Center \(VETTS line\)](#) to get a CAQH number and complete the application online.

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

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

ADVANCE DIRECTIVES

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

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

Peer Review

CREDENTIALING PROCESS

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

RE-CREDENTIALING PROCESS

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

PERFORMANCE REVIEW

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

APPLICANT RIGHTS AND NOTIFICATION

You have the right to review information you submitted to support your credentialing/re-credentialing application.

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

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

CONFIDENTIALITY

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

FAILURE TO MEET RE-CREDENTIALING REQUIREMENTS

If you don't meet our re-credentialing requirements, we will end your participation with our network. We will give you a written termination notice. The termination notice will include the reasoning, the effective date and an explanation of your appeal rights, if applicable.

Resolving Disputes

CONTRACT CONCERNS

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

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

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

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

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

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

HIPAA Compliance – Your Responsibilities

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

TRANSACTIONS AND CODE SETS

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

UNIQUE IDENTIFIER

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

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

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

SECURITY

Covered entities must meet basic security measures:

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

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



Find additional information on HIPAA regulations at [cms.hhs.gov](https://www.cms.hhs.gov).

Ethics & Integrity

INTRODUCTION

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

COMPLIANCE PROGRAM

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required seven elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program.
- Development and implementation of ethical standards and business conduct policies.
- Creating awareness of the standards and policies by educating employees.
- Assessing compliance by monitoring and auditing.
- Responding to allegations of violations.
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

REPORTING AND AUDITING

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.



To facilitate the reporting process of questionable incidents involving members or care providers, call our [Fraud and Abuse line](#).

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.



Report any unethical, unlawful or inappropriate activities by any employee to the Ethics and Compliance Help Center at **800-455-4521**.

EXTRAPOLATION AUDITS OF CORPORATE-WIDE BILLING

UnitedHealthcare Community Plan will work with the Commonwealth of VA to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the VA Department of Medical Assistance Services.

RECORD RETENTION, REVIEWS AND AUDITS

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the VA program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until one year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet VA program standards.

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

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

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

DELEGATING AND SUBCONTRACTING

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

Office Site Quality

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

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

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

CRITERIA FOR SITE VISITS

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

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

Chapter 11: Billing and Submission

Our Claims Process

UnitedHealthcare Community Plan follows the same claims process as UnitedHealthcare.



For a complete description of the process, go to UHCprovider.com/guides > View online version > Chapter 9 Our Claims Process.

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions.



If you have not applied for a NPI, contact [National Plan and Provider Enumeration System \(NPPES\)](#). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call the [UHG VETSS](#) line or [Provider Services](#).

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

Virginia Medicaid Provider Identification Number

All care providers serving Medicaid members are encouraged to apply for participation in the Medicaid fee-for-service program and obtain a provider identification number. While not a current requirement for billing, future claims submitted by providers without this ID may be rejected. Once you have received your Medicaid provider ID, please give it to us for your record.



To apply for participating provider status with the Commonwealth of Virginia go to: virginiamedicaid.dmas.virginia.gov.

General Billing Guidelines

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

Fee Schedule

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

Modifier Codes

Use the appropriate [modifier codes](#) on your claim form. The modifier must be used based on the date of service.

Member ID Card for Billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Medicaid ID. UnitedHealthcare Community Plan prefers you bill with the member ID.

Acceptable Claim Forms

UnitedHealthcare Community Plan only processes claims submitted on 1500 and UB-04 claim forms.

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

Clean Claims and Submission Requirements

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Clean claims have:

- A health service provided by an eligible health care provider to a covered UnitedHealthcare Community Plan member.
- All the required documentation, including correct diagnosis and procedure codes.
- The correct amount claimed.

We may require additional information for some services, situations or state requirements.

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

Care Provider Coding

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

Electronic Claims Submission and Billing

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

- OptumInsight can provide you with clearinghouse connectivity or your software vendor can connect through an entity that uses OptumInsight.

- All claims are set up as “commercial” through the clearinghouse.
- Our payer ID is 87726.
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don’t successfully transmit.
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms.

If you treat another diagnosis, use that ICD CM code as well.



For more information, contact [EDI Claims](#). You can also see [enshealth.com](https://www.enshealth.com) or contact Provider Services.

EDI Companion Documents

UnitedHealthcare Community Plan’s companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan’s business purposes when the IG allows multiple choices.
- Provide values the health plan will return in outbound transactions.
- Outline which situational elements the health plan requires.

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.



The companion documents are located on [UHCprovider.com/edi](https://www.UHCprovider.com/edi) > Go to companion guides

Importance and Usage of EDI Acknowledgment/Status Reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.



To get your reports, make sure your software vendor has connected to our clearinghouse OptumInsight at enshealth.com.

If you are not yet an OptumInsight client, we will tell you how to receive Clearinghouse Acknowledgment Reports.

e-Business Support

UnitedHealthcare Community Plan offices are open 8 a.m. – 9 p.m. (EST), Monday through Friday. They can help you with Electronic Remittance Advices (ERAs) and Electronic Funds Transfers (EFTs). To use ERAs, you must enroll through a clearinghouse or entity that uses OptumInsight.

Support is also available for [EDI Claims](#) and [EDI Log-on Issues](#).

Find more information at UHCprovider.com/edi to find the Electronic Data Interchange menu.

IMPORTANT EDI PAYER INFORMATION

- Claim Payer ID: 87726
- ERA Payer ID: UFNEP

Completing the CMS 1500 Claim Form



Companion documents for 837 transactions are on UHCprovider.com/edi.

Visit the [National Uniform Claim Committee](#) website to learn how to complete the CMS 1500 form.

Completing the UB-04 Form

Bill all hospital inpatient, outpatient and emergency room services using revenue codes and the UB-04 claim form:

- Include ICD CM diagnosis codes.
- Identify other services by the CPT/HCPCS and modifiers.

Capitated Services

CAPITATED CARE PROVIDERS

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period of time. We pay you whether or not that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

We use the term “medical group/IPA” interchangeably with the term “capitated care providers.” Capitation payment arrangements apply to participating physicians, health care providers, facilities and ancillary care providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, and
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital they received emergency room treatment, observation or other outpatient hospital services.

We deny claims submitted with service dates that don't match the itemization and medical records. This is a billing error denial.

Form Reminders

- Note the Attending Provider Name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims.
- Send the Referring Provider NPI and name on outpatient claims when this care provider is not the Attending Provider.
- Include the attending provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims.
- Behavioral health care providers can bill using multiple site-specific NPIs.

Subrogation and Coordination of Benefit

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

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party causes the injury or illness.
- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

Hospital and Clinic Method of Billing Professional Services

Hospital and clinics must bill for professional services bill on a CMS 1500. The servicing provider's name is placed in box 31, and the servicing provider's group NPI number is placed in box 33a.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

COMPREHENSIVE AND COMPONENT CODES

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures:** Only report these codes when performed independently:
- **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services:** Don't report combinations where one code includes and the other excludes certain services.
- **Medical practice standards:** Services part of a larger procedure are bundled.
- **Laboratory panels:** Don't report individual components of panels or multichannel tests separately.

Clinical Laboratory Improvements Amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 410-786-3531 or go to the [cms.gov](https://www.cms.gov).

Billing Multiple Units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units.

- The total bill charge is the unit charge multiplied by the number of units.

Billing Guidelines for Obstetrical Services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we will deny the claim:

- If billing for both delivery and prenatal care, use the date of delivery.
- Use one unit with the appropriate charge in the charge column.
- Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Billing Guidelines for Transplants

DMAS covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation.

Ambulance Claims (Emergency)

Ambulance claims must include the point of origin, destination address, city, state, and ZIP.

National Drug Code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed.
- HCPCS/CPT code and units of service for the drug billed.
- Actual metric decimal quantity administered.

Submit the NDC on all claims with procedure codes for

care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes.

Medical Necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See Chapter 4 for more information about medical necessity.

Place of Service Codes

Go to [CMS.gov](https://www.cms.gov) for Place of Service codes.

Asking About a Claim

You can ask about claims through UnitedHealthcare Community Plan Provider Service and the UnitedHealthcare Community Plan Provider Portal. To access the portal, go to UHCprovider.com. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

PROVIDER SERVICE

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

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern. Limit phone calls to five issues per call.

UNITEDHEALTHCARE COMMUNITY PLAN PROVIDER PORTAL

You can view your online transactions with Link by signing in to Link on UHCprovider.com with your Optum ID. This portal offers you with online support any time. If you are not already registered, you may do so on the website.

LINK: YOUR GATEWAY TO UNITEDHEALTHCARE COMMUNITY PLAN ONLINE PROVIDER TOOLS AND RESOURCES


Link lets you move quickly between applications. This helps you:

- Check member eligibility.
- Submit claims reconsiderations.
- Review coordination of benefits information.
- Use the integrated applications to complete multiple transactions at once.
- Reduce phone calls, paperwork and faxes.

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

Find Link training on [UHCprovider.com](https://www.uhcprovider.com).

Resolving Claim Issues

 To resolve claim issues, contact [Provider Services](#), use Link or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5230
Kingston, NY 12401

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

FOR PAPER CLAIMS

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:

- Member name.
- Date of service.
- Claim date submission (within the timely filing period).

TIMELY FILING

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier.
- Another carrier's explanation of benefits.

- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service.

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Unless otherwise specified in your contract, UnitedHealthcare Community Plan must receive all information necessary to process your claims no more than 365 days from the date of discharge from a facility; or 365 days from the date services are rendered to the UnitedHealthcare Community Plan CCC Plus or Medallion enrollee. Any claims received after this time may be rejected for payment at UnitedHealthcare Community Plan's discretion.

United Healthcare Community Plan will pay claims for health services in accordance to the contractual agreement.

Balance Billing

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ.
- We deny a claim for late submission, unauthorized service or as not medically necessary.
- UnitedHealthcare Community Plan is reviewing a claim.

You are able to balance bill the member for non-covered services if the member provides written consent prior to getting the service. Members do not have a cost share other than the established patient pay amount. If you have questions, please contact your provider advocate.



If you don't know who your provider advocate is, email [VA PR Team@uhc.com](mailto:VA_PR_Team@uhc.com). A provider advocate will get back to you.

Chapter 12: Claim Reconsiderations, Appeals and Grievances

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

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

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	PROVIDER CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Member Appeal	A request to change an adverse benefit determination that we made.	<ul style="list-style-type: none"> Member Care provider on behalf of a member with member's written consent Member's authorized representative (such as friend or family member) with written member consent 	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHC provider.com	CCC Plus: 877-843-4366 Fax: 866-622-1428 Medicaid/ FAMIS Phone: 844-284-0146 Fax: 801-994-1082	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	Expedited appeals – must receive within 5 business days. Standard appeals-60 business days	Expedited appeals We will respond within 72 hours Standard appeals = 30 days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	PROVIDER CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Member Grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns.	<ul style="list-style-type: none"> • Member • Care provider on behalf of a member with member consent • Member's authorized representative (such as friend or family member) with written member consent 	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHC provider.com	CCC Plus 877-843-4366 Fax: 866-622-1428 Medicaid/ FAMIS Phone: 844-284-0146 Fax: 801-994-1082	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	N/A	30 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS								
SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	PROVIDER CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Care Provider Claim Resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission	Care Provider	UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402-5240	UHC provider.com	CCC Plus: Phone: 877-843-4366 Fax: 866-622-1428 Medicaid/ FAMIS: Phone: 844-284-0146 Fax: 844-882-7133	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	For network providers: timely filing limit is based on the contract. For out of network providers: If claim is submitted 12 months after services rendered, then the claim is denied. Resubmitted claims will be accepted within 365 days of the date of service or within 180 days from the last PRA date within 365 days of the date of service, whichever is later.	30 business days

APPEALS AND GRIEVANCES STANDARD DEFINITIONS AND PROCESS REQUIREMENTS

SITUATION	DEFINITION	WHO MAY SUBMIT?	SUBMISSION ADDRESS	ONLINE FORM FOR FAX OR MAIL	PROVIDER CONTACT PHONE NUMBER/ FAX	WEBSITE (Care Providers Only) for Online Submissions	CARE PROVIDER FILING TIMEFRAME	UnitedHealthcare Community Plan RESPONSE TIMEFRAME
Care Provider Claim Reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care Provider	UnitedHealthcare Community Plan P.O. Box 5270 Kingston, NY 12402-5240	UHC provider.com	CCC Plus: Phone: 877-843-4366 Fax: 866-622-1428 Medicaid/ FAMIS: Phone: 844-284-0146 Fax: 844-882-7133 Provider Services can create reconsideration requests to send to the rework team.	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	For network providers: timely filing limit is based on the contract. For out of network providers: If claim is submitted 12 months after services rendered, then the claim is denied. Reconsiderations are accepted within 365 days from the date of service or 180 days from the last time the claim was processed, whichever is later.	45 business days
Care Provider Claim Formal Appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care Provider	UnitedHealthcare Community Plan Grievances and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364	UHC provider.com	CCC Plus: 844-752-9434 Fax: 801-994-1082 Medicaid/ FMAS 844-284-0146 Fax: 801-994-1082	Use the Claims Management or ClaimsLink application on Link. To access Link, go to UHCprovider.com/link .	30 days from last adverse determination	30 business days

The above definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

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

Denial

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

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

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

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

Other top reasons for denial include:

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

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

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

Claim not covered by UnitedHealthcare Community Plan. Avoid claim denials for non-covered services using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim Correction

What is it?

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

When to use:

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

How to use:

Use the claims reconsideration application on Link. To access Link, sign in to UHCprovider.com using your Optum ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5240

Additional Information:

When correcting or submitting late charges on 837 institution claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim.

Resubmitting a Claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address.
- Errors in care provider data.
- Wrong member insurance ID.
- No referring care provider ID or NPI number.

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5240

Warning! If your claim was denied and you resubmit it, you will receive a [duplicate claim rejection](#). A denied claim has been through claim processing and we determined it cannot be paid. You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Claim Reconsideration (step one of dispute)

What is it?

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

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

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

For medical necessity denials:

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

How to use:

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

- **Electronically:** Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link.
- **Phone:** Call Provider Services at **877-843-4366** – CCC Plus Provider Services, **844-284-0146** – Medallion Provider Services or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.
- Mail: Submit the Claim Reconsideration Request Form to:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5240

This form is available at UHCprovider.com.

- Fax: Send the Claim Reconsideration Request Form to **801-994-1224**.

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?

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

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

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

How to use:

Submit a reconsideration request electronically, phone, mail or fax with the following information:

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

Additional Information:

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

Appeals (step two of dispute)

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

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

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically, by mail or fax. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use the Claims Management or ClaimsLink application on Link. You may upload attachments.
- **Mail:** Send the appeal to:
UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364
- **Fax:** Send the appeal to **801-994-1082**.

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

TIPS FOR SUCCESSFUL CLAIMS RESOLUTION

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved.
- Call [Provider Services](#) if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call [Provider Services](#).
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Overpayment

What is it?

An overpayment happens when we overpay a claim you don't dispute.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call Provider Services.

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

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number.

Where to send:

Mail refunds with an Overpayment Return Check or the Return Overpayment through Adjustment Request form to:

UnitedHealthcare Community Plan

ATTN: Recovery Services

P.O. Box 740804

Atlanta, GA 30374-0800

Instructions and forms are on UHCprovider.com.

If you do not agree with the overpayment findings, submit a dispute within the required timeframe as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

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

***The information provided is sample data only for illustrative purposes.**

Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of Service	Original Claim #	Date of Payment	Paid Amount	Amount of Overpayment	Reason for Overpayment
11111	01/01/14	14A000000001	01/31/14	115.03	115.03	Double payment of claim
2222222	02/02/14	14A000000002	03/15/14	279.34	27.19	Contract states \$50, claim paid 77.29
3333333	03/03/14	14A000000003	04/01/14	131.41	99.81	You paid 4 units, we billed only 1
44444444	04/04/14	14A000000004	05/02/14	412.26	412.26	Member has other insurance
55555555	05/05/14	14A000000005	06/15/14	332.63	332.63	Member terminated

Provider Grievance

What is it?

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

When to file:

You may file a grievance about:

- Benefits and limitations.
- Eligibility and enrollment of a member or care provider.
- Member issues or UnitedHealthcare Community Plan issues.
- Availability of health services from UnitedHealthcare Community Plan to a member.
- The delivery of health services.
- The quality of service.

How to file:

File verbally or in writing.

- **Phone:** Call Provider Services toll free at:
 - 877-843-4366 – CCC Plus Provider Services
 - 844-284-0146 – Medallion Provider Services
- **Mail:** Send care provider name, contact information and your grievance to:

UnitedHealthcare Community Plan
Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

Member Appeals and Grievances Definitions and Procedures

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

APPEALS

What is it?

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

You or a member may appeal when the plan:

- Makes a harmful determination or limits a requested service(s). This includes the type or level of service.
- Lowers, suspends or ends a previously authorized service.
- Refuses, in whole or part, payment for services.
- Fails to provide services in a timely manner, as defined by the state or CMS.
- Doesn't act within the time frame CMS or the state requires.

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

Call, mail or fax the information within 60 calendar days from the date the service was denied to:

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

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

Fax: **800-757-2617**

Member can appeal in person Monday through Friday, 8 a.m. to 5 p.m. ET at:

9020 Stony Point Parkway, Building II
Richmond, VA 23235

How to use:

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

- Receive a copy of the rule used to make the decision.
- Ask someone (a family member, friend, lawyer, health care provider, UnitedHealthcare Community Plan, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- The member or representative may review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal.

- Ask for an expedited appeal if waiting for this health service could harm the member's health. You have two business days to provide certification of the appeal and evidence in person or in writing. Provider certification is a written confirmation from you that the expedited request is urgent.
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service.
- We must resolve a standard appeal 30 calendar days from the day we receive it.
- We must resolve an expedited appeal two working days from when we receive it. We may extend the response up to 14 calendar days if the following conditions apply:
 1. Member requests we take longer.
 2. We request additional information and explain how the delay is in the member's interest.

MEMBER GRIEVANCE

What is it?

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

When to use:

You may file a grievance as the member's representative.

Where to send:

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

Mailing address:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

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

State Fair Hearings

What is it?

A Fair Hearing lets members share why they think VA Medicaid services should not have been denied, reduced or terminated.

When to use:

Members have 120 calendar days from the appeal resolution letter to ask for a hearing. At that point, they will be mailed a hearing form. Once they complete the form and send it back, we set a hearing date.

How to use:

The UnitedHealthcare Community Plan member may ask for a state fair hearing by writing a letter to:

**Department of Medical Assistance
Services (DMAS)**
Appeals Division
600 E Broad Street
Richmond, VA 23219

- The member may ask UnitedHealthcare Community Plan Customer Service for help writing the letter.
- The member may have someone attend with them. This may be a family member, friend, care provider or lawyer.
- Hearings are held on the phone. Members may go to the local Family Support Division office for the hearing or take part from home.

Processes Related to Reversal of Our Initial Decision

If the State Fair Hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, we authorize or provide the disputed services as quickly as the member's health condition requires. If the decision reverses denied authorization of services and the disputed services were received pending appeal, we pay for those services as specified in policy and/or regulation.

Fraud, Waste and Abuse



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

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection

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

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

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



Find the UnitedHealth Group policy on Fraud, Waste and Abuse at uhc.com/fraud or call **866-242-7727**.

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

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and

abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

EXCLUSION CHECKS

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

- [Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities \(LEIE\)](#)
- [General Services Administration \(GSA\) System for Award Management](#)

WHAT YOU NEED TO DO FOR EXCLUSION CHECKS

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Chapter 13: Care Provider Communications & Outreach

The UnitedHealthcare Community Plan care provider education and training program is built on years of experience with you and the Commonwealth of Virginia's Medicaid managed care program. It includes the following care provider components:

- Website
- Forums/town hall meetings
- Office visit
- Newsletters and bulletins
- Manual

Care Provider Websites

UnitedHealthcare Community Plan promotes the use of web-based functionality among its provider population. The UHCprovider.com portal facilitates care provider communications related to administrative functions. Our interactive website empowers you to electronically determine member eligibility, submit claims, and view claim status.

We have also implemented an internet-based prior authorization system on UHCprovider.com. This site lets you request medical and advanced outpatient imaging procedures online rather than by phone. The website also has:

- An online version of this manual
- Clinical practice guidelines (which cover diabetes, ADHD, depression, preventive care, prenatal, and other guidelines)
- Electronic data interchange
- Quality and utilization requirements

- Educational materials such as newsletters and bulletins
- Provider service updates – new tools and initiatives (UHC on Air, PreCheck MyScript, etc.)

In addition, we have created a member website that gives access to the Member Handbook, newsletters, provider search tool and other important plan information. It is UHCCommunityPlan.com > select Member.

Care Provider Office Visits

Care Provider Advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a care provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care Provider Newsletters and Bulletins

UnitedHealthcare Community Plan produces a care provider newsletter to the entire Virginia network at least four times a year. The newsletters include articles about:

- Program updates
- Claims guidelines
- Information regarding policies and procedures
- Cultural competency and linguistics
- Clinical practice guidelines
- Special initiatives
- Emerging health topics

The newsletters also include notifications about changes in laws and regulations. UnitedHealthcare Community Plan posts electronic bulletins on [UHCprovider.com/news](https://www.uhcprovider.com/news) to quickly share urgent information that affects the entire network.



Find more information about the Network Bulletin, Medical Policy Update Bulletin and other communications on [UHCprovider.com/guides](https://www.uhcprovider.com/guides) > Provider Communication Chapter 17.

Care Provider Manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for Provider Services, a removable quick reference guide and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

Find the following forms on the state's website at [virginiamedicaid.dmas.virginia.gov/](https://www.virginiamedicaid.dmas.virginia.gov/):

- Sterilization Consent Form
- Informed Consent for Hysterectomies Form
- Provider Service Agreement (MC 19 Form)

Chapter 14: Glossary

ABD

Aged, blind, disabled

Abuse (by care provider)

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

Abuse (of member)

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

Action

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

Acute Inpatient Care

Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Advance directive

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

Ambulatory Care

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

Ambulatory Surgical Facility

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

Ancillary Provider Services

Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Appeal

A member request that their health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Authorization

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

Billed Charges

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

Capitation

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

Case Manager

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

Centers for Medicare & Medicaid Services (CMS)

A federal agency within the U.S. Department of Health and Human Services that administers Medicare, and Medicaid programs.

Clean Claim

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

CMS

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

Contracted Health Professionals

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

Coordination of Benefits (COB)

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

Covered Services

The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

Credentialing

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

Current Procedural Terminology (CPT) Codes

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

Delivery System

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

Disallow Amount (Amt)

Network provider should not receive payment from UnitedHealthcare Community Plan for medical charges or bill the member. Examples are:

- The difference between billed charges and in-network rates.

- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits.

Discharge Planning

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

Disenrollment

The discontinuance of a member's eligibility to receive covered services from a contractor.

Dispute

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

Durable Medical Equipment (DME)

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

Early Periodic Screening Diagnosis and Treatment Program (EPSDT)

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

Electronic Data Interchange (EDI)

The electronic exchange of information between two or more organizations.

Electronic Funds Transfer (EFT)

The electronic exchange of funds between two or more organizations.

Electronic Medical Record (EMR)

An electronic version of a member's health record and the care they have received.

Eligibility Determination

Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency Care

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

Encounter

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

Enrollee

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

Enrollment

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

Evidence-Based Care

An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited Appeal

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

Expedited Grievance

A grievance where delay in resolution could harm the member's health or life.

FAMIS

Family Access to Medical Insurance Security program.

Fee For Service (FFS)

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

FHC

Family Health Center

Fraud

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

Grievance

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

Health Plan Employer Data and Information Set (HEDIS)

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

HIPAA

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

Home Health Care (Home Health Services)

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

In-Network Provider

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

Medicaid

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

Medical Emergency

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

- Their health would be put in serious danger; or

- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body.

Medically Necessary

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

Member

An individual who is eligible and enrolled with UnitedHealthcare Community Plan and receives services pursuant to the Agreement.

NPI

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

Out-Of-Area Care

Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Preventative Health Care

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

Primary Care Provider (PCP)

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

Prior Authorization (Notification)

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

Provider Group

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

Quality Management (QM)

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

Rural Health Clinic

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

Service Area

The geographic area served by UnitedHealthcare Community Plan, designated and approved by Virginia DMAS.

Specialist

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

State Fair Hearing

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

TANF

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

Third-Party Liability (TPL)

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

Timely Filing

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

Title XIX

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

UnitedHealthcare Community Plan

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

Utilization Management (UM)

Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Appendix

CENTRAL REGION					
007	AMELIA	085	HANOVER	730	PETERSBURG
025	BRUNSWICK	087	HENRICO	145	POWHATAN
033	CAROLINE	670	HOPEWELL	147	PRINCE EDWARD
036	CHARLES CITY	097	KING AND QUEEN	149	PRINCE GEORGE
041	CHESTERFIELD	099	KING GEORGE	760	RICHMOND CITY
570	COLONIAL HEIGHTS	101	KING WILLIAM	159	RICHMOND CO.
49	CUMBERLAND	103	LANCASTER	175	SOUTHAMPTON
053	DINWIDDIE	111	LUNENBURG	177	SPOTSYLVANIA
595	EMPORIA	115	MATHEWS	179	STAFFORD
057	ESSEX	117	MECKLENBURG	181	SURRY
620	FRANKLIN CITY	119	MIDDLESEX	183	SUSSEX
630	FREDERICKSBURG	127	NEW KENT	193	WESTMORELAND
075	GOOCHLAND	133	NORTHUMBERLAND		
081	GREENSVILLE	135	NOTTOWAY		

TIDEWATER REGION					
001	ACCOMACK	095	JAMES CITY CO.	740	PORTSMOUTH
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	131	NORTHAMPTON	830	WILLIAMSBURG
093	ISLE OF WIGHT	735	POQUOSON	199	YORK

NORTHERN & WINCHESTER REGION					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER

CHARLOTTESVILLE WESTERN REGION					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBERG		
540	CHARLOTTESVILLE	113	MADISON		

ROANOKE/ALLEGHANY REGION					
005	ALLEGHANY	067	FRANKLIN CO.	155	PULASKI
017	BATH	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
063	FLOYD	141	PATRICK		

SOUTHWEST REGION					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE