Delaware 2017

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

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

Easily find information in this manual using the following steps:
1. CTRL+F.
2. Type in the key word.
3. Press Enter.

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

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

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

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

We amend the manual as policies change.
Our Structure and Administration

Welcome to Delaware’s State Government Health Care Benefits Program, otherwise known as UnitedHealthcare Community Plan.

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

Our goal is to help ensure our members have convenient access to high quality care provided according to the most current and efficacious treatment protocols available. We are committed to working with and supporting you and your staff to achieve the best possible health outcomes for our members. If you have any questions about the information or material in this administrative guide or about any of our policies or procedures, please do not hesitate to contact the Provider Services Line at 800-600-9007.

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

About This Manual

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

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<th><strong>UnitedHealthcare Community Plan Website</strong></th>
<th><strong>UHCCommunityPlan.com</strong></th>
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<tr>
<td>Manuals and forms, newsletters, bulletins, Electronic Data Interchange (EDI)</td>
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<tr>
<th><strong>UnitedHealthcare Website</strong></th>
<th><strong>UHCprovider.com</strong></th>
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<tr>
<td>Access online transactions for your patients enrolled in a UnitedHealthcare product, including Medicaid, commercial and Medicare.</td>
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<tr>
<th><strong>Administrative Office</strong></th>
<th>4051 Ogletown Road, Suite 200 Newark, DE 19713</th>
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<tr>
<th><strong>Provider Services</strong></th>
<th>800-600-9007</th>
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<tr>
<td>Representatives are available Monday through Friday, 8 a.m. to 5 p.m. (ET).</td>
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<tr>
<th><strong>Interactive Voice Response Line</strong></th>
<th>800-600-9007</th>
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<td>Check claim status, member eligibility and access benefits self-service.</td>
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<th><strong>Utilization Management (UM)</strong></th>
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<tr>
<td>Staff is available Monday through Friday, 8 a.m. to 5 p.m. (ET), to assist with routine prior authorizations, admissions, discharges and coordination of members’ care. On-call staff is available 24/7 for emergency prior authorization purposes.</td>
<td>800-366-7304 877-877-8230 (fax)</td>
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<tr>
<th><strong>Member Services</strong></th>
<th>Medicaid: 877-877-8159, TTY 711 Medicaid Long Term Care (LTC): 877-542-9248, TTY 711</th>
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<tr>
<td>Representatives are available Monday through Friday, 8 a.m. to 7 p.m. ET.</td>
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<tr>
<th><strong>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</strong></th>
<th>877-877-8159</th>
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<td>For UnitedHealthcare Community Plan Medicaid members under 21 years of age.</td>
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<tr>
<th><strong>Routine Non-Emergent Transportation</strong></th>
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<td>Logisticare</td>
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<tr>
<th><strong>Care Management Services</strong></th>
<th>Medicaid Providers: Contact Member Services at 877-877-8159 (TTY 711) to receive more information about programs available to eligible members. Medicaid LTC Providers: Contact LTC Care Management at 855-821-9102 (TTY 711) to receive more information about programs and services available to eligible LTC members.</th>
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<tr>
<td>Representatives are available Monday through Friday, 8 a.m. to 5 p.m. (ET).</td>
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<tr>
<th><strong>Healthy First Steps (Pregnancy) Program</strong></th>
<th>800-599-5985 877-353-6913 (fax)</th>
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<tr>
<td>Representatives are available Monday through Friday, 8 a.m. to 5 p.m. (ET). It is critical that we receive the Healthy First Steps™ Obstetrical Health Risk Assessments via fax.</td>
<td>877-844-8844 TTY 711 877-215-9811 (fax)</td>
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<tr>
<th><strong>Special Needs Unit (SNU)</strong></th>
<th>800-600-9007</th>
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<tr>
<td>To help care providers and members with special medical, behavioral and social conditions access health care benefits and community resources.</td>
<td>877-614-0484</td>
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<tr>
<th><strong>OptumHealth Behavioral Solutions (United Behavioral Health) Provider Network Management</strong></th>
<th>866-261-7692</th>
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<tr>
<td>For inquiries related to credentialing, demographic updates or adding a new provider to your practice.</td>
<td>800-842-4195</td>
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<tr>
<th><strong>OptumHealth Behavioral Solutions (United Behavioral Health) Provider Clinical Authorization Line</strong></th>
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<td>855-609-5152</td>
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<tr>
<th><strong>Pharmacy</strong></th>
<th>Pharmacy is covered by UnitedHealthcare Community Plan.</th>
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<td>800-609-5152</td>
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<th><strong>Dental</strong></th>
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<td>Age 20 and younger: covered by Delaware Medicaid. Age 21 and older: covered by UnitedHealthcare.</td>
<td>855-609-5152</td>
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*Note: Practitioner is defined as an individual provider of clinical services. Provider is a broader term that also includes institutional or ancillary facilities.*
1: UnitedHealthcare Websites

**UHCCCommunityPlan.com**

You can access UnitedHealthcare Community Plan’s website at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) by selecting “For Health Care Professionals” at the top of the page and selecting Delaware.

Once you have selected Delaware, you can navigate through several tabs on the left-hand side of the page, such as:

- Provider Information
- Clinical Practice Guidelines
- Electronic Data Interchange (EDI)
- Reimbursement Policy
- Newsletters
- Bulletins

**Secure Provider Website**

All online transactions for UnitedHealthcare Community Plan members are accessible through Link at [UHCprovider.com](http://UHCprovider.com). If you are not registered, you may do so directly on the [UHCprovider.com](http://UHCprovider.com) home page. This secure portal offers an innovative suite of online health care management tools. Use of this website is intended for Community Plan providers, facilities and medical administrative staff and offers the convenience of online support anytime.

The provider portal can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.

**Link**

To access to Link, the secure provider website, please go to [UHCprovider.com](http://UHCprovider.com) and either sign in or create a user ID for Link. You will receive your user ID and password within 48 hours.

On the secure provider website, you may:

- Verify member eligibility including secondary coverage
- Review benefits and coverage limit
- Check prior authorization status
- Submit claims
- Check claim status
- View your panel roster
- Access remittance advice and review recoveries
- Review your preventive health measure report
- Access the EPSDT toolset
- Submit demographic profile change
- Reduce your time on the phone
2: Eligibility and Membership Information

2.1 Enrollment

UnitedHealthcare Community Plan is only offered to eligible Medical Assistance (MA) recipients, as determined by the Department of Social Services. Enrollment for the managed Medicaid program is done by the Health Benefits Manager (HBM). Once enrolled, the recipient will be pre-nominated by random assignment to a Medicaid or Delaware Healthy Children Program (DHCP) managed care plan. If the member does not respond within 30 days, the member is auto-assigned to one of the state’s Medicaid plans. Members auto-assigned to a health plan have the option of changing their health plan for up to 90 days after enrollment.

Under the program, an independent enrollment assistance program specialist is available in local State Services Centers to distribute materials describing the UnitedHealthcare Community Plan program and its benefits. Potential members meet with the enrollment representative to discuss rights and responsibilities of being a UnitedHealthcare Community Plan Medicaid member. The potential member may choose to complete an application for enrollment. The enrollment broker submits enrollment applications to HBM for enrollment approval. HBM will then establish an HMO membership effective date. Initial effective dates will be the first of the calendar month following the receipt of enrollment application approval.

Open enrollment is held in May of each year, at which time members choose a health plan. UnitedHealthcare Community Plan has a continuous enrollment process for new Medicaid Managed Care (MMC) members who have been enrolled by HBM as noted above. Newborns may also be enrolled in UnitedHealthcare Community Plan after the mother notifies the case worker or Change Report Center of the birth and completes the enrollment process. Babies can only be enrolled in UnitedHealthcare Community Plan if the mother was enrolled in the Plan for the birth month; otherwise, the baby would need to wait until the following month before enrolling. Members may transfer to or from UnitedHealthcare Community Plan for good cause, as determined by the Delaware Health and Social Services’ Division of Medicaid & Medical Assistance (DMMA).

2.2 Diamond State Health Plan Plus (DSHP Plus) – Delaware Medicaid Long Term Care Enrollment

The Division of Medicaid & Medical Assistance (DMMA) determines eligibility for enrollment in the Delaware Medicaid Long-term Care (LTC) program (DSHP Plus). All referrals are handled at one central intake unit to review medical and financial eligibility to determine if the individual meets the level of care threshold and financial eligibility. Once the member is approved for enrollment, they are required to select a managed care organization.

The DSHP Plus expansion of Medicaid managed care includes the following DMMA populations:

- Individuals who are determined medically and financially eligible for long term care services (i.e. they require a nursing facility level of care AND have income at or below 250% of the SSI standard and countable assets below $2,000), who:
  - Choose to receive services in the community (under the former Elderly & Disabled or AIDS 1915(c) Home & Community-Based Waiver programs) or
  - Choose to receive services in a nursing facility, including pediatric nursing facilities
- Individuals who are medically eligible for out-of-state rehabilitation hospital services and have income at or below 250% of the Supplemental Security Income (SSI) standard.
- Full benefit dual eligibles (Medicaid + Medicare) living in the community.

DMMA’s medical Pre-Admission Screening (PAS) units determine whether individuals require the level of care necessary to receive LTC services. By Federal mandate, all individuals applying for placement in a Medicaid certified nursing facility, regardless of pay source, must have a Level I Pre-Admission Screening and Resident Review (PASRR) for Mental Illness (MI) or Mental Retardation (MR). Based on results of a Level I PASRR Screening, the PAS nurse may determine that further screening, a Level II PASRR, is warranted prior to determination of a level of care.
DMMA’s financial eligibility units determine whether individuals meet the income and resource criteria. Once determined eligible for Medicaid, the client or their representative is required to report any changes in status (death, change in residence, family size, income, job status, etc.) to DSS or DMMA LTC Medicaid.

2.3 Member Health Care ID Cards

Every UnitedHealthcare Community Plan member receives a personal member health care identification (ID) card. When more than one member of a family enrolls, UnitedHealthcare Community Plan issues a separate ID card to each member. All member ID cards display the UnitedHealthcare Community Plan logo, Member Services number, the Primary Care Provider’s (PCP’s) name and telephone number (if applicable), the member’s name and the member’s Delaware Medicaid ID number. The back of the health care ID card lists the utilization management number, the claims submission address and instructions to members about accessing routine and emergency care.

The member should present their member health care ID card whenever seeking UnitedHealthcare Community Plan covered services. No member should be denied services because of a failure to have a member health care ID card at the time of service, though. You can verify eligibility by calling 800-600-9007. A PCP who believes that an incorrect PCP name is listed on the member card can call to confirm the PCP and verify the member’s eligibility. The following are examples of the UnitedHealthcare Community Plan of Delaware member health care ID cards.

On the front of the member’s health care ID card, we list the plan in which the member is enrolled.

For our basic Medicaid population (non-DSHP Plus), “UnitedHealthcare Community Plan for Families” or “UnitedHealthcare Community Plan for Kids” (for Delaware Healthy Children Program-DHCP) will be shown in the bottom right corner on the front of the member’s ID card. These members are eligible for our basic Medicaid Benefits.

There are two different versions of the health care ID card for Long Term Care members (those enrolled in DSHP Plus) depending on their level of care:

• If the member has “Diamond State Health Plan - Plus” only in the top right corner of the card, they have not met the Long Term Care level of care and have the basic Medicaid benefit plan, but have Medicare as their primary insurance. The bottom-right corner of the front of their health care ID card will read “UnitedHealthcare Community Plan for Families.”

• If the member has met the Long Term Care level of care, “Diamond State Health Plan - Plus LONG TERM CARE” is shown in the top-right corner of their card, and “UnitedHealthcare Community Plan – Long Term Care” is shown in the bottom-right. These members are eligible for both the basic and enhanced Medicaid benefits.
2: Eligibility and Membership Information

**Medicaid Member Health Care ID Cards**

**Medicaid DHSP Plus Member Health Care ID Card – Dual (Medicare/Medicaid)**

**Medicaid DHSP Plus Long Term Care Member Health Care ID Card, Non-dual (Medicaid)**

**Medicaid DHSP Plus Long Term Care Member Health Care ID Card, Dual (Medicare/Medicaid)**
2: Eligibility and Membership Information

2.4 Eligibility Verification

You are responsible for checking the member's eligibility at the time of service. This includes eligibility with UnitedHealthcare Community Plan and assignment to you as a Primary Care Provider (PCP). To verify a member's enrollment with us, and the member's PCP:

- Verify on the monthly member roster sent to PCP offices before the first of every month. New member additions to the practice will be indicated by an asterisk.
- Use the Link eligibility application on UHCprovider.com.
- Call Provider Services at 800-600-9007. You can also get COB information. Before calling, be sure to have your UnitedHealthcare Community Plan provider number, the member’s UnitedHealthcare Community Plan ID number (or Social Security number) and the member's date of birth.

2.5 Primary Care Provider Selection

Every member enrolling in UnitedHealthcare Community Plan must select a participating PCP (unless the member is a Dual Eligible Medicaid LTC member and has both Medicare and Medicaid). Within one week of enrollment we attempt to reach the member to either verify their PCP selection, or encourage them to make one. We also verify the member’s demographic information and reinforce education of membership responsibilities, the role of the PCP and general health plan guidelines. If a new member does not select a PCP, we assign the member to a PCP based on geographic location. The member may change this selection later for any reason.

Members may change or verify their PCP at any time by calling Member Services; although we encourage members to select a PCP they intend to remain.

2.6 Primary Care Provider – Initiated Transfers

As a PCP, you may recommend that a member be removed from your practice due to member non-compliance or a failure to establish a mutually beneficial relationship. You must have made reasonable efforts (three attempts within 90 days) to accommodate the member. You may not use the member's health status as cause to transfer a member. To transfer a member, you must submit a written request to Provider Relations. Upon receipt of the request, Member Services will contact the member to facilitate selection of a new PCP. The representative will address educational issues as necessary. The new PCP effective date and a new member health care ID card are issued as soon as possible. You may be required to provide care to the member for up to 30 days from our receipt of the request or until a new PCP is chosen. A new PCP will be selected for the member if we are unable to contact the member by telephone. A letter is sent to the member indicating the name of the new PCP and the reasons for the change.

2.7 Primary Care Provider (PCP) Member Rosters

PCPs receive a monthly roster of members who have chosen their practice for primary care services. The lists are sent to PCP offices before the first of every month. New member additions to the practice will be indicated by an asterisk. Termination dates of members who are disenrolling from the plan or practice will also be indicated. Consulting care providers do not receive monthly rosters. We recommend that all PCPs and consulting care providers verify member eligibility prior to each service by calling Provider Services, or visiting UHCprovider.com.
2.8 Member Rights and Responsibilities

All members have certain rights and responsibilities which are listed below.

Members have the right to:

• Pick their own Primary Care Provider (PCP) within the UnitedHealthcare Community Plan care provider network;
• Ask for and get information about UnitedHealthcare Community Plan, our services, participating care providers, providers' and members' rights and responsibilities and how to use their benefits;
• Get quality health care and be treated with respect and due consideration for their dignity and privacy;
• Participate with practitioners in making decisions about their health care;
• Know the names, titles and educational backgrounds of all physicians and others helping them;
• Understand their medical and health needs, what should be done for them, what choices they have and what risks are involved;
• Receive free language assistance if they speak another language or are hearing impaired;
• Say no to treatment and to take the responsibility for the consequences of saying no to treatment;
• Not have their medical records shown to others without their approval, unless permitted by law, and be told who has been given a copy of their medical records;
• Have their privacy respected during an office visit, when getting treatment or when talking to UnitedHealthcare Community Plan;
• See all their medical records in accordance with applicable federal and state laws, and have these records kept private;
• Ask that corrections be made to their medical records if they notice a mistake;
• Have an advance directive;
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
• Make recommendations to improve UnitedHealthcare Community Plan's procedures, policies, member rights and member responsibilities;
• Get a second opinion from a qualified participating care provider or a non-participating care provider, if a participating care provider is not available;
• Be told in writing when any of their covered services are reduced, suspended, terminated or denied;
• File an appeal regarding any medical or administrative decisions if they disagree;
• Be sure their PCP and the staff of UnitedHealthcare Community Plan know their rights;
• Have these rights regardless of gender, culture, economic status, education, race, ethnicity, age, national origin, sexual orientation, physical or mental disability, type of illness or condition, ability to pay, ability to speak English or religious background;
• Receive information on treatment options, alternatives and costs whether the treatment is covered or not;
• Know how we pay our providers, control costs and make decisions about which services are covered;
• Get emergency care without having to get a prior approval when they have a true medical emergency; and
• Voice a grievance (complaint) about the health plan or the care it provides.

Members have the responsibility to:

• Let Medicaid, Delaware Healthy Children Program (DHCP) and UnitedHealthcare Community Plan know if they or a family member changed a name, address or phone number;
• Let Medicaid, DHCP and UnitedHealthcare Community Plan know if they have a change in family size, if they or a family member loses a job or changes jobs, if a member becomes employed, or if they have other health insurance;
• Call the local Medicaid office in the county where they live and give them all of their new information if it changes;
2: Eligibility and Membership Information

- Respect the doctors, staff and people giving them health care services;
- Be sure they are the only one who uses their member health care ID card and to let us know if it is lost or stolen;
- Be sure to show their UnitedHealthcare Community Plan and Medicaid ID cards each time they have a doctor’s appointment; if they have any other health care insurance, they must show their PCP the card for that too;
- Be sure to go to their assigned PCP for all of their non-emergency health care unless their PCP sends them to a specialist for care; if they are pregnant and do not wish to go to their PCP, they may go to an in-network obstetrician/gynecologist;
- Ask questions if they do not understand what their providers are saying to them and to participate in developing agreed upon treatment goals;
- Answer all questions and provide all information about their health that will help their PCP take care of them;
- Follow instructions for care that you have agreed to with your practitioner.
- Keep their scheduled health care appointments;
- Schedule and keep wellness checkups, including EPSDT (well-child) appointments for members younger than 21 years of age;
- Get care as soon as they learn they are pregnant and keep all pregnancy appointments;
- Give their doctor a copy of any advance directives, including a living will;
- Be on time and call their PCP’s office at least 24 hours in advance, when possible, if they need to cancel an appointment;
- Let their PCP know when they went to the emergency room, or have someone do it for them, within 24 hours of emergency care;
- Let us know if they have another insurance company that may pay for their medical care for any reason (health, auto, home or workers’ compensation, for example); and
- Give their approval for us to use their health information.

2.9 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.
3: Participating Provider Responsibilities

3.1 General Requirements

In contracting with UnitedHealthcare Community Plan, all care providers (practitioners, other health professionals, hospitals, facilities and agencies) agree to:

- Never bill UnitedHealthcare Community Plan members for covered services. Sending bills or balance bills to UnitedHealthcare Community Plan members for covered services is a violation of your Participating Provider Agreement with UnitedHealthcare Community Plan and violates Delaware law and regulation. Instruct your office staff to ask for appropriate documentation of a patient’s insurance coverage and accurately maintain this information in all billing systems. If your office has not received payment for covered services provided to a UnitedHealthcare Community Plan member, call 800-600-9007. UnitedHealthcare Community Plan’s participating providers may not seek compensation from a member unless:
  - The member is informed in advance that a proposed service is not a covered benefit; and
  - The member accepts financial responsibility, in a signed document that includes the services provided, the cost of non-covered services, notification that UnitedHealthcare Community Plan will not pay or be liable for said services, and notification that the member will be financially liable for such services;

- Advise patients who request services not covered by UnitedHealthcare Community Plan of their financial obligation for those services prior to rendering them;

- Offer access to office visits on a timely basis in compliance with the standards in this manual;

- Maintain medical records and patient confidentiality as outlined in this manual;

- Maintain malpractice insurance, all licenses and certifications required to practice and render services without any encumbrances, limitations or restrictions and provide copies of such licenses and certifications to UnitedHealthcare Community Plan for verification and (re)credentialing purposes;

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

- Respect the rights of UnitedHealthcare Community Plan members;

- Coordinate and provide in-office interpretation services for members that speak languages other than languages that the provider speaks. If you need assistance locating an interpreter, contact the Special Needs Unit (SNU). Interpreters provided by UnitedHealthcare Community Plan are covered at no cost to you. If you choose not to use an UHC Community Plan interpreter, you are obligated to cover the costs. Health care professionals or facilities cannot directly or indirectly impose a surcharge on an individual with limited English proficiency to offset the cost of the interpreter;

- Notify us of any change in office location, office hours or additional office locations at least 30 days prior to the date when services will be rendered at the new location(s);

- Notify us promptly of any changes in the information originally submitted in the application to participate in UnitedHealthcare Community Plan;

- Submit all data necessary to characterize the content and purpose of each member encounter. When you submit a claim or encounter information you are certifying the information is accurate, complete and truthful;

- Never employ or contract with individuals who are excluded from participation in any public sector health plan or with entities that employ or contract with such individuals;

- Be aware and comply with the following:
  - Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 C.F.R. Part 84
  - The Age Discrimination Act of 1975, as implemented by regulations at 45 C.F.R. Part 91
  - The Rehabilitation Act of 1973
  - The Americans with Disabilities Act
3: Participating Provider Responsibilities

- The informed consent procedures for hysterectomy and sterilization specified in 42 CFR, Part 441, sub-part F
- Other laws applicable to recipients of federal funds
- Standards set forth by the UnitedHealthcare Community Plan compliance program
- All other applicable laws and rules;
- Cooperate with and participate in UnitedHealthcare Community Plan QI and UM programs; and
- Notify Provider Relations when members miss appointments. When a member misses an appointment, you should complete a Member Education form (located on our provider website at UHCCommunityPlan.com). Provider Relations will review the form and forward it to Member Services to contact the identified member and discuss the member's responsibilities regarding appointments. For Medicaid LTC members, please contact the LTC Member Advocate at 877-901-5523 or the patient's Care Coordinator regarding member non-compliance. LTC Member Services may be reached at 877-542-9248; for LTC Care Management, call 855-821-9102.

3.2 Provider Office Standards

We require you to a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities Act (ADA) standards. The hours of operation that practitioners offer to Medicaid members must be no less than those offered to commercial members.

3.3 Allowable Office Waiting Times

The member's wait time should be no more than 45 minutes or up to one hour if you encounter an unanticipated urgent visit or is treating a member with a difficult medical need. Emergency cases should be seen immediately.

All PCPs are contractually required to be available to their members 24/7 to make certain the members have timely access to necessary care, including emergency care, and to allow the PCP to continue to act as the medical home. Offices must have a phone message or answering service available to members after office hours that instructs the member on how to contact the provider for urgent or emergency conditions.

3.4 Charging Medicaid Clients for Missed Appointments

CMS prohibits providers from billing Medicaid clients who miss scheduled appointments. A missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider's overall costs of doing business. The Medicaid rate covers the cost of doing business, and you may not impose separate charges on Medicaid clients.

3.5 Medical Records and Charting Standards

The UnitedHealthcare Community Plan QI program confirms that medically necessary services are provided to members in both a timely and confidential manner. Medical records must be maintained in a manner that is current, detailed and organized and that permits effective and confidential patient care and quality review. The Medical Record Documentation Standards, based on NCQA standards, were developed by Quality Improvement and approved by the National Quality Management Oversight Committee (NQMOC) and board of directors.

Your agreement with us requires all records, including medical records and financial documents, to be maintained and available for review, audit or evaluation by authorized state personnel or their representatives. You must retain the source records for operational data reports for a minimum of seven years and have written policies and procedures for storing such information.

Our agreement with you allows us to have timely access to member medical records for the purpose of: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.

PCPs are evaluated on the medical record standards at the time of initial credentialing and every 24 months. You will receive feedback at the conclusion of the audit indicating the level of compliance with Medical Record Documentation Standards. The score required to pass is 80% or greater. The reviewers will give clear and concise instructions to the provider through the feedback form, which serves as a corrective action plan for noted deficiencies.
The initial review includes an evaluation of the medical record keeping practices. Subsequent reviews evaluate the adequacy of completed medical records. Up to ten medical records of various patient ages will be reviewed for each practice. The reviewer will investigate the quality of care, the continuity and coordination of care, under- and over-utilization and preventive health care, as well as other medical record keeping practices.

3.5.1 Standards by Demographics

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

3.5.2 Standards by Patient History

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

3.5.3 Standards by Diagnosis and Treatment Plan

- Lab and other studies must be appropriate to patient symptoms and physical findings.
- Documents should include subjective and objective data.
- Working diagnoses should be consistent with physical, X-ray, lab and consult findings.
- Action and treatment plans should be consistent with diagnoses.
- Follow-up visits should be documented in days, weeks or months when clinically appropriate.
- Unresolved problems from previous visits should be documented in the subsequent visit.

3.5.4 Standards by Continuity

- There should be evidence to support the use of consultations.
- If referred by the primary doctor, documentation of the consulting provider's findings, skilled nursing facility progress notes or discharge summaries, inpatient discharge summaries and home health care notes and discharge summaries should be noted in the medical record.
- All consults, summaries, lab and imaging studies need to be initialed or have explicit notation of review in the medical record.
- Abnormal labs, consults, imaging studies and summaries should have explicit notations of a follow up treatment plan.
• There should be no evidence that the patient is placed at inappropriate risk by a treatment plan.

3.5.5 Standards by Prevention

• A completed immunization record should be present in all children’s medical records, including a notation of chicken pox history or vaccination.
• Height, weight and BMI should be noted.
• An appropriate immunization record should be present in adult medical records.
• Preventive health issues should be appropriately addressed in the medical record and are audited using the applicable Preventive Health audit tools. These preventive health guidelines by age appropriateness are located at UHCCommunityPlan.com. Click on the “For Health Care Professionals” tab at the top of the page, then select Delaware and Medicaid. The guidelines are available by clicking on the Clinical Guidelines link in the left-hand menu.
• Documentation of the presence or absence of an advance directive should be present on the chart.
• There should be evidence of patient teaching.

3.6 Requests for Medical Records

Members are entitled to a free copy of their medical records when the purpose of their request is directly related to their ongoing health care needs. Examples of this would include changing Primary Care Providers (PCPs), being referred to a specialist, and medical services that require a prior authorization form. When a member changes PCPs, the current PCP must forward the member’s medical records or copies of the medical records to the new PCP within ten business days from receipt of request.

You are prohibited from billing members for copying medical records because it is considered a routine part of their business, and reimbursement is included in the rates paid to providers. However, if the member’s request doesn’t directly relate to their ongoing health care needs, like a copy of the medical record is needed for personal or educational purposes or personal legal proceedings, you are permitted to follow your normal policy on billing for this service. You must tell the member in advance about this charge.

3.7 Access and Safety Review

When medical records are reviewed, UnitedHealthcare Community Plan QI nurse reviewers also assess compliance with appointment access standards and patient safety regarding treatment and medication safety. This focused review will also be discussed with the office staff and recommendations for improving deficiencies will be noted. Those care providers falling below the acceptable level of 80% will be referred to the medical director for further action. Both the medical record review and the focused access/safety review will become part of the care provider’s credentialing file.

3.8 Credentialing and Recredentialing Standards

All participating care providers undergo a careful review of their qualifications, including education, training, board certification status, license status, hospital privileges and malpractice and sanction history. Credentialing and recredentialing activities are performed by the UnitedHealthcare National Credentialing Center (NCC). All care providers undergo initial credentialing and recredentialing every three years and are reviewed and approved by the NCC. Re-credentialing decisions incorporate findings from quality of care or member satisfaction issues identified at the care provider level.

Detailed Policies and procedures exist to describe the credentialing and recredentialing process. Our credentialing standards are more extensive than (though fully compliant with) the National Committee on Quality Assurance (NCQA) requirements.

Credentialing applications should be completely processed within 45 calendar days of receipt of a completed credentialing application. Completely processed means: receive, approved, load into provider files in claims processing system or deny, notify care provider, and help ensure care provider is not used for services.
You have the following rights with respect to the credentialing/recredentialing process:

- To review information submitted to support their credentialing application,
- To correct erroneous information,
- To receive the status of their application upon request,
- To receive notification of these rights.

**3.8.1 Credentialing (Behavioral Health)**

We have contracted with OptumHealth Behavioral Solutions to provide and manage the provider network and delivery of all behavioral health and substance abuse services for members.

The credentialing process for participation in the network is independent from your previous credentialing with UnitedHealthcare Community Plan. If you are already participating in the OptumHealth network, you do not have to complete the credentialing process again.

OptumHealth credentials clinicians according to rigorous criteria that reflect professional and community standards, as well as applicable laws and regulations.

For a more specific list of OptumHealth participating provider and credentialing criteria, please refer to the OptumHealth Network Manual, which can be found at [ProviderExpress.com](http://ProviderExpress.com), or call 877-614-0484. The OptumHealth portal can also be reached at [UHCCommunityPlan.com](http://UHCCommunityPlan.com).

**3.8.2 Home & Community Based Service (HCBS) Provider Credentialing (LTC-specific)**

We contract with credentialed home and community based care providers that service the Delaware Medicaid LTSS waiver population. HCBS services include:

- Assisted Living Facilities
- Day Habilitation
- Personal Assistance Service Agencies/Attendant Care (PASA)
- Home Modifications
- Consumer-Directed Care
- Respite Care (In-Home and In-patient)
- Personal Emergency Response Systems (PERS)
- Adult Day Services
- Home Delivered Meals

HCBS care providers are required to complete a HCBS Provider Application and submit all supplemental documentation to their Provider Advocate for participation. HCBS care providers must have the following in order to become part of the network:

- W-9 for the business
- Proof of Current Liability Insurance for BOTH Current Professional Malpractice and Comprehensive General Liability Insurance Policies (if applicable)
- Copy of Medicare Participation Certification (if applicable)
- Copy of Certifications and/or Accreditation Certificates (e.g., Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Medicare, etc., if applicable)
- State Business License or 501(c)(3) status and copy of appropriate license
- Signed UnitedHealthcare Community Plan Attestation
- Signed and dated Disclosure of Ownership Form
- Attestation of Compliance with Section 6032 of the Federal Deficit Reduction Act
- Current Medical Staff Listing (if applicable)
- Brochures and other literature about the organization
- Credentialing and training criteria for professional staff, independent and/or sub contractors, volunteers, etc.

To initiate the credentialing process, please call Provider Services at 800-600-9007 or your Provider Advocate.
3.8.3 Credentialing and Recredentialing Applications

For questions regarding the credentialing process:

**Phone:** 800-600-9007

**Online:** UHCprovider.com > Resource Library > Join Our Network and Credentialing > Credentialing for Care Providers

You can submit credentialing and recredentialing applications by phone or online using the information above. The online portal also offers the ability to:

• Review the information submitted to support your credentialing application;

• To correct erroneous information; and

• Check on status of your credentialing or recredentialing application

3.9 Adverse Credentialing

Care providers that do not meet the criteria set forth by the Credentialing Committee will be notified in writing. The letter will define the committee’s determination, along with the right to appeal and a copy of the appeals process (if applicable). Possible factors that would prohibit a care provider from meeting the committee’s criteria include a lack of admitting privileges to a participating hospital or not meeting baseline criteria of license, education or board certification. Section 17 of this manual, “Provider Dispute Procedures – Appeals of Credentialing Decisions and Contract Termination Decisions,” provides instructions if you disagree with the decision of the credentialing committee or if you wish to appeal the decision.

3.10 Cultural Competency

As a company dedicated to managing the health of beneficiaries of public sector health care programs, we recognize the importance of serving members in a culturally and linguistically appropriate manner. We know from direct experience that:

• Some members have limited proficiency with the English language; this includes members whose native language is English but who are not fully literate;

• Some members have disabilities or cognitive impairments that impede their communicating with the health plan or providers and their use of health care services;

• Some members come from other cultures that view health-related behaviors and health care differently than the dominant culture; and

• Some members from economically disadvantaged segments of society have faced longstanding barriers to good health and thus exhibit disproportionately high rates of certain diseases.

We recruit a diverse array of care providers to help ensure that our network is built around significant traditional care providers to reflect the needs of the population served. Our care providers and support services value diversity and are committed to serving people of racial and ethnic minorities. Though it is unlikely that the make-up of the care provider network will reflect the composition of the enrolled population exactly, we strive to achieve the best possible match in each community.

Language is often cited as a barrier to accessing appropriate health care. To address this concern, our care providers must offer interpretation services to our members. If you encounter language barriers call Provider Services or the Special Needs Unit (SNU) for assistance.
3.11 Advance Directives

The adult member has the right to make health care decisions and to execute advance directives. An advance directive is a formal document that the member prepares in advance of an incapacitating illness or injury. You should be aware of and maintain a copy of the member’s completed advance directive in the patient’s medical record, but should not send a copy to us. Members are not required to initiate an advance directive and cannot be denied care if they do not have an advance directive.

If a member believes that a care provider has not complied with an advance directive, they may file a grievance with a medical director or UnitedHealthcare Community Plan representative. We will notify members in writing of any changes to laws and regulations governing advance directives as soon as possible (but no later than 90 days after the effective date of the change). For additional information about advance directives, please contact:

Division of Services for Aging and Adults with Physical Disabilities
Main Administration Building
1901 N. DuPont Highway
New Castle, DE 19720
Phone: 302-255-9390 or 800-223-9074
4: Primary Care Provider (PCP) Policies

4.1 Role of the PCP

The PCP plays a vital role as a physician care manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas: access, coordination, continuity and prevention. The PCP is the point of entry into the delivery system – except for services allowing self-referral, emergencies and out-of-area urgent care – and is the medical home for all members on the PCP’s roster.

As a PCP you are responsible for the provision of initial and basic care to members who have selected you make referrals as required for specialty and ancillary care, and coordinate all care delivered to members. We expect PCPs to communicate the reason for the referral to specialists by use of a prescription or letter and to note this in the patient’s medical record. We expect a specialist to communicate significant findings and recommendations for continuing care to the PCP. A specialist may not refer the patient directly to another specialist.

We work with members and care providers to help ensure that all participants understand, support and benefit from the primary care system.

4.2 24/7 Availability

PCPs must be available to members by telephone 24/7 or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating PCP. A medical director must approve coverage arrangements that vary from this requirement. PCPs are expected to respond to after-hours patient calls within 30 to 45 minutes for non-emergency symptomatic conditions and within 15 minutes for crisis situations. We track and investigate all instances of PCP inaccessibility. We also conduct periodic access surveys to help ensure that all access standards are met. PCPs are required to participate in all activities related to these surveys.

4.3 Responsibilities of the PCP

In addition to the requirements applicable to all care providers (see Section 3), the responsibilities of the PCP include providing primary and preventive health care services and acting as the member’s advocate in recommending and arranging care, based on medical necessity. Determinations of medical necessity for covered care and services, whether made on a prior authorization, concurrent review or post-utilization basis, must be in writing and be covered by the UnitedHealthcare Community Plan fee schedule. We will base our determination on medical information provided by the member, the member’s family/caretaker and the PCP, as well as any care providers, programs or any other agencies that evaluate the member. Medical necessity determinations will be made by qualified and trained care providers.

Satisfaction of the following standards results in authorization of the service for UnitedHealthcare Community Plan Medicaid members:

• The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
• The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
• The service or benefit will help the member achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities appropriate for members of the same age.

Other PCP responsibilities include:

• Maintaining continuity of member’s health care;
• Directing care to participating providers and emergency care facilities;
• Maintaining, copying or forwarding a member’s medical record and documenting all services provided to the member. The record must note the execution of advance directives for all adult patients. An advance directive constitutes written instruction, such as a living will or durable power of attorney, relating to the provision of health care if the patient is incapacitated;
4: Primary Care Provider (PCP) Policies

• Demonstrating a willingness and ability to make distinctions between treatment methods consistent with the member’s cultural background and maintaining consistency in providing quality care across a variety of cultures;
• Having a process to allow use of TTY or language assistance for members;
• Coordinating behavioral health services; and
• Complying with the UnitedHealthcare Community Plan Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children up to age 21.

As agreed upon in the PCP agreement with UnitedHealthcare Community Plan, the PCP will:
• Not differentiate or discriminate in the treatment or the quality of services delivered to members on the basis of race, color, age, national origin, religion, economic status, source of payment, health status or health care needs; and
• Observe, protect and promote the rights of members as patients. The PCP agrees to maintain a written sexual harassment policy and will inform its employees of the policy.

As stated in the Americans with Disabilities Act, 28 C.F.R. 35.101 et. seq., the PCP understands and agrees that no individual with a disability will, on the basis of the disability, be excluded from participation in the PCP agreement or from activities provided for under the PCP agreement. As a condition of accepting and executing the PCP agreement, the PCP agrees to comply with the “General Prohibitions Against Discrimination,” 28 C.F.R. 35.130, and all other regulations promulgated under Title II of the Americans with Disabilities Act applicable to the benefits, services, programs and activities provided by government agencies with whom UnitedHealthcare Community Plan has entered into a contract for the provision of health care services, including guidelines issued by the governing regulatory agencies.

UnitedHealthcare Community Plan Medicaid care providers must abide by Delaware state laws and the relevant department regulations of the Delaware DOH and DMMA accessibility standards:
• Emergency appointments must be scheduled immediately or referred to an emergency facility (i.e. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room visits). If emergency care is denied, the member must be seen at once by the PCP or referred to an open urgent care clinic.
• Urgent appointments must be scheduled the same day (i.e. persistent rash, recurring high-grade temperature, nonspecific pain, fever).
• Routine care appointments must be scheduled within 14 days of member request.
• EPSDT and child preventive care appointments must be scheduled within two weeks of member request.

4.4 Member Encounters

Primary Care Providers (PCPs) are required to report to UnitedHealthcare Community Plan all services they provide for UnitedHealthcare Community Plan members. PCPs must submit patient encounters on a CMS 1500 or a UB-04 claim form or electronically within 90 days of the service date. This information is evaluated for utilization purposes and is required by our government sponsors. In accordance with the provider assessment guidelines, care providers will make medical records and financial statements available to a clinical nurse reviewer for a member encounter audit.

4.5 Second Opinions

Members may ask for and receive a second opinion from a qualified, UnitedHealthcare Community Plan-participating care provider or a non-participating care provider, if a participating care provider is not available, for any diagnoses that they receive from their PCP or specialists.
4.6 Primary Care Provider (PCP) Compensation

Our PCP compensation plans are designed to compensate PCPs for the services they are contractually obligated to provide and to encourage the delivery of preventive services and the documentation of encounters through financial incentives. To further help ensure quality, there are no incentives (such as withholds) to reduce or deny services.
5.1 Responsibilities of Specialty Providers

In addition to the requirements applicable to all care providers (see Section 3), the responsibilities of specialist care providers include the following:

- Offer access to office visits on a timely basis according to the standards outlined in this manual.
- Provide specialty medical services to UnitedHealthcare Community Plan members who are directed by the member’s PCP or who self-refer.
- Refer services requiring prior authorization to UM as appropriate. UnitedHealthcare Community Plan recommends calling at least 72 hours in advance of the admission or surgery. A care provider may appeal any adverse decision made by UnitedHealthcare Community Plan. Procedures for filing an appeal are detailed in each specific plan's section of this manual.
- Provide the PCP copies of all medical information, reports and discharge summaries resulting from the specialist’s care.
- Communicate in writing to the PCP all findings and recommendations for continuing patient care and note them in the patient’s medical record.
- Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan-participating hospital.
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws and regulations.

5.2 Specialist Access Standards

Specialists are required to adhere to the following access standards:

- Emergency care appointments must be scheduled immediately.
- Urgent care appointments must be seen within 48 hours of referral.
- Routine appointments for patients must be seen within three weeks of referral.

5.3 Specialists as Primary Care Providers (PCPs)

To assist our members with complex illnesses or conditions that require frequent visits to a specialist, care may be improved by having a specialist serve as a member’s PCP. If you are a specialist who receives frequent requests for a member with special health care needs, believe that the member’s care may be enhanced by your serving as their PCP and can be available to the member 24/7, please call the Special Needs Unit at 877-844-8844. A UnitedHealthcare Community Plan medical director will review the case and, if necessary, begin the credentialing process to allow you to serve as the member’s PCP.

5.4 Member Notification of Terminations

At least 30 days prior to the effective date of your termination or your group's termination from the network, UnitedHealthcare Community Plan will send, by regular mail, notification to our affected members/your patients. Your affected patients/our members will include those UnitedHealthcare Community Plan members for whom a claim was filed on your behalf or on behalf of your medical group within the six months prior to the effective date of termination or departure.
6.1 Emergency Medical Conditions

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

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

6.1.1 Medical Emergency

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

6.2 Emergency Ambulance Services

Ambulance services are covered in emergency situations. Members may access immediate medical transport in true medical emergencies, as well as for non-emergency facility-to-facility transports. Medical transport for non-emergency cases (except facility-to-facility transports) is covered by DMMA.

6.3 Emergency Room Services

In non-emergency cases, members are required to contact their Primary Care Provider (PCP) prior to visiting an emergency room. The facility should verify member eligibility as soon as possible after a visit to the emergency room.

6.3.1 Emergency Inpatient Admissions

Authorization is not required if a member is treated for a medical emergency as defined in the provider contract. However, UnitedHealthcare Community Plan providers are required to notify UM within 48 hours, the next business day or after post-stabilization of a hospital admission arising from an emergency medical condition. If the admission/surgery is approved, UM will issue the certification to the appropriate party. Any requests that do not meet UnitedHealthcare Community Plan’s criteria or which are not addressed by these criteria will be referred to the medical director for further review.

6.3.2 Non-Emergency Inpatient Admissions

In order for UnitedHealthcare Community Plan to monitor the quality of care and utilization of services by our members, all UnitedHealthcare Community Plan providers must obtain prior authorization by contacting UM for all hospital admissions not meeting the definition of an emergency medical condition. UnitedHealthcare Community Plan accepts prior authorization requests for non-emergency services from the PCP or ordering provider. No party should assume the other has obtained prior authorization. The requesting care provider should make every attempt to request the above prior authorization at least 72 hours prior to admission.

6.3.3 Hospital Transfers

In the event of a transfer to another facility, the transferring facility or attending care provider must contact UM prior to the transfer. No party should assume that another party has obtained prior authorization.

6.4 Outpatient Services

Please see the Benefit Grid to determine appropriate authorization requirements based upon the type of service. Upon receiving outpatient services, if a member’s condition requires immediate admission, prior authorization must be obtained. The admitting facility must contact UM within 48 hours or the next business day. In the event that a UnitedHealthcare Community Plan Medicaid member is admitted due to complications of an outpatient surgery, the SPU charges and inpatient services must be billed separately. Please be sure that all claims include your appropriate provider ID numbers and appropriate authorization information for each place of service.
6.5 Inpatient Concurrent Review

UM must monitor the progress of members throughout the inpatient stay. This is accomplished by UM receiving clinical information from the hospital on a clinically appropriate basis that details the member’s progress to date. UM monitors appropriateness of continued inpatient stay according to established criteria under the direction of the UnitedHealthcare Community Plan medical director. As part of the concurrent review process, UM coordinates the discharge plan and assists in arranging additional services, special diagnostics, home care and durable medical equipment.

6.6 Home Health Services

Upon discharge, home health care services and related durable medical equipment must be prior authorized through UM as necessary.

6.7 Skilled Nursing Units

UnitedHealthcare Community Plan care providers may use a skilled nursing unit only when prior authorized by UM. The ordering provider or the discharging facility may make the request for such prior authorization. The requesting provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission. UnitedHealthcare Community Plan is financially responsible for the first 30 inpatient days of medically necessary skilled nursing care provided in a Medicaid-approved facility for UnitedHealthcare Community Plan members with or without an additional primary insurance carrier.

6.8 Inpatient Rehabilitation Unit

UnitedHealthcare Community Plan care providers may use an inpatient rehabilitation unit only when prior-authorized by UM. The ordering care provider or the discharging facility may make the request for such prior authorization. The requesting care provider should make every attempt to make the above prior authorization request at least 72 hours prior to admission.

6.9 Difference in Coverage for UnitedHealthcare Community Plan Medicaid Members during Inpatient Admissions

When a recipient is admitted to a hospital under the FFS delivery system and assumes MCO coverage while still in the hospital, but is then discharged or transferred from the initial inpatient hospital to another hospital (provider type 11, 12 or 13) after the MCO effective date, then the FFS delivery system is responsible for the inpatient hospital bill covering the initial hospital stay only from the admission date through the date of discharge (on the effective date of MCO coverage, the MCO delivery system is responsible for provider services, DME and all other covered services not included in the initial inpatient hospital bill). The MCO delivery system assumes responsibility for the subsequent hospital bill upon admission.

Example:

• Recipient enters Hospital “A” on January 15 under the FFS delivery system.
• MCO coverage becomes effective on February 1 – the MCO delivery system becomes responsible for provider services, DME and all other covered services not included in the Hospital “A” bill.
• Recipient transfers from Hospital “A” to Hospital “B” on March 1.
  • The FFS delivery system is responsible for the entire Hospital A bill through the date of discharge on March 1.
  • The MCO delivery system is responsible for the Hospital “B” bill upon admission on March 1.
7.1 Role of the OB/GYN

To enhance access to OB/GYN services and promote the highest level of care coordination, UnitedHealthcare Community Plan members may self-refer to any participating OB/GYN care provider for an annual exam, suspected pregnancy or any other medical visit. UnitedHealthcare Community Plan permits Primary Care Providers (PCPs) to perform routine gynecological exams, Pap smears and provide pregnancy care if they are credentialed by UnitedHealthcare Community Plan to provide these services.

7.2 OB/GYN Responsibilities

• Notifying the PCP of the treatment plan and the estimated duration of specialty or prenatal care. The OB/GYN may use established means of communicating this information.

• Arranging and ordering medically appropriate services.

• Complying with UnitedHealthcare Community Plan’s administrative prior authorization and member self-referral guidelines.

• Maintaining a member’s medical record documenting all specialty services provided to the member.

• A willingness and ability to make distinctions between treatment methods consistent with the member’s cultural background and to maintain consistency in providing quality care across a variety of cultures.

• Providing care to members without regard to race, color, creed, sex, religion, age, national origin, marital status, sexual orientation, language, health status, pre-existing conditions and physical or mental handicap.

7.3 Family Planning Services

UnitedHealthcare Community Plan members may self-refer for family planning services, including contraceptive care and urine pregnancy tests. UnitedHealthcare Community Plan members may self-refer to any provider in or out of UnitedHealthcare Community Plan’s provider network to provide family planning services. There is no limit to the number of family planning visits a UnitedHealthcare Community Plan member may have in a calendar year.

7.4 Abortions

Abortions are covered by Medical Assistance under either of the following conditions:

• A care provider must certify that due to a condition, illness or injury, a woman is in danger of death unless an abortion is performed.

• The woman was a victim of rape or incest that was reported to a law enforcement agency prior to the performance of the abortion, unless a provider certifies that, in their professional judgment, the patient was physically or psychologically unable to report the crime. In cases of incest where the victim is under 18 years of age, the incident must also have been reported to the Department of Services for Children, Youth and Their Families. The identity of the offender must have been reported by the victim of rape or incest, if the identity is known.

The treating care provider must complete an Abortion Justification Form, which can be found on the UnitedHealthcare Community Plan website, for all abortions. In addition to the Abortion Justification Form, the treating care provider must attach the complete medical record to the CMS 1500. It is the responsibility of the treating provider to supply a copy of the form and the complete medical record to the hospital and the anesthesiologist for their billing purposes, if needed.

7.5 Sterilization

UnitedHealthcare Community Plan members may elect for outpatient sterilization surgery. Prior authorization must be obtained once the Sterilization Consent Form has been signed (member must be 21 years old or older at the time of signature) and submitted with the claim and the 30-day waiting period has expired. According to state guidelines, UnitedHealthcare Community Plan members have 180 days to act from the date of the signature on the consent form.
7: OB/GYN Provider Policies

Contact UM to prior-authorize tubal ligations. The Sterilization Consent Form has to be completed and signed and the 30-day waiting period must expire prior to contacting UM. The form must be submitted with the claim for payment. The Sterilization Consent Form can be found online at UHCCommunityPlan.com.

7.6 Gynecological Services

All UnitedHealthcare Community Plan members may self-refer for annual gynecological exams, mammograms and Pap smears to any UnitedHealthcare Community Plan participating care provider contracted to provide gynecological services. Gynecology care providers may order related diagnostic tests such as mammograms and Pap smears. The gynecological care provider must refer the member back to the PCP for services unrelated to the gynecological diagnosis. Per Delaware law, OB/GYN physicians may serve as PCPs.

7.7 In-Office Surgery

Surgeries performed in the office by the gynecological provider do not require additional authorizations from the PCP prior to rendering services.

7.8 Hysterectomy

UnitedHealthcare Community Plan members who are undergoing a hysterectomy should sign the Patient Awareness Form (DE form 221.455). UnitedHealthcare Community Plan members undergoing sterilization should sign the Sterilization Consent Form. Care providers are required to submit a copy of these forms to UnitedHealthcare Community Plan. Copies of these forms should be retained in the member’s medical record.

7.9 Obstetric Services

A member may self-refer for obstetric services to any UnitedHealthcare Community Plan participating provider contracted to provide obstetrical services. An OB Needs Assessment Form must be completed as part of routine prenatal care to identify conditions that may place the member at risk of an adverse pregnancy. The OB Needs Assessment Form is located at UHCCommunityPlan.com. We cooperate with the state of Delaware Smart Start program, which includes services such as skilled nursing services at home. Smart Start visits may be requested by calling Case Management. The obstetrician should evaluate OB needs by using the criteria indicated on the OB Needs Assessment Form. A copy of the OB Needs Assessment Form must be faxed or sent to the pregnancy case manager within five days from the initial assessment.

OB needs should be assessed throughout the course of the member’s pregnancy. Consult the instructions on the back of the form for completion frequency. In addition, the OB Needs Assessment Form may be submitted to the pregnancy case manager at any time during prenatal care if a member’s condition constitutes a change of the risk status. Each needs assessment request will be evaluated to identify the risk status of the pregnancy. The member’s PCP must be notified of the pregnancy.

UnitedHealthcare Community Plan requires an authorization for all inpatient stays. Two day normal delivery or up to a four day C-section does not require an authorization for claims payment. For emergency admissions that do not result in a delivery, UnitedHealthcare Community Plan requests that Utilization Management be contacted for authorization of admission within 48 hours of admission or the next business day.

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

Prenatal care appointments must be accessible within the following time frames:

- First trimester appointments must be scheduled within three weeks of request.
- Second trimester appointments must be scheduled within seven calendar days of request.
- Third trimester appointments must be scheduled within three calendar days of request.
- High-risk pregnancy appointments must be scheduled within three calendar days of identification of a high risk. If an emergency exists, then the member must be seen immediately.

7.11 Pregnancy Case Management

Healthy First Steps provides pregnancy case management services for members who are at risk of an adverse pregnancy. Members identified who have moderate to high risk are outreached to and followed by an experienced OB Case Manager. Regardless of risk status, a member may require additional services to assure a safe and healthy delivery.

Listed below are some of the options obstetricians can choose for their patients:

- Non-stress test (NST’s)
- Contraction stress test (CST’s)
- Amniocentesis
- Ultrasounds (except for 3D)
- C-sections
- Nutritionist
- Postpartum visit
- Pap smears
- Versions (positioning fetus)
- Genetics and counseling
- RH factor – RhoGAM
- Maternal fetal specialist

Members are eligible for a postpartum home visit within two weeks of delivery. Subsequent home visits must be authorized by UM. The postpartum home visit is coordinated by UM upon discharge from the delivering facility. For questions or member case management support, please call Healthy First Steps at 800-599-5985.

7.12 Healthy First Steps Program

The Healthy First Steps program is a non-clinical program implemented by Case Management. The goal of the program is to assist members in every aspect of prenatal care to promote a safe and healthy delivery. A Healthy First Steps representative will maintain regular contact with an expectant mom to develop a relationship throughout prenatal care. During this time, the Healthy First Steps representative addresses issues such as the member’s pregnancy history and current environmental situation. The representative assists with scheduling prenatal appointments and arranging for transportation when needed.
8: Ancillary Provider Policies

8.1 How to Arrange for the Delivery of Ancillary Services

UnitedHealthcare Community Plan offers ancillary or supplemental services to compliment the benefit packages available through UnitedHealthcare Community Plan.

8.1.1 Ambulance Services

Ambulance services are covered in emergency situations and non-emergency facility-to-facility transports. In non-emergency cases, UnitedHealthcare Community Plan providers should contact UM for prior authorization, except for facility-to-facility transports.

8.1.2 Vision Services

UnitedHealthcare Community Plan has contracted with March Vision Care to manage its eye care benefit for UnitedHealthcare Community Plan members (see section 9: Summary of Benefits). The provider directory lists participating March Vision Care providers. Member inquiries regarding vision care may be directed to Member Services. Care provider inquiries regarding vision care may be directed to March Vision Care at 888-493-4070.

8.2 Imaging Services

8.2.1 Imaging Ordered by the Primary Care Provider (PCP)

Please refer to the prior authorization table for a list of imaging services that require authorization. The PCP may direct a member to any UnitedHealthcare Community Plan participating hospital, independent licensed imaging facility or portable imaging company for outpatient imaging services. The PCP must contact UM for imaging services requiring a prior authorization.

8.2.2 Imaging Ordered by the Consulting Provider

Consulting care providers may perform or order any outpatient imaging services. The PCP referral authorizes the consulting care provider to perform imaging services within the office setting. The consulting care provider may direct a member to any UnitedHealthcare Community Plan participating hospital, independent licensed imaging facility or portable imaging company for outpatient imaging services. The consulting care provider must contact UM for imaging services requiring prior authorization.

8.3 Laboratory Services

8.3.1 Participating Laboratories

UnitedHealthcare Community Plan participates with Lab Corp for laboratory services. In accordance with our existing outpatient laboratory policy, all outpatient lab services must be rendered at a participating laboratory. Prior authorization may be required for some outpatient laboratory services.

8.3.2 Pre-Admission Laboratory Services

Laboratory services required prior to a facility admission or outpatient surgery should be performed by a participating laboratory. If the tests are performed by the admitting facility within 72 hours of the admission or surgery, payment for those services will be included in the inpatient or surgery payment. If the labs do not fall within the 72-hour period, prior authorization is required. The ordering provider is responsible for obtaining the prior authorization.
8.4 Ancillary Services Without Valid Codes

UnitedHealthcare Community Plan recognizes that some requested services do not have valid codes. Any item that does not have a valid code must be prior authorized through UM. The following information should be submitted by the ordering provider for the determination of medical necessity:

- Common or brand name of the item
- Date of service
- Diagnosis
- Number of units being requested
- Definition of a unit (i.e. per each, per box, per case)
- MSRP per unit
- Total charges for supplies
- Copy of manufacturer’s specification sheet, if available
- Appropriate HCPCS code or Medicare code, if available
- All treatment the member has received for their medical condition.

8.5 Pharmacy

Member ID Cards for Prescription Benefits

All UnitedHealthcare members must use their UnitedHealthcare member health care ID card to obtain covered prescription drugs.

Prescription Drug Coverage

Prescription and over-the-counter drugs covered by the Medicaid program. Prescriptions for some members are subject to copays.

For details regarding drugs covered under the UnitedHealthcare pharmacy benefit and the list of drugs that require prior authorization, providers can go to UHCCommunityPlan.com or UHCprovider.com.

Prescriptions Requiring Prior Authorization

For Pharmacy Prior Authorization call 800-310-6826 or fax the prior authorization request 866-940-7328. Physicians should consult the UnitedHealthcare Drug Formulary to identify the drugs that require prior authorization to verify if prior authorization is necessary.

Physicians should receive prior authorization before giving an UnitedHealthcare member a prescription for a medication that requires prior authorization.

UnitedHealthcare makes prior authorization determinations within 24 hours of receiving all the necessary information from the provider. The member is entitled to a three-day supply of most medications while awaiting the prior authorization determination. Denial determinations will include information about appeals.

Pharmacy Network

Most chain pharmacies and many independent pharmacies fill prescriptions for UnitedHealthcare Community Plan members. To locate a pharmacy that is convenient for a member, please reference a listing of participating pharmacies in the UnitedHealthcare Community Plan provider directory, or go to “Find a Pharmacy” at UHCCommunityPlan.com.

Generic Drugs

Generic drugs are provided when available as required by state mandatory generic substitution regulations. Generic drugs are approved by the Food and Drug Administration (FDA) to be equivalent to their brand name counterparts. If a generic drug is available, a brand name drug will not be provided to the member. However, if a physician requests for a brand drug, documentation supporting medical necessity must be submitted with the prior authorization request.

Physicians submitting a request for prior authorization for brand name drugs should call the Pharmacy Prior Authorization service at 800-310-6826 to present the information supporting the medical necessity of the brand drug.
Pharmacy Benefit Exclusions

Certain drugs not covered by the pharmacy benefit include:

• Drugs for weight loss or appetite suppression
• Drugs for cosmetic purposes
• Drugs to treat infertility
• Drugs to treat erectile dysfunction
• Drugs to stimulate hair growth or prevent hair loss
• Investigational and experimental drugs, unless a Medical Director gives prior authorization
• DESI drugs

UnitedHealthcare will investigate the issue and take the appropriate action, which may include, but is not limited to:

1. Reporting the member to the state.
2. Enrolling the member in the UnitedHealthcare Pharmacy Recipient Restriction Program.
3. Informing the appropriate provider network of the member’s activity.
4. Informing the Division of Medicaid and Medical Assistance (DMMA) of member’s activity.

Medicaid Recipient Restriction Program

If you suspect that a member is misusing or abusing the Medicaid benefit by obtaining prescriptions from multiple providers or requesting controlled substances for questionable indications, please call the Fraud and Abuse Hotline at 800-600-9007.

Additionally, UnitedHealthcare monitors non-compliant members through the Recipient Restriction Program. The Recipient Restriction Program restricts a member to a single pharmacy and/or physician for obtaining prescriptions. **Stolen prescription pads and suspected forged prescriptions should be reported immediately to UnitedHealthcare using the phone number above.**
## UnitedHealthcare Community Plan of Delaware – Medicaid Dental Provider Quick Reference Guide

### Important Telephone Numbers

<table>
<thead>
<tr>
<th>Call to Inquire About</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Dental Provider Services To verify eligibility, benefits and obtain claim status</td>
<td>855-609-5152</td>
</tr>
<tr>
<td>Interactive Voice Response (IVR) System – available 24 hours a day, seven days a week</td>
<td></td>
</tr>
</tbody>
</table>

### Important Addresses

<table>
<thead>
<tr>
<th>Reason for Mailing</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>UnitedHealthcare Dental P.O. Box 2064</td>
</tr>
<tr>
<td></td>
<td>Milwaukee, WI 53201</td>
</tr>
<tr>
<td>Claims Dispute for Care Providers</td>
<td>UnitedHealthcare Dental Attn: Appeals</td>
</tr>
<tr>
<td></td>
<td>Department P.O. Box 361</td>
</tr>
<tr>
<td></td>
<td>Milwaukee, WI 53201</td>
</tr>
<tr>
<td>Correspondence regarding your participation, contractual issues, dentist changes or office changes</td>
<td>UnitedHealthcare Dental Provider Relations</td>
</tr>
<tr>
<td></td>
<td>6220 Old Dobbin Lane</td>
</tr>
<tr>
<td></td>
<td>Columbia, MD 21045</td>
</tr>
</tbody>
</table>

### Helpful Information

<table>
<thead>
<tr>
<th>Electronic Submission</th>
<th>EDI Payer Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Electronic Claims &amp; Prior Authorization Submission</strong></td>
<td>GP133</td>
</tr>
<tr>
<td>EDI Payer Number</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Provider website</strong></td>
<td>UHCProviders.com</td>
</tr>
<tr>
<td>Eligibility, claims and other functions</td>
<td></td>
</tr>
<tr>
<td>Correspondence regarding your participation, contractual issues, dentist changes or office changes</td>
<td>UnitedHealthcare Dental Provider Relations</td>
</tr>
<tr>
<td></td>
<td>6220 Old Dobbin Lane</td>
</tr>
<tr>
<td></td>
<td>Columbia, MD 21045</td>
</tr>
</tbody>
</table>
8: Ancillary Provider Policies

Dental Benefits

Limited adult dental benefit services for members age 21 and over are covered under this plan, including preventive and diagnostic services only. The plan does not require prior authorizations and does not have a deductible, coinsurance or annual maximum.

For a complete listing of covered services and frequency limits, please see the list of covered services document. Should you have any questions regarding the benefits please contact the Dental Provider Services Department at 855-609-5152.

Timely Filing Limit

Claims must be submitted within 90 days of the date of service.

Provider Claim Dispute and Appeals

Dental care providers with complaints are to contact UnitedHealthcare Dental's Provider Service Department at 855-609-5152. Network provider contractual disputes and reprocessing requests are logged into the appeals database.

Care provider disputes:
UnitedHealthcare Dental
Attn: Appeals Department
P.O. Box 361
Milwaukee, WI 53201

Member appeals are reviewed by the health plan, and are not delegated to UnitedHealthcare Dental. All Member appeals (includes pre-service appeals) should be mailed to the address below.

Member appeals:
Grievance and Appeals
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364

Care provider appeals must be submitted within 60 calendar days after the payment, denial or recoupment of a timely claim submission. We can give you more time if you have a good reason for missing the deadline. If you are appealing a claim that was denied because filing was not timely, for:

Electronic Claims – include confirmation that UnitedHealthcare Dental or one of its affiliates received and accepted your claim.

Paper Claims – include a copy of the original claim or a screen print from your accounting software to show the date you submitted the claim.

UnitedHealthcare Dental recognizes that a provider request may contain elements of both an appeal and a dispute, and will follow the procedures for both appeals and disputes in those instances.
8: Ancillary Provider Policies

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Procedure Description</th>
<th>Age Range</th>
<th>Frequency Limit</th>
<th>Prior Authorization Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0150</td>
<td>Comprehensive Oral Examination</td>
<td>Age 21 and Over</td>
<td>1 Every 12 Months</td>
<td>No</td>
</tr>
<tr>
<td>D0120</td>
<td>Periodic Oral Evaluation – Established Patient</td>
<td>Age 21 and Over</td>
<td>1 Every 12 Months</td>
<td>No</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral – Complete Series or Radiographic Images</td>
<td>Age 21 and Over</td>
<td>1 Every 3 Years</td>
<td>No</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings – Two Radiographic Images</td>
<td>Age 21 and Over</td>
<td>1 Every Year*</td>
<td>No</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings – Four Radiographic Images</td>
<td>Age 21 and Over</td>
<td>1 Every Year*</td>
<td>No</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis – Adult</td>
<td>Age 21 and Over</td>
<td>1 Every 12 Months</td>
<td>No</td>
</tr>
</tbody>
</table>

*Frequency limit is one every year for either D0272 or D0274.
All benefits listed below are subject to UnitedHealthcare Community Plan policies and procedures.

### 9.1 Delaware Basic Medicaid Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicaid</th>
<th>DHCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Covered (under certain circumstances; consent form required)</td>
<td>Covered (under certain circumstances; consent form required)</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health (partial hospitalization, intensive outpatient)</td>
<td>Adults (18 &amp; Older)* Covered</td>
<td>Children (17 &amp; Younger) Covered by DSCYF</td>
</tr>
<tr>
<td>Behavioral Health - Inpatient (mental health and substance abuse)</td>
<td>Adults (18 &amp; Older)* Covered Children (17 &amp; Younger) Covered by DSCYF</td>
<td>Adults (18 &amp; Older)* Children (17 &amp; Younger) Covered by DSCYF</td>
</tr>
<tr>
<td>Behavioral Health - Outpatient (mental health and substance abuse)</td>
<td>Adults (18 &amp; Older) Covered Children (17 &amp; Younger) 30 Visits Per Year</td>
<td>Adults (18 &amp; Older) Covered Children (17 &amp; Younger) 30 Visits Per Year</td>
</tr>
<tr>
<td>Behavioral Health - Residential Treatment Facility</td>
<td>Adults (18 &amp; Older)* Covered Children (17 &amp; Younger) Covered by DSCYF</td>
<td>Children (17 &amp; Younger) Covered by DSCYF</td>
</tr>
<tr>
<td>Bone Mass Measurement (bone density)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Bony Impacted Wisdom Teeth Removal</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Case/Disease and Care Management</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Colorectal and Prostate Screenings</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Age 20 and Younger: Covered by DE Medicaid. Age 21 and older: Covered by UnitedHealthcare. One cleaning (prophylaxis) and one periodic evaluation per year, one full mouth series x-ray per three years. Removal of bony impacted wisdom teeth is covered under the medical benefit.</td>
<td>Age 18 and Younger: Covered by Delaware Healthy Children Program.</td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic Supplies and Equipment (under $500)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>
## 9: Summary of Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicaid</th>
<th>DHCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Supplies and Equipment (over $500)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Dialysis (at participating facilities)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Dialysis (at non-participating facilities)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Durable Medical Equipment (under $500)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment (over $500)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Emergency Medical Transportation</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Routine Covered if age 20 or younger</td>
<td>Routine Covered if age 20 or younger</td>
</tr>
<tr>
<td>Eye Exam Medical (for conditions such as diabetes and eye infections)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Eyeglasses or Contacts</td>
<td>Covered if age 20 or younger</td>
<td>Covered if age 20 or younger</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Genetic Testing (including chromosome analysis)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See full prior authorization list in section 12.6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids and Batteries</td>
<td>Covered if age 20 or younger</td>
<td>Covered if age 20 or younger</td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Imaging (CT, MR, PET, SPECT office cardiac nuclear studies)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Infertility Testing and Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inpatient Hospitalization (acute care)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Lab Tests and X-rays</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Mammograms (screening)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Medication/Methadone Maintenance</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Non-Emergency Medical Transportation</td>
<td>Covered by DE Medicaid</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Participating Provider</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Observation</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Obstetrical/ Maternity Care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Organ Transplant Evaluation</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>
## 9: Summary of Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicaid</th>
<th>DHCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ Transplant</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Orthotics and Prosthetics (under $500)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Orthotics and Prosthetics (over $500)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td><strong>Outpatient Surgery:</strong> Amniocentesis, Non-Coronary Angiogram, Biopsy, Catheter Insertion, Hardware Removal, Paracentesis, Thoracentesis, Endoscopy (colposcopy, colonoscopy, cystoscopy, EGD, ERCP, laryngoscopy)</td>
<td>Covered</td>
<td>Covered*</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pap Smears and Pelvic Exams</td>
<td>Covered (Routine Foot Care for Diabetes and Vascular Disease)</td>
<td>Covered (Routine Foot Care for Diabetes and Vascular Disease)</td>
</tr>
<tr>
<td>Podiatry Care</td>
<td>Covered (Routine Foot Care for Diabetes and Vascular Disease)</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Primary Care Provider Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation (inpatient)</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Rehabilitation (outpatient occupational, physical and speech therapies)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Services Rendered Outside the U.S.</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Sleep Apnea Studies</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Specialty Provider Services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Tobacco Cessation Counseling</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>* Prior Auth Required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 9.2 Delaware Medicaid Long Term Care (LTC) Enhanced Benefits

All eligible Delaware LTC members may receive the following enhanced benefits in addition to the basic Medicaid benefits. Except where otherwise noted below, LTC services require Prior Authorization.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Daycare</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>Cognitive Services</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Community-based Residential Alternatives that include Assisted Living Facilities</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Day Habilitation</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>Home-delivered Meals</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Minor Home Modifications</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Personal Care Attendant/Care Services</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
<tr>
<td>Specialized Durable Medical Equipment and Supplies</td>
<td>Prior Authorization Benefit Limits</td>
</tr>
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<td>Support for Customer Direction</td>
<td>Prior Authorization Benefit Limits</td>
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<tr>
<td>Transition Services (Money Follows the Person Program)</td>
<td>Prior Authorization Benefit Limits Max $ Limits</td>
</tr>
<tr>
<td>Transition Services Workshop</td>
<td>Prior Authorization</td>
</tr>
</tbody>
</table>

### Covered Benefit Changes

UnitedHealthcare Community Plan may change the benefits and services we cover. If we do change our benefits, we will tell you in writing, when we can, before the change occurs.

10: Claims Policies and Procedures

10.1 Code Sets/Claim Forms

Claims must be submitted to UnitedHealthcare Community Plan using HIPAA-compliant CPT-4 or HCPCS codes. Hospitals should bill on a UB-04. Other care providers, including ancillary care providers, should bill using the CMS 1500 (02-12 version), either electronically or on paper. All paper claims must be billed on red and white claim forms; black and white claim forms will not be accepted. UnitedHealthcare Community Plan requires care providers to use a National Provider Identifier (NPI) and/or Atypical number when submitting claims and EDI transactions. The member ID number, listed on the member’s health care ID card, must be submitted with all claims to UnitedHealthcare Community Plan for payment.

10.2 Time Frame for Clean Claims Submission

Please allow 30 days for the processing of clean claims. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a care provider who is under investigation for Fraud, Waste or Abuse, or a claim under review for Medical Necessity.

10.3 Claim Status

You can check claim status online at UHCprovider.com. The portal requires a unique user ID and password combination to gain access. If you do not have a user ID and password, you need to register through the link on that page.

10.4 Billing UnitedHealthcare Community Plan Members for Services

Payment by UnitedHealthcare Community Plan is considered payment in full. UnitedHealthcare Community Plan’s participating care providers may not seek compensation from a member unless the member:

- Is informed in advance that a proposed service is not a covered benefit; and
- Accepts financial responsibility in a signed document that includes:
  - The services provided;
  - The cost of non-covered services;
  - Notification that UnitedHealthcare Community Plan will not pay or be liable for the listed services; and
  - Notification that the member will be financially liable for listed services.

You may need to submit copies of these documents to UnitedHealthcare Community Plan if the member contests receipt of a bill.

10.5 Electronic Claims (EDI)

Electronic Data Interchange (EDI)

EDI is our preferred choice for conducting business transactions with contracting/participating physicians and healthcare industry partners.

EDI tools

We offer an array of EDI tools designed to help you save time and money by automating several of your daily office administrative and reimbursement functions. Please refer to the UnitedHealthcare Community Plan published Companion Guides for the required data elements. Companion guides are available for viewing or download within the EDI section of your state home page at UHCCommunityPlan.com.

EDI claims/encounters

EDI claim is the preferred method of submission for contracted physicians and health care providers. You may submit all professional claims and/or encounters electronically for UnitedHealthcare Community Plan. The HIPAA ANSI X12 837 format is the only acceptable format for submitting claims/encounter data.

To submit directly to UnitedHealthcare Community Plan electronically, please visit our secure Provider Portal at UHCprovider.com.

Claims requiring medical record attachments require paper submission. However, do not submit medical record attachments unless instructed to do so by UnitedHealthcare Community Plan.
Secondary Claims

Please refer to the 837 Companion Guide located UHCprovider.com/edi for technical requirements. Do not send paper claim backup for claims that have already been submitted electronically.

If UnitedHealthcare Community Plan is not the primary payer, you have 365 days from the date of service to submit a claim.

To set up Carrier Tables within your Software

Set your system payer tables for UnitedHealthcare Community Plan to generate electronic claims instead of paper claims. Make sure the Payer ID (87726) for the plan is spelled correctly and setup is consistent. Contact your software vendor or clearinghouse with any questions regarding placement of information on your system.

<table>
<thead>
<tr>
<th>Field Description</th>
<th>CMS Form</th>
<th>UB-04 Form</th>
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<tbody>
<tr>
<td>NPI Number or Atypical Number</td>
<td>Box 24J</td>
<td>Box 56</td>
</tr>
<tr>
<td>Member ID Number</td>
<td>Box 1a</td>
<td>Box 60</td>
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<tr>
<td>Type of Service Code</td>
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<td>N/A</td>
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<tr>
<td>Date of Service</td>
<td>Box 24A</td>
<td>Box 6 &amp; 45**</td>
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<td>DRG Number</td>
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<td>Box 37</td>
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<tr>
<td>Place of Service</td>
<td>Box 24B</td>
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Electronic Payments & Statements (EPS)

EPS can reduce administrative costs, simplify bookkeeping, and offer greater security. EPS can significantly reduce reimbursement turnaround time and funds are available as soon as they are posted to your account. To enroll in EPS for UnitedHealthcare Community Plan, please visit the EDI section of your state home page on UHCCommunityPlan.com. For additional information on how to enroll in EPS, call 866-842-3278, option 1 for enrollment.

Electronic Remittance Advice (ERA)

ERA allows you to obtain an electronic version of the Explanation of Payment (EOP). Depending on your system’s capability, the data may be uploaded directly to the ledger of your practice computer system. ERA can potentially replace the tedious process of Guide EOP reconciliation, posting and data entry. This transaction is available only in the HIPAA ANSI X1 2 835 format.

Electronic eligibility inquiry/response

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. This EDI transaction is a powerful productivity tool that allows providers to instantly obtain members’ eligibility and benefit information in “real-time,” using a computer instead of the phone, prior to scheduling and confirming the patient’s appointment. The HIPAA ANSI X1 2 270/271 format is the only acceptable format for this EDI transaction.

Electronic claims status inquiry/response

This EDI transaction allows a care provider to send and receive in “real-time” an electronic status of a previously submitted claim using a computer. Claims with missing or inaccurate information can be resubmitted, which greatly enhances the provider’s receivables and cash flow cycle. The HIPAA ANSI X1 276/277 format is the only acceptable format for this EDI transaction. Some software vendors and/or clearinghouses, may also offer Electronic Claims Status and Inquiry transaction services.

Please refer to the UnitedHealthcare Community Plan Companion Guides for the data elements required for these transactions. Companion guides are available for viewing or download at UHCCommunityPlan.com.
10.6 Paper Claims

Care providers that do not yet have the ability to submit electronic claims should submit their claims in the traditional paper format. If you are mailing claims to UnitedHealthcare Community Plan, please address the envelope to the correct plan for which the claim is being submitted. If you do not list the plan name, your claim may take longer to process. To submit a claim for an EPSDT, submit a CMS 1500 or UB-04 with a check mark placed in the box labeled 24b.

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

10.6.1 Payment

All UnitedHealthcare Community Plan care providers are reimbursed at a fee-for-service rate according to their contract. Reimbursement of services is contingent upon proper authorization and member eligibility. Please be sure to submit every claim with a complete and accurate NPI number or Atypical number. Confirmation of eligibility through Provider Services or website does not guarantee payment. Information about eligibility is only good on the date of query, as the details may change.

10.6.2 Claims

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

To help ensure timely filings, new claims for all plans must be submitted within 90 days from the date of service. If UnitedHealthcare Community Plan is not the primary payer, the provider has 365 days from the date of service to submit a claim. UnitedHealthcare Community Plan forwards a remittance advice and reimbursement within 30 days from receipt of a claim. However, reimbursement is contingent upon proper authorization and member eligibility.

10.7 Denial of a Claim

10.7.1 Denied Claims

Services are to be provided in accordance with UnitedHealthcare Community Plan's policies and the respective provider agreement. Reimbursement is likely to be denied for services determined not to be medically necessary or services that have not been properly authorized. Providers will receive a remittance advice for all claims submitted to UnitedHealthcare Community Plan. If a claim is denied, a reason for the denial is included on the remittance advice.

10.7.2 Corrected Claim Process

If you receive a denial and need to submit a corrected claim to UnitedHealthcare Community Plan, you must submit within 45 days of UnitedHealthcare Community Plan's remittance advice. You may correct the claim according to the corrected claims policy below and include any additional supporting information to the following address. On the envelope, include the appropriate health plan name for which you are submitting the corrected claim.

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

For professional and institutional paper claim forms, the only mechanism accepted to indicate the claim is a correction or a void of a previous processed claim is the following:

Claim Form: CMS 1500
Box Number: 22
Title: Medicaid Resubmission and/or Original Reference Number
Instructions: When resubmitting a claim, enter the appropriate claim frequency code left justified in the left-hand side of the field.
10: Claims Policies and Procedures

7 – Replacement of prior claim
8 – Void/cancel of prior claim

**Claim Form:** UB04  
**Box Number:** 4  
**Title:** Type of Bill

**Instructions:** When resubmitting a claim, enter the appropriate claim frequency code in the 3rd position of the Type of Bill

7 – Replacement of prior claim
8 – Void/cancel of prior claim

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

**Loop:** 2300  
**Segment:** CLM05-3  
**Name:** Claim Frequency Type Code  
**Instructions:** When resubmitting a claim, enter the appropriate claim frequency code

Corrected Claim Process 2010
7 – Replacement of prior claim
8 – Void/cancel of prior claim

For instructions on the proper completion of the CMS 1500, visit [nucc.org](http://nucc.org), for the UB 04, visit [nubc.org](http://nubc.org) or you may go directly to the CMS Claims Processing Manual at [cms.hhs.gov/Manuals/IOM/list.asp](http://cms.hhs.gov/Manuals/IOM/list.asp) and refer to the CMS-1450 and CMS-1500 data sets. For electronic claim submission, please refer to the HIPAA Implementation Guides located at [wpc-edi.com](http://wpc-edi.com).

For questions regarding this policy, please call Provider Services at 800-600-9007.

UnitedHealthcare Community Plan provides notification of the claim status on a future remittance advice within 30 days of receipt of the corrected claim. UnitedHealthcare Community Plan accepts subsequent corrected claims for the same claim if there is additional supporting documentation that has not yet been submitted and if the corrected claims policy is followed. Care providers still disputing the reimbursement determination after submitting all supporting information may file an appeal.
11: Special Claims Procedures

11.1 Billing Multiple Procedures

When billing for two or more surgical procedures (provider only) for the same date of service, reimbursement is per Delaware Medicaid guidelines.

11.2 Assistant Surgeon

Assistant surgeon services are reimbursed based on Delaware Medicaid guidelines if an assistant surgeon is required according to the facility bylaws where the procedure is being performed.

11.3 Physician Assistants

In accordance with DMMA’s policies and procedures, a practitioner is permitted to bill for covered services provided by a certified and registered physician’s assistant and licensed registered nurse, provided that the individual performing the service is in an enrolled practitioner’s or an enrolled group’s employee.

11.4 Newborns

During a member’s pregnancy, a Healthy First Steps representative aids the member in the enrollment and Primary Care Provider selection process for the newborn. Newborns are enrolled with the mother’s Medical Assistance health plan as of the date of birth. Coverage will exist for at least the first 30 calendar days of life. Reimbursement for newborn services and continuance of coverage with the mother’s Medical Assistance health plan is contingent upon notice of delivery to the Department of Health and Social Services and eligibility. Care providers may bill newborn services under the mother’s ID number until the baby is assigned an ID number.

11.5 Family Planning Provider Claims and Billing

UnitedHealthcare Community Plan members may self-refer for family planning services, including contraceptive care and urine pregnancy tests. There is no limit to the number of family planning visits a UnitedHealthcare Community Plan member may have in a calendar year. Reimbursement of family planning services is contingent upon member eligibility. Family planning services for UnitedHealthcare Community Plan members are reimbursed on a fee-for-service rate based on the appropriate fee schedule. Claim submissions must be submitted on a CMS 1500 or UB-04, either by paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. UnitedHealthcare Community Plan must receive a properly completed claim within 90 days from the date of service.

11.6 Gynecology Claims and Billing

Members may self-refer for gynecological care by a participating gynecological care provider. Reimbursement for gynecological care is contingent upon member eligibility. Gynecological services for UnitedHealthcare Community Plan members are reimbursed on a fee-for-service rate based on the appropriate fee schedule. Claim submissions must be submitted on a CMS 1500 or UB-04, either by paper or electronically, and must include HIPAA compliant codes and valid diagnosis codes. UnitedHealthcare Community Plan must receive a properly completed claim within 90 days from the date of service.

11.7 Obstetrics Claims and Billing

Members may self-refer to a UnitedHealthcare Community Plan–participating OB/GYN for pregnancy care. The treating OB/GYN must contact UM to schedule the delivery and inpatient stay authorization. Reimbursement for obstetric services is contingent upon member eligibility. Obstetric services are reimbursed on a fee-for-service rate based on the appropriate fee schedule. A copy of the Prenatal Risk Assessment Form must be faxed or sent to Utilization Management within five days from the initial assessment.

Regardless of the pregnancy risk status, OB/GYN care providers must submit itemized obstetric procedures on a CMS 1500 or UB-04, either by paper or electronically, and must include HIPAA–compliant codes and valid diagnosis codes. UnitedHealthcare Community Plan must receive a properly completed claim within 90 days from service date.
The OB/GYN may refer any pregnant member for additional services, including the Smart Start program, after obtaining a pregnancy authorization upon completion of the prenatal assessment. UM will authorize and coordinate the following prenatal services with a UnitedHealthcare Community Plan-participating care provider:

- Psychosocial counseling
- Nutrition assessment by a registered dietitian
- Smoking (tobacco) cessation counseling
- Substance abuse assessment and counseling
- Genetic risk assessment and counseling (two units per pregnancy)
- Prenatal parenting (one program per pregnancy)
- Prenatal exercise (one program per pregnancy)
- Skilled nurse visits

**11.7.1 OB Incentive**

Global authorizations are no longer required for obstetrical care.

However, it is critical that we continue to receive the Healthy First Steps™ Obstetrical Health Risk Assessments by fax. The fax number to use is 877-353-6913. This assessment allows our case management department to:

1. Identify pregnant members
2. Conduct outreach to these members
3. Assess any identified needs
4. Work with the members who miss appointments to schedule additional ones
5. If necessary, arrange transportation.

The importance of receiving these assessments has led us to initiate an incentive payment of $25 for each completed Obstetrical Risk Assessment Form on a quarterly basis. Payment will only be issued for risk assessment forms received within five days of first visit, are legible and contain the following information:

- Physician name and plan provider ID number
- Current pregnancy information, e.g. gestational diabetes, preterm labor, PROM
- Prior OB history e.g. delivery of a baby with a birth weight of less than 4 pounds, Cerclage, etc.
- Current Medical conditions e.g. Sickle Cell Disease, bleeding or clotting abnormalities and any other problems that increase pregnancy risk
- Hospitalizations related to pregnancy complications

We are very excited about this new incentive program and truly appreciate the care you have provided to UnitedHealthcare Community Plan pregnant members. If you would like additional information related to HFS or have any questions, please call Provider Services at 800-600-9007.

**11.8 Basic (Low- or No-Risk) Pregnancies**

UnitedHealthcare Community Plan will cover prenatal services, delivery and postpartum care in accordance with the state prenatal guidelines. Additional postpartum home care must be coordinated through UM. The pregnancy will be certified as basic if there is low or no risk of an adverse pregnancy.

You must submit itemized obstetric procedures on a CMS 1500 or UB-04, either by paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. UnitedHealthcare Community Plan must receive a properly completed claim within 90 days from the date of service. A copy of the Prenatal Risk Assessment Form must be faxed or sent to pregnancy case management 877-353-6913 within five days from the initial assessment in order to receive a provider incentive.
11.9 High-Risk Pregnancies

UnitedHealthcare Community Plan covers prenatal services, delivery and postpartum care in accordance with the state prenatal guidelines. Additional postpartum home care must be coordinated through UM.

A UnitedHealthcare Community Plan member must meet UnitedHealthcare Community Plan's high-risk criteria in order for services to be reimbursed at the high-risk rate. A copy of the Prenatal Risk Assessment Form must be faxed or sent to pregnancy case management 877-353-6913 within five days from the initial assessment in order to receive a provider incentive. Providers must submit itemized obstetric procedures on a CMS 1500 or UB-04, either by paper or electronically, and must include HIPAA-compliant codes and valid diagnosis codes. UnitedHealthcare Community Plan must receive a properly completed claim within 90 days from the date of service.

11.10 Professional Component Billing

When processing claims for the professional component, the hospital claim is considered the lead claim. The claim for the professional component of the services, which are provided in a hospital setting, is processed in accordance with the information provided on the hospital claim.

11.11 Hospital Billing Procedures

Hospital claims are submitted to UnitedHealthcare Community Plan using a UB-04. To assure that claims are processed for the correct member, the member's UnitedHealthcare Community Plan Medicaid ID number must be used on all claims. All participating hospitals have numerous care provider numbers. Hospitals providing OB/GYN and PCP services will continue to have separate provider numbers for these services. Please be sure to submit every claim with a complete and accurate provider number. Please call your hospital's Provider Relations representative at 800-600-9007 with any questions about your provider ID numbers.

11.12 Anesthesia Billing Procedures

Anesthesia billing should use appropriate ASA (American Society of Anesthesiologists) codes:

- Minutes should be billed in box 24G of the CMS-1500.
- Start and Stop time should be billed in box 19 of the CMS-1500.
- UnitedHealthcare Community Plan will calculate time and base units.
- Modifiers AA, QK, QX, QY and QZ must be reported as appropriate. According to current coding guidelines, modifiers that affect pricing are QK and QX. When appended to a procedure, it will cause a reduction in reimbursement.

11.13 Professional Services Rendered by a Behavioral Health Provider

OptumHealth (United Behavioral Health) manages the behavioral health care for UnitedHealthcare Community Plan membership. The claims submission address for behavioral health claims is:

UnitedHealthcare Community Plan – Delaware Health Plan
PO Box 8207
Kingston, NY 12402

For a complete description of OptumHealth claims submission guidelines, please see the OptumHealth Network Manual at providerexpress.com. For questions regarding the processing of behavioral health claims, please call UnitedHealthcare Community Plan Provider Services at 800-600-9007.

11.14 Coordination of Benefits

As a Medical Assistance managed care choice, UnitedHealthcare Community Plan coverage is the ‘payer of last resort’ when a primary insurer is present. A UnitedHealthcare Community Plan member may have primary insurance coverage through Medicare or a commercial insurance carrier.
You must first submit the claim to the primary insurance or third party carrier. Upon receipt of payment from the primary insurer, you must submit a copy of the Explanation of Benefits to UnitedHealthcare Community Plan. This also includes the difference between the amount received from the third party payer and the contracted amount. UnitedHealthcare Community Plan will process the claim and, if appropriate, issue payment up to the health plan’s contracted fee schedule or the primary payer’s allowed amount, whichever is less (i.e., benefit less benefit provision). Before you may bill UnitedHealthcare Community Plan for copayments, you must verify the member’s UnitedHealthcare Community Plan Medicaid eligibility on the date of service. UnitedHealthcare Community Plan-participating care providers must accept the UnitedHealthcare payment disposition as payment in full and may not charge a member unless the following circumstances exist:

- The care provider is not a participating care provider of Delaware Medicaid, UnitedHealthcare Community Plan, Medicare, or the private carrier, or;
- If the recipient has Medicare and is advised, by the provider, prior to receiving a non-Medicare covered service that the member is responsible for the copay.

The care provider must adhere to UnitedHealthcare Community Plan’s prior authorization guidelines, except in situations in which Medicare is primary. If the service is not a covered benefit under Medicare, prior authorization by UnitedHealthcare Community Plan is required.

### 11.15 Subrogation Policy

UnitedHealthcare Community Plan is responsible for the medical care of a member who is injured or becomes ill as a result of an act by a third party. UnitedHealthcare Community Plan is required to notify the DMMA. UnitedHealthcare Community Plan and the care provider must reciprocate notification of involvement in such cases. Treating care providers should notify UM as soon as possible.

#### 11.16 Payments Outside the U.S.

In March 2010, President Obama signed the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, and collectively referred to as the Affordable Care Act (ACA).

Section 6505 of the ACA prohibits states from providing payment for items or services provided under the state Medicaid plan or under a waiver to any financial institution or entity located outside of the United States (U.S.). This provision became effective on Jan. 1, 2011.

In accordance with this provision, the table below summarizes the circumstances under which Medicaid payment will be denied:

Because UnitedHealthcare Community Plan is obligated to remain in compliance with federal law, as of August 2011, UnitedHealthcare Community Plan will deny claims when:

- services for the Community Plan patient were rendered outside of the U.S. (or U.S. territories) and;
- payment is requested to be sent outside of the U.S. (or U.S. territories), regardless of where the service was rendered.

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<tr>
<th>Services Rendered</th>
<th>Payment sent</th>
<th>Inside the U.S. (or U.S. territories)</th>
<th>Outside of the U.S. (or U.S. territories)</th>
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12: Prior Authorization

12.1 Services that Require Prior Authorization

UnitedHealthcare Community Plan includes a broad range of benefits to meet a member’s health care needs. The prior authorization process evaluates the appropriateness, the intensity and proposed location of a requested service. UM accepts prior authorization requests from either the PCP or consulting provider.

The initial authorization for LTC services is based on the following:

- a physician’s order
- a nursing assessment
- a social assessment

The initial authorization process procedures must be communicated to members. The plan may accept a request for LTC services from a Care Coordinator, the member, or the physician. Once the request is accepted, the PCP must provide an order that includes all required information supporting the request.

Beginning April 1, 2017, the following cosmetic and reconstructive procedure codes no longer require prior authorization:

- 15876
- 21282
- 67916
- 21137
- 21295
- 67917
- 21138
- 21296
- 67921
- 21139
- 36468
- 67914
- 67915
- 67922
- 67911
- 67923
- 67922
- 21208
- 67923
- 21209
- 67924
- 21280
- 67911
- 21280
- 67917
- 67915
- 67911
- 21280

Although prior authorization requirements are being removed, post-service determinations may still be applicable based on criteria published in medical policies and/or local and national coverage determination criteria.

12.2 Responsibility for Requesting Prior Authorization

The PCP or specialist can request an authorization the following ways:

- Call Utilization Management by phone at 800-366-7304
- Request a prior authorization online
- Fax a request to Utilization Management* – 877-877-8230. A standard prior authorization form may be found online.

*In order for us to reply back to you by fax, it is critical that you indicate that your fax line is dedicated to your business and it is secure. It is also critical that you certify that you will comply with all state and federal privacy laws as they relate to the transmission and use of personal health information. If using the accompanying standard fax form, please answer the applicable question included on the form. If you do not use the standard fax form, please include a statement on future cover sheets certifying that the fax line used to receive a transaction is a secure fax line and that you will comply with both federal and state laws as they relate to the transmission and use of personal health information.

UM provides on-call staff availability 24/7 for prior authorization purposes. Medical directors and UM representatives use plan-specific criteria for the review of service requests. All decisions are based upon medical necessity.

The type of request will also be reviewed by UM upon receipt of the documentation. STAT requests are defined as a standard request from the provider to escalate a review that does not meet the definition of urgent; all requests for STAT review by a care provider are expedited.

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

- Member name, DOB and recipient identification number
- Provider name and ID number
12: Prior Authorization

- Caller name, phone/fax number
- Date(s) service will be performed
- Name and ID number of facility where services will be performed
- Diagnosis by ICD-10 code
- Procedure by CPT or HCPCS code
- Supporting clinical information and treatment plan

If the criteria are not met, the case is presented to a UnitedHealthcare Community Plan medical director. Under these circumstances, the medical director may discuss the case with the member’s treating provider. The medical director may also consult the EQIC and other network care providers. The treating care provider may contact the medical director to discuss the case.

For UnitedHealthcare Community Plan members, peer review is always used in the case of payment denial for services provided to a member under age 21.

Any change or reduction to the original request is considered a denial and a denial letter will be issued to the care provider and the member. The requesting care provider or appropriate party will always be supplied with the rationale of the denial determination. A denial may be based on one or more of the following:

- Lack of proper notification (procedural denial)
- Service is not a covered benefit or not medically necessary
- Place of service not medically necessary
- Delay in service not attributable to the patient’s condition.

Care providers may request a copy of the clinical criteria and may appeal medical and procedural denials according to the UnitedHealthcare Community Plan appeal process found in the Member Grievance and Appeal Procedures section of this manual. To request this criteria, please call the Office of the Medical Director at 866-694-9662.

12.3 Medical Necessity

Medical necessity is defined as the essential need for medical care or services (all covered state Medicaid plan services, subject to age and eligibility restrictions and EPSDT requirements) which, when prescribed by the beneficiary’s Primary Care Provider or Care Manager and delivered by or through authorized and qualified care providers, will:

- Be directly related to the diagnosed medical condition or the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary’s condition) and be provided to the beneficiary only;
- Be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, abilities and environment) of the beneficiary and the beneficiary’s family;
- Be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, the beneficiary’s family or the beneficiary’s provider;
- Be timely, considering the nature and current state of the beneficiary’s diagnosed condition and its effects, and be expected to achieve the intended outcomes in a reasonable time;
- Be the least costly, appropriate, available health service alternative and will represent an effective and appropriate use of program funds;
- Be the most appropriate care or service that can be safely and effectively provided to the beneficiary and will not duplicate other services provided to the beneficiary;
- Be sufficient in amount, scope and duration to reasonably achieve its purpose;
- Be recognized as either the treatment of choice (i.e. prevailing community or statewide standard), common medical practice by the provider’s peer group or the functional equivalent of other care and services commonly provided; and
- Be rendered in response to a life threatening condition or pain or to treat an injury, illness or other diagnosed condition or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including the loss of physical or
mental functionality or developmental delay, and will be reasonably determined to:

• Diagnose, cure, correct or ameliorate defects physical and mental illnesses, diagnosed conditions or the effects of such conditions; or
• Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, result in illness or infirmity or have caused or threaten to cause a physical or mental dysfunction, impairment, disability or developmental delay; or
• Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or
• Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury or other diagnosed condition or the effects of the illness, injury or condition; or
• Provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat or support a diagnosed condition or the effects of the condition; in order that the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety and integration into all natural family, community and facility environments and activities.

12.4 New Technology

If requests are received for services involving new technologies, the medical directors will review all available sources of information prior to making a determination in accordance with our policy. This process includes a review of available published literature, consultation with services that evaluate new technologies (including medical procedures, behavioral health procedures, pharmaceuticals and devices) and a consultation with experts, as needed, before rendering a decision on coverage of the requested service. UnitedHealthcare Community Plan evaluates new technology that is not covered on a case-by-case basis. You are encouraged to contact UM or a medical director for prior authorization of these services.

12.5 Durable Medical Equipment

You must obtain a prior authorization from UnitedHealthcare Community Plan for DME items with a billable charge greater than $500. A DME Prior Authorization Form may be faxed to UM at 877-877-8230. Care providers for all UnitedHealthcare Community Plan products must also receive a prior authorization from UM for all DME rentals. The rental will be approved for up to three months or for the actual purchase price of the equipment, whichever is the lesser amount. The treating care provider should contact UnitedHealthcare Community Plan for DME authorizations.

12.6 UnitedHealthcare Community Plan Prior Authorization Guide

12.6.1 Delaware Medicaid and DHCP

Please refer to the list below for the UnitedHealthcare Community Plan Medicaid and DHCP services requiring prior authorization.

• Admissions to a hospital or any other facility (emergency admissions require authorization within 48 hours of admission, or the next business day).
• ASH elective procedures* (i.e. abortion, sterilization, hysterectomy, vasectomy) – *Do not require prior authorization but consent form may be required.
• Bariatric surgery
• Bone growth stimulator
• BRCA genetic testing
• Breast reconstruction (non-mastectomy)
• Cochlear & auditory implants
• Cosmetic & reconstructive
• Durable medical equipment over $500
• Enteral/parenteral therapy
• Experimental & investigational
• Home health care
• Injectable medications - Botulinum Toxins, Acthar HP, IVIG, Xolair
• Behavioral Health: Inpatient, Residential, Partial Hospital, Intensive Outpatient and Non-routine OP services
• Joint replacement
• Muscle flap
• Orthognathic
• Orthotics and prosthetics (over $500)
• Out-of-network services
• Proton beam
• Radiology services – magnetic resonance image (MRI), magnetic resonance angiography (MRA), computerized axial tomography (CT), positron-emission tomography (PET), nuclear medicine, nuclear cardiology
• Cardiology services – diagnostic heart catheterization, stress echocardiography, transthoracic echocardiography, cardiac implantable devices
• Septoplasty/rhinoplasty
• Sleep apnea procedures & surgeries
• Sleep study
• Spinal stimulator
• Spine surgeries
• Transplants
• Vagus nerve stimulation
• Vein procedures
• Ventricular assist devices

12.6.2 Delaware Medicaid Long Term Care

In addition to the basic Medicaid benefits that all eligible Delaware LTC members may receive, there are certain enhanced benefits specific to eligible LTC members only. These LTC services require prior authorization and are outlined in Section 9.2 Delaware Medicaid Long Term Care Enhanced Benefits.

12.7 Medical Director/UM Reviewer Availability

A UnitedHealthcare Community Plan medical director is available to discuss any UM process or denial decisions. Call Provider Services at 800-600-9007.

12.8 Affirmative Statement about Incentives

UnitedHealthcare Community Plan affirms that UM decision-making is based only on the appropriateness of care and services and the existence of coverage. UnitedHealthcare Community Plan does not specifically reward providers or other individuals for issuing denials of coverage or care. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

12.9 Access to UnitedHealthcare Community Plan Staff Members

The UM staff is available at least eight hours a day, during normal business hours, for inbound calls regarding UM issues. The staff can receive inbound communication regarding UM issues after normal business hours. Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. Staff members identify themselves by name, title and organization name when making calls about UM issues. If you have any questions about the UM process, please call 800-366-7304.
13: Preventive Health and Clinical Guidelines

13.1 Preventive and Clinical Health Care Standards

UnitedHealthcare Community Plan’s National Quality Committee develops, reviews and revises preventive care and clinical practice guidelines (CPGs) relevant to the populations served by UnitedHealthcare Community Plan plans and in keeping with contractual, regulatory and external accreditation programs. Guidelines are reviewed, revised and approved every two years and as necessary when national guidelines change. Documentation of the review is maintained either at the corporate office or at the health plan, depending upon who performs the review. Preventive health care guidelines and CPGs are available at UHCCommunityPlan.com.

UnitedHealthcare Community Plan’s goal is to partner with providers to help ensure that members receive preventive care. UnitedHealthcare Community Plan endorses and monitors preventive health standards recommended by recognized medical and professional organizations. UnitedHealthcare Community Plan monitors the provision of these services and the adherence to our guidelines through chart reviews and analysis of encounter data.

13.2 Preventive Care and Screening Tests

Preventive care and screening tests include: bone mass measurements, colorectal screenings, immunizations, mammography screenings, pap smears, pelvic exams, clinical breast exams, prostate cancer screening exams, cardiovascular screening blood tests and routine physical exams, and others as noted in the current preventive health guidelines.

13.3 Mammogram Screenings

UnitedHealthcare Community Plan supports access to and utilization of mammography through the education of members and by encouraging self-referral to participating providers for mammogram screenings.

13.4 EPSDT Information for UnitedHealthcare Community Plan Providers

UnitedHealthcare Community Plan’s Pediatric Services program includes EPSDT screenings for children up to age 21. It is essential that children enrolled in UnitedHealthcare Community Plan Medicaid receive screening exams at the appropriate ages. The PCP member roster identifies those members who are due for an EPSDT screen in the upcoming month. UnitedHealthcare Community Plan will work with the PCP to notify members due for an EPSDT screening.

13.4.1 Scheduling EPSDT Appointments

UnitedHealthcare Community Plan closely monitors EPSDT compliance. The PCP is responsible for providing EPSDT outreach and follow-up care. Appointments for EPSDT screenings should be made within two weeks after the initial request.

13.4.2 Reporting EPSDT Encounters

All EPSDT screening services should be reported to UnitedHealthcare Community Plan on a HIPAA-compliant claim form. The following information is required:

- Diagnosis code V20.2 must be noted as the primary diagnosis.
- Appropriate evaluation and management codes must be included.
- Appropriate charges must be listed for each line item.
- You have 90 days to submit completed EPSDT encounters.

For care providers electing to submit on a UB-04 or 837I, both an appropriate procedure code and revenue code must be provided.
13.4.3 Childhood Immunizations

The UnitedHealthcare Community Plan EPSDT guidelines include immunizations for children through the age of 18 in compliance with the Vaccines for Children (VFC) program. The State of Delaware participates in VFC to provide vaccines to all public and private health care providers who agree to participate in the program. The PCP should distribute biologicals obtained through VFC to UnitedHealthcare Community Plan members requiring immunizations. The State of Delaware operates an immunization registry and UnitedHealthcare Community Plan strongly encourages providers to work with the registry.

The member’s immunization encounter must be documented on a CMS-1500 or UB-04. The PCP will not be reimbursed for biologicals obtained through VFC.

13.4.4 Lead Screening Guidelines

The UnitedHealthcare Community Plan EPSDT guidelines include blood lead level screenings for children who are between the ages of six and 72 months. A Lead Screening Questionnaire should be completed at the time of each routine office visit for children of this age group. The questionnaire assesses the potential for high-dose lead exposure. All children regardless of risk are required to have an initial blood lead test performed between the ages of nine and 12 months and a second blood test at 24 months. The results of the Lead Screening Questionnaire will dictate the frequency of subsequent lead screenings. UnitedHealthcare Community Plan has contracted with and participating hospital laboratories for blood testing.

13.4.5 Pediatric Expanded Services

Children may be eligible for additional services under the EPSDT program. Requests for expanded services must be submitted in writing to UM.

13.4.6 Fluoride Varnish Application, Risk Assessment, and Dental Home Referral for Pediatric Patients

Qualified primary care providers who hold the appropriate state license and who received the certificate of completion for the Smile for Life Oral Health Curriculum Course 6 can apply fluoride varnish to pediatric patients in their practice setting. Qualified practitioners include physicians, nurse practitioners, physician assistants and registered nurses.

Risk Assessment & Dental Home Referral

Health care providers must complete a caries risk assessment prior to application of the fluoride varnish. A child with high caries risk assessment under age of one must be referred to a Medicaid dental provider for treatment. A child age one with low caries risk should be referred to a dental home for routine care. Dietary counseling must also be given to all patients and should be part of anticipatory guidance during the well visit.

Billing for Fluoride Varnish

Pediatric patients between ages six months and five years old are eligible to receive fluoride one time every six months. Fluoride varnish can only be given during the well-child visit. Qualified primary care providers can receive reimbursement with CPT procedure code 99188. Currently 99188 is reimbursed to Medicaid health care providers for $20.00.

Important information:

Medicaid dental providers for members under the age of 21: insurekidsnow.gov/state/delaware/delawareoral.html

Smiles for Life Curriculum Course 6: Smilesforlifeoralhealth.org

14: Quality Improvement (QI) Program

14.1 Overview

The QI program is designed to continually evaluate, monitor and improve the quality of care and services that UnitedHealthcare Community Plan manages. The program identifies and recommends ways to improve health care and related services delivered to UnitedHealthcare Community Plan members through the use of continuous QI concepts and methods, such as:

• Evaluating clinical and administrative aspects of care and services provided to members to determine areas for improvement,

• Recommending corrective plans of action to improve the quality of care and service,

• Implementing the plans of action, and

• Measuring the effectiveness of interventions to improve the quality of care, member service and the health status for the members it serves.

14.2 Provider Participation in Quality Management

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

14.3 Quality Goals

To continually enact comprehensive and effective change and improvement throughout UnitedHealthcare Community Plan’s health plan operations, the QI program has established the following objectives:

• To evaluate procedures designed to help ensure that members and providers are treated with respect and that privileged information is held in confidence

• To coordinate QI activities in accordance with applicable plan/product requirements

• To help ensure that the providers in the UnitedHealthcare Community Plan network meet or exceed the minimal standards of availability, accessibility and quality

• To help ensure that the range of expertise of the providers in the UnitedHealthcare Community Plan network is sufficient to meet the needs of UnitedHealthcare Community Plan members

• To monitor UnitedHealthcare Community Plan’s and network-participating providers’ clinical and administrative performance and to identify areas where improvement is required

• To evaluate the health status of UnitedHealthcare Community Plan members and identify specific health problems that require improvements in health promotion, disease prevention and health care services

• To evaluate the effectiveness of interventions designed to improve UnitedHealthcare Community Plan and network participating care provider performance

• To identify the most common chronic illnesses occurring in UnitedHealthcare Community Plan members and assist UnitedHealthcare Community Plan team members in evaluating the impact of care management and disease management programs designed to improve the quality of their care

• To assist UnitedHealthcare Community Plan team members in educating care providers to improve their performance, when required

• To evaluate the satisfaction of UnitedHealthcare Community Plan members and care providers with services and recommend appropriate ways to improve services when warranted

• To monitor, evaluate and intervene on grievances about administrative processes or access to UnitedHealthcare Community Plan through Member Services, Provider Relations, UM and the Pharmacy to help ensure that the highest level of service to all members is maintained

• To implement educational programs for personnel, in collaboration with UnitedHealthcare Community Plan team members, to improve the quality of company operations
14: Quality Improvement (QI) Program

• To promote a supportive milieu for members and care providers that addresses improving patient safety through member education, pharmaceutical management and physician and provider education.

14.4 Monitoring and Improving Quality of Care

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

• The accessibility of care providers, which is evaluated by analysis of grievance data and on-site and investigative reviews
• Care provider availability, which is monitored by GEO access reports and subsequent analysis of standards
• Member and care provider satisfaction with the plan services and UM process, which is monitored by CAHPS® and care provider satisfaction survey results and grievances
• Credentialing and recredentialing standards, which are monitored by adherence to standards and time frames
• Care provider adherence to published clinical practice guidelines, which is measured by annual guideline measures
• Preventive health services, which are measured by HEDIS measures and chart audits
• Continuity and coordination of care processes, which are evaluated by survey and chart audits
• Access to Member Services team members, which are evaluated by telephone statistics
• Quality of care problems evaluated by member grievances and sentinel events
• Patient safety, which is monitored by site reviews and adverse sentinel events
• Disease management program process and outcome measures, which are evaluated through Health Management analysis
• Health promotion services for children and adults, which are measured by HEDIS measures and chart audits.

14.5 Development of Clinical Practice Guidelines

UnitedHealthcare Community Plan develops and distributes clinical practice guidelines associated with acute and chronic conditions prevalent in the membership population in an effort to assist providers and members with health care decisions.

The guidelines are available on the UnitedHealthcare Community Plan website at UHCCommunityPlan.com.

14.6 Ongoing Evaluation Activities

QI activities that support the goals and objectives of the QI program are coordinated on an annual basis.

The program cycle is based on the calendar year, January through December. The QI work plan is the document that identifies the yearly activities that support the QI program. Included in this work plan are the objectives for the year, the program scope and clinical and service quality activities. A time frame for implementation will be noted for each activity along with the person or department responsible for that activity and a highlight of when interval analysis takes place. The annual QI program evaluation includes a summary of QI activities, the impact of the QI program and the need for revision.

Throughout the year, potential risk management cases and quality of care problems (including critical incidents and sentinel events) is evaluated through a formal program which will identify those cases that require investigation and follow-up and establish the data collection mechanism for trending purposes. This process will be conducted as part of UnitedHealthcare Community Plan’s peer review activities. Each potential risk management or potential quality of care problem is reported to Quality Improvement, and is investigated to determine the assignment of a quality concern level and initiation of an action plan. Quality Improvement will refer all necessary issues to the medical director for review.

Information used for tracking and trending purposes includes:
• Date of incident or identification
• Member identification number
14: Quality Improvement (QI) Program

- Involved participating provider, if other than Primary Care Provider (PCP)
- Facility (site) where the problem occurred
- Problem description
- Quality concern level
- Action steps
- PCP name
- Outcome/follow-up.

At least quarterly, Quality Improvement will prepare a summary of tracking activities for review by the QI Committee. The PAC Committee acts as a forum in trending quality of care issues and monitoring for system-wide problems. Focused studies/audits or multi-disciplinary teams may be recommended for pursuing QI initiatives for system-wide problems.

14.6.1 Critical Incident

UnitedHealthcare Community Plan’s Care Management Program is a holistic approach to helping our member’s live healthier lives.

a. Definition of a critical incident
Long Term Care member issues which are potentially harmful to person or property are known as critical incidents. Critical incidents include but are not limited to the following:
- Unexpected death of a member
- Suspected physical, mental or sexual abuse and/or neglect of a member
- Theft or financial exploitation of a DSHP Plus member
- Severe injury sustained by a member
- Medication error involving a member
- Inappropriate/unprofessional conduct by a care provider involving a member

b. How to report a critical incident
Incidents that may be considered critical can be reported by the member or an individual on behalf of the member to the health plan. A critical incident may occur at various locations such as:
- Assisted Living Facilities
- Skilled Nursing Facilities
- Adult Day Care Centers (ADC)
- Other Home and Community-Based Services (HCBS) Provider Sites
- Any provider location - doctor’s offices, transportation vendors, hospitals
- The member’s home

If you believe an issue involving a UnitedHealthcare Community Plan member may potentially be a critical incident, you can report it directly to the Health Plan by:
- Calling Member Services at 877-542-9248
- Calling the Member Advocate Team 877-901-5523
- Contacting your Provider Advocate Representative
- Contacting the member’s care coordinator

14.7 Monitoring Member and Provider Satisfaction

UnitedHealthcare Community Plan monitors member satisfaction to help ensure that all member interactions are effective and to identify opportunities to improve the full range of our operational processes, including:
- Availability and accessibility of health providers and services
- UM procedures
- Quality and service provided in practice settings
- Quality of Member Services.

UnitedHealthcare Community Plan analyzes member satisfaction data from all sources, including member satisfaction survey data and member grievances, and provides for interval analysis and an annual aggregate report. The report includes the assessment of member satisfaction data and the monitoring methodology, a quantitative and qualitative analysis, year-to-year trending, comparisons to goals and benchmarks, barrier analysis, opportunities for improvement and evaluation of the effectiveness of past interventions.
UnitedHealthcare Community Plan employs the Consumer Assessment of Health Plans Survey (CAHPS)™ data and member grievances. The CAHPS survey provides an integrated set of carefully tested and standardized questions to collect and report meaningful and reliable information about the experiences of the members. In addition, UnitedHealthcare Community Plan collects and reports all member grievances, which are categorized by reason when entered into the information system and reported by number and grievances per 1,000 members. Grievances are reported quarterly to the Service Quality Improvement Subcommittee (SQIS). All member grievances are logged upon receipt by the Grievance and Appeals staff and categorized by reason. Grievances are reported quarterly to the PAC Committee.

UnitedHealthcare Community Plan evaluates provider satisfaction using an annual satisfaction survey. The surveys, which are used for PCPs, high-volume specialty care providers, ancillary care providers, hospitals, dental providers and behavioral health providers are managed by Quality Improvement. These care providers receive surveys in the mail. High-volume specialists are determined from claims analysis based on volume and include OB/GYN care providers. The following categories of ancillary care providers also receive surveys: DME, home health, hospice, infusion, medical supplies and orthotics/prosthetics.

14.8 Peer Review Procedures

The UnitedHealthcare Community Plan medical director will always contact a care provider if there is a question about grievances, credentialing, the quality of care, sentinel events or services delivered. If the medical director and individual provider or practice cannot resolve the issues adequately and pursuant to state and federal regulations, the issues will then be sent to the appropriate UnitedHealthcare Community Plan PAC Committee.

14.9 Additional Program Information

To obtain additional information on the QI program, including a description and report of activities and process toward its goals, please write to:

Quality Improvement
UnitedHealthcare Community Plan
4051 Ogletown Road, Suite 200
Newark, DE 19713
15.1 A Resource to Address Complicated Medical and Social Needs

UnitedHealthcare's member-centric care management program encourages member to be active in setting practical goals (plan of care) to improve their overall health. This approach also is levied to establish a medical home and to keep members healthy in their communities. We have found available resources and member-centric care improves a member's overall functional and emotional status.

Care management goals are:

- To assure the member is leveraging personal, family, and community strengths.
- To help ensure that we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities.
- To modify approach or services based on the feedback from the member, family, and other health care team members.
- To monitor outcomes
- To communicate effectively to establish a medical home and to coordinate services with provider/specialist.
- Involve the care provider in developing or supporting the plan of care
- To evaluate member satisfaction

The plan of care addresses the following needs of the member:

- Psychosocial
- Nutritional
- Medication
- Prevention
- Self-monitoring
- Signs and Symptoms
- Appropriate health care utilization

15.2 Care Provider Involvement

Care providers can be actively involved in our care management programs in several ways. The plan recognizes the importance of care management and provider collaboration to develop an individualized plan of care to help ensure better healthy outcomes. Care provider involvement includes:

- Each treating care provider is notified in writing at the time of a patient's enrollment into a Care Management Program and is invited to participate/develop the initial and ongoing individualized plan of care.
- The Case Manager or Care Coordinator will outreach to the physician's office with any serious changes in a member's condition to update and redirect the plan of care.
- Care providers are strongly encouraged to refer patients to care management as needed.

If you identify a Medicaid member who may benefit from Care Management, please call Member Services at 877-877-8159 (TTY 711). For more information on Care Management for LTC members, please call 855-821-9102.

15.3 Health Care Management Programs

15.3.1 Care Management and Disease Management

UnitedHealthcare Community Plan's Care Management Program is a holistic approach to helping our member's live healthier lives.

Our primary focus is to work with you to keep members healthy and independent in the community by decreasing barriers to care.

Our program encourages and promotes member self-management, active decision-making, and active participation in health care planning, interventions and outcomes.
Our Case Manager or Care Coordinator assists to coordinate services, support, educate and encourage the member on the established plan of care. In addition, we work with you and the member to help ensure timely access to the right care provider, at the right time, at the right place of service.

UnitedHealthcare Community Plan's Care Management Program is inclusive of care and disease management. The primary disease specific management programs incorporated into the holistic care management model are:

- **Respiratory Case Management** with a focus on moderate to severe asthma or COPD
- **Cardiac Case Management** with a focus on CHF, CAD or HTN
- **Diabetes Case Management**
- **Transplant Case Management**
- **HIV/AIDS Case Management**
- **High Risk Pregnancy Case Management**

If you identify a Medicaid member who may need care/disease management services, please call Member Services at 877-877-8159 (TTY 711). For more information on care management for LTC members, please call 855-821-9102.

### 15: Case Management Services

#### 15.3.2 Long Term Care Case Management

**Case Management and the Role of the Case Manager**

UnitedHealthcare Community Plan is responsible for managing all the services necessary to meet physical health, mental health and long-term care needs. UnitedHealthcare Community Plan does this through case management.

Our program takes a holistic approach to helping our member’s live healthier lives. Our focus is to work with the member, their PCP and service providers to keep our members healthy and independent in the community.

Our program encourages and promotes member involvement, active decision-making, and active participation in planning their health care needs.

Our Case Managers provide support and education and they assist in coordinating services to help ensure timely access to care with the right provider, at the right time, at the right place of service.

UnitedHealthcare Community Plan assigns each member a Case Manager. The Case Manager is the main contact person for members and care providers.

**Case Management and the Physician**

- Case Managers help members find PCPs
- Case Managers help facilitate the sharing of information between PCPs and other providers on any assessments and screenings the member has had
- A copy of the member’s Plan of Care (POC) is sent to the PCP

**Plan of Care (POC)**

Every Delaware Medicaid Long Term Care member has a POC developed. This plan encompasses physical, mental health and long term care needs. A copy is sent by secure fax or email (per care provider’s preference) to every provider that services the member. The POC includes the service provider’s name, service type, frequency, authorization number and duration of approved service.

Services may be provided in:

- The member’s home
- Another place in the community (such as an assisted living facility)

**Waiver approval and level of care determination remains with the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD).**

Members that reside in a nursing home may be able transition to their own home; however, the cost of that care cannot be more than the cost of care in a nursing home.
No member is forced to leave the nursing home if they do not want to do so, even if we think care in the community costs less, as long as the member qualifies for nursing home care. Care Coordinators works with members to discuss changes that need to be considered when deciding what setting is the best place to meet their needs and assure their well-being.

If the member receives care in a nursing home, the Case Manager will:

- Be part of the care planning process at the nursing home.
- Perform any additional needs assessment that may be helpful in managing the health and long-term care needs of our members.
- Supplement the nursing home’s plan of care if there are services needed to help manage health problems or coordinate other kinds of physical and mental health needed.
- Determine if our members are interested and able to move from the nursing home back to the community and if so, help facilitate.

Members can also help choose the care providers who provide care. This could be an assisted living or nursing home, or the agency that will provide care at home. The Case Manager can assist members who choose to hire their own workers for some kinds of care (Consumer Direction).

If a member receives care at home, the Case Manager will:

- Help coordinate POCs so they work like they should to meet our members’ needs.
- Monitor our members’ health care and make sure that they are getting the care they need. If additional care is needed, the Case Manager will assist in facilitating.
- Provide information about community resources that might be helpful.
- Facilitate services for members at home based on their needs.
- Help coordinate care and service needs.

UnitedHealthcare Community Plan of Delaware provides all participating service care providers with a contact list for escalation of any issue/concern that cannot be addressed by our members’ assigned case manager.

15.4 Behavioral Health Case Management (Mental Health and Substance Abuse)

The philosophy for providing optimal treatment for our members is a holistic approach. Therefore, the coordination of care between the member, the member’s family, the behavioral health providers, the medical providers and UnitedHealthcare Community Plan case managers is essential to meet this goal. UnitedHealthcare Community Plan offers case management for members with complex behavioral health and substance abuse conditions.

Once involved in the behavioral health case management program, members can expect a call from one of the behavioral health case management staff on an ongoing basis to answer questions and provide education related to behavioral health/substance abuse needs. Members are primarily identified through utilization of behavioral health and substance abuse services and both internal and external referrals. Members may also self-refer to the Behavioral Health Case Management program.

Members seeking behavioral health treatment receive care on multiple levels. The following list includes ways our care providers can help serve members:

- Establish communication between providers at the facility and provider level to coordinate care.
15: Case Management Services

- Meet behavioral health appointment standards as follows:
  - Life-threatening emergency should be seen immediately or referred to an emergency facility,
  - Non-life-threatening emergency within six hours,
  - Urgent need within 48 hours,
  - Routine office visit within seven calendar days.
- Begin the discharge planning process once a member is admitted. The UnitedHealthcare Community Plan case manager will assist in the provision of in-network options and linkage.
- Follow the Health Plan Employer Data and Information Set (HEDIS) requirement of following up after hospitalization, occurring ideally within seven days of discharge and, at the most, within 30 days of discharge. The goal for UnitedHealthcare Community Plan BHS is to meet this requirement as this measure assists in continuity of care for the member and decreases the risk of re-admission to an acute setting. Facilities and providers are to assist in the planning for a follow-up after hospitalization to meet this standard. Follow the HEDIS recommended specific appointment follow-up for the prescription of antidepressant and Attention Deficit/Hyperactivity Disorder (ADHD) medication. The expectations from HEDIS are as follows:
  - Antidepressant Medication Management: Pertains to any member 18 years of age or older. Members who are diagnosed with a new episode of depression and are started on anti-depressants are optimally scheduled with either a mental health provider or a non-mental health provider for three follow-up visits within 12 weeks of the initial prescription. At least one of the three visits must be with the prescribing care provider.
  - Attention Deficit/Hyperactivity Disorder (ADHD) Medication Management: Pertains to members between the ages of 6 and 12 years of age. For those started on a new prescription, the expectation is that a prescribing care provider will have a follow-up visit with the member within 30 days of the start of medication.

15.4.1 Behavioral Health Utilization Management

The UnitedHealthcare Community Plan Behavioral Health utilization managers possess either a registered nurse license or they are master’s-level licensed clinicians. The UnitedHealthcare Community Plan case manager will review treatment requests first as a prior authorization and then on a concurrent review basis using OptumHealth (United Behavioral Health) criteria for mental health reviews and American Society of Addiction Medicine (ASAM) for substance abuse reviews. The following services require review by a UnitedHealthcare Community Plan case manager (please refer to the benefit chart for limitations):
- Inpatient and partial hospitalization
- Intensive outpatient
- Psychological testing
- Outpatient ECT
- Outpatient detoxification
- Home health services.

Individual outpatient services do not require prior authorization. UnitedHealthcare Community Plan’s behavioral health staff reviews the outpatient services rendered and reserves the right to request a clinical progress review.

15.5 Special Needs Unit (SNU)

UnitedHealthcare Community Plan has a Special Needs Unit (SNU) to assist your members who have special needs because of ongoing physical, developmental, emotional or behavioral conditions. Our Special Needs Staff is able to assist with:
- Finding a Specialist
- Identifying and Connecting with Community and State Resources
- Accessing services offered through public education system
- Connecting with Behavioral Health Providers/Case Management
- Accessing the Transportation Benefit
15: Case Management Services

• Coordinating Benefits

These are just some examples how the SNU can help you. If you have a member who may need extra help, please call or have your member call our Special Needs Unit at 877-844-8844.

15.6 Member Advocates

UnitedHealthcare Community Plan’s member advocates work with members and providers to facilitate the delivery of health care services. Member advocates can help members to access their care and provide training and educational materials to providers to enhance understanding of the values and practices of all of our members’ cultures. Member advocates also provide input to UnitedHealthcare Community Plan on how provider changes will affect member access, quality of care and continuity of care issues, as well as medical record requests. Member advocates can be reached by calling 877-901-5523.

15.7 Member Services Call Center

UnitedHealthcare Community Plan Member Services representatives are available Monday through Friday from 8 a.m. to 7 p.m. ET to answer member questions. Members who call after hours for urgent care are encouraged to call their PCP. Member Services representatives take advantage of every opportunity to educate members on the role of the PCP, the importance of getting regular check-ups and practicing preventive care to prevent the need for urgent/emergency care.

15.8 24/7 NurseLine

Members may call UnitedHealthcare Community Plan’s 24/7 nurse advice line to obtain information about their health problems and seek advice. The 24/7 line is not intended to be a triage center, as it provides information of a more general nature. The 24/7 NurseLine numbers are:

• Medicaid and CHIP Members 866-877-5403
• Long Term Care Members 866-915-0311
16.1 Compliance Program

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

- Oversight of the Ethics and Compliance Program,
- Development and implementation of ethical standards and business conduct policies,
- Creating awareness of the standards and policies through education,
- Assessing compliance by monitoring and auditing,
- Responding to allegations or information regarding violations,
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty,
- Reporting mechanisms for employees, managers and others to alert management and/or Compliance Program staff to violations of law, regulations, policies and procedures, or contractual obligations.

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

16.2 Definition of Fraud, Waste and Abuse (FWA)

**Fraud** – An intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law.

**Abuse** – For purposes of program integrity, provider practices inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid and CHIP program, or in reimbursement for services not Medically Necessary or that fail to meet professionally recognized standards for health care. Abuse also includes client/member practices that result in unnecessary cost to the Medicaid and CHIP program (see 42 CFR 455.2).

**Waste** – Health care spending that can be eliminated without reducing quality of care.

16.2.1 FWA Timeframe for reporting overpayment

Care providers must report overpayments to us within 60 calendar days from the date the overpayment is identified. Overpayments that are not reported and returned within 60 calendar days from the date of the overpayment was identified may result in a penalty pursuant to State or Federal law.

16.3 Reporting and Auditing

Any unethical, unlawful or otherwise inappropriate activity by a UnitedHealthcare Community Plan employee which comes to the attention of a care provider should be reported to a UnitedHealthcare Community Plan senior manager in the health plan or at 877-401-9430. UnitedHealthcare Community Plan’s Anti-Fraud, Waste and Abuse Program is an important component of the Compliance Program. This program focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by providers and plan members. To report fraud and abuse, or other questionable incidents involving plan members or care providers, call Provider Services at 800-600-9007.
Through the Anti-Fraud, Waste, and Abuse Program, UnitedHealthcare Community Plan’s mission is to prevent paying fraudulent, wasteful or abusive health care claims, as well as identify, investigate and recover money it has paid for fraudulent, wasteful or abusive claims. UnitedHealthcare will also appropriately refer suspected fraud, waste and abuse cases to law enforcement, regulatory, and administrative agencies pursuant to state and federal law. UnitedHealthcare seeks to protect the ethical and fiscal integrity of the company and its employees, members, providers, government programs, and the public, as well as safeguard the health and well-being of its members.

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

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

An important aspect of the Compliance Program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing periodic reviews and audits to help ensure compliance with law, regulations, and contracts. When informed of potentially irregular, inappropriate or fraudulent practices within the plan or by our providers, UnitedHealthcare Community Plan will conduct an appropriate investigation. Providers are expected to cooperate with the company and government authorities. The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid aimed at reducing fraud within the health care programs funded by the Federal government. Under Section 6032 of the DRA, every entity that receives at least five million dollars in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any contractor or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws.

As a contracted care provider with UnitedHealthcare Community Plan, you and your staff are subject to this provision. The UnitedHealth Group policy, titled “Integrity of Claims, Reports and Representations to Government Entities” can be found at UHCCommunityPlan.com. This policy details our commitment to compliance with the federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers.

16.4 Protecting Confidentiality of Member Data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all records and information about their health care. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records.

Physicians will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of member medical information. Physicians agree specifically to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations, in addition to the American Reinvestment and Recovery Act (ARRA) applicable state laws and regulations. UnitedHealthcare uses member information for treatment, operations and payment. UnitedHealthcare has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes policies and procedures governing administrative and technical safeguards of protected health information. Training is provided to all personnel on an annual basis and to all new employees within the first 30 days of employment.
UnitedHealthcare Community Plan is proud of its success in implementing the required HIPAA standards. UnitedHealthcare Community Plan is Claredi certified as to the administrative simplification standards for transactions and code sets. We are capable of interacting directly with providers through HIPAA-compliant EDI transactions. UnitedHealthcare Community Plan also contracts with a clearinghouse which providers can use to submit and receive noncompliant EDI transactions. If you are interested in communicating with us through EDI, please contact Provider Services.

The UnitedHealthcare Community Plan health care ID card reminds our members that, by enrolling in UnitedHealthcare Community Plan managed care product, they agreed to our limited use of their PHI for appropriate purposes. UnitedHealthcare Community Plan reminds care providers that they are obligated, both by applicable law and the standard provider participation agreement, to obtain the consent of our member, who is their patient, regarding use of PHI for any purposes other than those permitted by law. Care providers are also required to inform UnitedHealthcare Community Plan about any breach of the HIPAA privacy rules in a timely manner and cooperate with reasonable actions designed to remediate the adverse effects of such a breach.

The companies in the UnitedHealthcare insurance holding company system adopted ‘affiliated entity’ status for purposes of the HIPAA privacy standards. We use and disclose our members’ protected health information (PHI) only for purposes of treatment, payment and health care operations. Copies of the notices that describe our privacy practices for each UnitedHealthcare Community Plan managed care product can be accessed at UHCCommunityPlan.com (hard copies are available upon request).

16.5 Notice About Non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person’s race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that participate in federal and state programs, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for the state of Delaware.
17.1 Overview

It is UnitedHealthcare Community Plan’s goal to identify, eliminate and prevent provider dissatisfaction by making every effort to maintain open lines of communication. To help ensure that care provider disputes are resolved in a consistent manner, UnitedHealthcare Community Plan operates internal provider dispute procedures. If you have a complaint or other problem regarding any aspect of UnitedHealthcare Community Plan’s operations, you may contact Provider Services to register a complaint and seek resolution.

If a matter cannot be resolved to your satisfaction, you can exercise your dispute rights in writing. Requests must be received within the time frames specified below and should include all details relevant to the dispute and to the attempts at resolution prior to filing.

17.2 Care Provider Requests for Medical Necessity Reconsideration

Care providers disputing denials based upon the lack of medical necessity (prospective or retrospective) may use an alternative UnitedHealthcare Community Plan process rather than the dispute process detailed above. This process follows the same requirements and time frames as for other disputes outlined, but requires the written consent of the UnitedHealthcare Community Plan member. The written member consent must accompany the care provider’s request for a medical necessity review. External review of care provider requests for medical necessity reconsideration is conducted in accordance with procedures established by the Delaware Department of Health and Social Services. Care providers must request such review within 90 days of their receipt of the decision letter regarding the dispute.

17.3 Care Provider Disputes

Below is a brief description of UnitedHealthcare Community Plan’s various dispute processes. You may obtain further information regarding specific situations by contacting Provider Services. You may dispute the following decisions by UnitedHealthcare Community Plan:

- Denial of a claim or payment authorization request (failure to follow procedures or medical necessity guidelines)
- Credentialing or recredentialing denial
- Care provider contract termination by UnitedHealthcare Community Plan

17.4 Dispute of Denied Claims and Payment Authorization

Claims and requests for payment authorization may be denied for failure to follow required procedures or UnitedHealthcare Community Plan’s UM/QI plan (ex: failure to obtain required prior authorization or submit claims on time). While UnitedHealthcare Community Plan encourages care providers to seek informal resolution of all claim disputes challenging claim payments, denials or recoupments through Provider Services, the formal dispute process must be initiated no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. Disputes of denied claims must be submitted in writing to:

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

You should not resubmit denied claims or send disputes to the Claims Department. Disputes must include all supporting documentation and specify all reasons why the provider believes UnitedHealthcare Community Plan’s original decision is in error. Disputes over payment will generally be decided within 30 days of receipt; you may request an extension.
17.5 Appeals of Credentialing Decisions and Contract Termination Decisions

You may request review of credentialing decision or other professional review action. Professional review actions are peer review actions subject to all protections provided by law and are reviewed pursuant to care provider dispute process (as amended from time-to-time). Currently, such disputes are reviewed by a panel of network participating providers. You have the right (1) to appear and participate in person; (2) to submit verbal and written evidence; and (3) to be represented by an attorney in such proceedings. Care providers seeking review of professional review actions should submit their dispute in writing by certified mail within 30 days of the date of the professional review action notice to:

UnitedHealthcare Community Plan  
Attn: Medical Director  
4051 Ogletown Road, Suite 200  
Newark, DE 19713

You will receive a hearing notice setting the time, date and place of the hearing and relating your rights during the hearing process. A hearing will be held at least 30 days from the date of the hearing notice.

Care providers disputing contract termination decisions should, upon receipt of UnitedHealthcare Community Plan’s decision, immediately contact Provider Services.

17.6 Arbitration

You may also be able to seek review of any dispute through the arbitration process, as set forth in the provider agreement, if applicable. You are generally required to exhaust all available internal dispute processes before seeking arbitration.

17.7 Care Provider Dispute Process Revisions

The care provider dispute process described herein is subject to change, without notice, to accommodate revisions in applicable federal and state law. If you have any questions, contact Provider Services.

17.8 Member Appeals, Grievances and State Hearings

You may reference the member handbook provided with this manual or contact UnitedHealthcare Community Plan to request our policies and procedures for more detailed information regarding the member dispute process. UnitedHealthcare Community Plan’s member grievance procedures differ based on the rules and regulations of the government agency that oversees our health care plans. A brief description of the member dispute process is included in the following section. You may contact UnitedHealthcare Community Plan and request a copy of the member handbook or UnitedHealthcare Community Plan’s policies and procedures for more detailed information regarding the member dispute process, including deadlines for filing member disputes.
18.1 Member Appeal Process

The member, or authorized representative with the written consent of the member, may file an appeal regarding a UnitedHealthcare Community Plan action within 90 days of the date of the action.

Action means:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as defined by the State;
5. For a resident of a rural area that is covered by only one Contractor, the denial of a Medicaid MMC member's request to exercise their right to obtain services out of network:
   - From any other care provider (in terms of training, experience, and specialization) not available within the network;
   - From a care provider not part of the network that is the main source of a service to the recipient provided that the care provider is given the same opportunity to become a participating care provider as other similar care providers. If the care provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating care providers and is transitioned to a participating care provider within 60 days;
   - Because the only plan or care provider available does not provide the service because of moral or religious objections;
   - Because the recipient’s care provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
   - The state determines that other circumstances warrant out-of-network treatment.

The member may request that the authorized representative assist or represent the member during the process. The member, authorized representative, or provider may request to participate at the appeal review by telephone or in person at the local Delaware office located at 4051 Ogletown Rd., Ste 200, Newark, DE 19713. These requests must be written requests sent to the following address:

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

Member appeals are reviewed and a notice of the decision will be sent within 30 days of receipt. This period may be extended up to 14 calendar days upon member request or where UnitedHealthcare Community Plan demonstrates to the state of Delaware that the need for additional information is in the member's best interest.

UnitedHealthcare Community Plan will review the member’s appeal in an expedited manner if the member’s treating provider certifies that the member’s health will be harmed by deciding the appeal in the regular appeal time frames. The certification must include the clinical rationale and member-specific facts to support the provider’s opinion. The appeal will be reviewed and a notice of the decision will be sent within three working days of its receipt of the expedited appeal request. The member will also be notified of the decision promptly by telephone.

18.2 Member Grievance Process

The member, or an authorized representative of the member, may file a grievance with UnitedHealthcare Community Plan to express dissatisfaction with any aspect of UnitedHealthcare Community Plan's or a provider’s operation, provision of health care services, activities or behaviors, other than an action, within 90 calendar days of the date that the member became aware of the issue. Member grievances are reviewed and a notice of disposition is sent within 30 calendar days of receipt. This period may be extended by up to 14 calendar days upon member request or when UnitedHealthcare Community Plan demonstrates to the state of Delaware that the need for additional information is in the member’s best interest.
18.3 State Fair Hearings

The member, or an authorized representative with the written consent of the member, may also request a state fair hearing with the Delaware Department of Health and Social Services regarding any reduction, suspension, termination, denial or untimely delivery of a service or denial of payment. The member does not need to exhaust UnitedHealthcare Community Plan's appeal process before requesting a state fair hearing. The request must be filed within 90 calendar days of the date of UnitedHealthcare Community Plan's notice of action or the date of UnitedHealthcare Community Plan's written appeal decision. Requests must be mailed to:

DSS Fair Hearing Officer
Herman M. Holloway Campus, Lewis Building
P.O. Box 906
New Castle, DE 19720

You cannot use the hearing process to address claims payment disputes over failure to follow UnitedHealthcare Community Plan procedures. You may file appeals and grievances verbally or in writing.

18.4 Continuation of Services

The member may continue receiving services or items until a decision is made about his or her appeal or state fair hearing if:

• The member or the provider files the request for appeal or state fair hearing timely. Timely means it is hand-delivered or postmarked within ten days of the date of the notice or the intended effective date of the proposed action, whichever is later.
• The appeal or fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment.
• The services were ordered by an authorized provider.
• The authorization period has not expired.
• The member requests extension of the covered services.

If, at the member's request, UnitedHealthcare continues or reinstates the member’s covered services while the appeal or fair hearing is pending, the covered services must be continued until one of the following occurs:

• The member withdraws the appeal or fair hearing.
• Ten calendar days pass after the contractor sends the notice, providing the resolution of the appeal against the member, unless the member, within the 10-day timeframe, has requested a State Fair Hearing with continuation of covered services until a State Fair Hearing decision is reached.
• A State Fair Hearing officer issues a hearing decision adverse to the member.
• The time period or service limits of a previously authorized covered service has been met.

If the final resolution of the appeal or fair hearing is adverse to the member. The member may be liable for the cost of any continued benefits at the discretion of UnitedHealthcare Community Plan. or the Delaware DHSS.
UnitedHealthcare Community Plan is committed to preventing health care fraud, waste and abuse and fulfilling its obligations to comply with applicable federal and state laws including, but not limited to, Section 6032 of the Federal Deficit Reduction Act and the rules and regulations of the Medicare Advantage and Part D programs. Section 6032 of the Federal Deficit Reduction Act of 2005 requires us to provide information to our contractors on the federal and state false claims acts. The following has been drafted to assist us in fulfilling our compliance obligations.

The Federal False Claims Act is a statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false claim to the United States government for payment. People can be prosecuted under the Act for a variety of conduct that leads to the submission of fraudulent claims to the government. Penalties for violating the Act can be up to three times the value of the false claim, plus fines.

To encourage individuals to come forward and report misconduct involving false claims, the Act includes a “qui tam” or whistle-blower provision. This provision essentially allows any person with actual knowledge of false claims activity to file a lawsuit on behalf of the U.S. government. Individuals seeking whistle-blower status must meet several criteria including but not limited to being the original source of the information. If the lawsuit is successful (after being prosecuted by the government), the whistle-blower may receive an award ranging from 15 to 30 percent of the amount recovered by the government.

In addition to a financial award, the Act entitles whistle-blowers to additional relief, including employment reinstatement, back pay and any other compensation arising from retaliatory conduct against the whistle-blower for filing an action under the Act or committing other lawful acts, such as providing testimony or assisting in a False Claims Act action.

States in which UnitedHealthcare Community Plan does business have laws that contain civil or criminal penalties for false claims in addition to the penalties provided in the Act. Certain states also have whistleblower protections similar to the Act. In Delaware, the applicable laws are Delaware Statutes TI 6 Sect. 120 1-1209.

UnitedHealthcare Community Plan’s compliance plan and various departmental policies and procedures help ensure UnitedHealthcare Community Plan’s compliance with the Act and the various state false claims laws, as well as to detect and prevent fraud, waste and abuse in federal health care programs. Team members and the third parties that contract with UnitedHealthcare Community Plan, including but not limited to health care providers and other entities to whom UnitedHealthcare Community Plan has delegated obligations, must abide by UnitedHealthcare Community Plan’s compliance plan, which includes UnitedHealthcare Community Plan’s code of ethics and the relevant policies and procedures in this regard, all of which are discussed above. Please see the compliance page link on the UnitedHealthcare Community Plan website at UHCCommunityPlan.com for the most up to date version of the UnitedHealthcare Community Plan compliance plan and UnitedHealthcare Community Plan’s policy on fraud, waste and abuse. For more information on this topic, please contact UnitedHealthcare Community Plan’s compliance officer or Legal Department.