Fraud and Abuse Policies and Procedures

UnitedHealthcare Community Plan providers must have established policies and procedures on site that meet Arizona Health Care Cost Containment System (AHCCCS) requirements along with a process for reporting incidences of health care acquired conditions, abuse, neglect, exploitation, injuries and unexpected death. The policies and procedures should specify the process of submitting a report of health care acquired conditions, abuse, neglect, exploitation, injuries and unexpected death as listed here:

- Mail Supporting documentation of alleged fraud and abuse to:
  UnitedHealthcare Community Plan Attn: Compliance/Fraud and Abuse 1 East Washington Suite 800 for LTC Phoenix, AZ 85004 or

- Submit an email with supporting documentation to:
  • UnitedHealthcare Dual Complete and UnitedHealthcare Community Plan, Long Term Care (formerly Evercare Select): azecsqm@uhc.com

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Important information for health care professionals and facilities

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• Medicaid, Children’s
Rehabilitative Services,
Developmentally Disabled:
apipa_qualityofcare@uhc.com

For all AHCCCS eligible,
non-UnitedHealthcare Community Plan
members, call: 602-417-4000 or
888-ITS-NOT-OK. For more information
and submission forms, please see our Provider

Enhanced Payments for
Primary Care Services

The Centers for Medicare and Medicaid
Services (CMS) must approve the AHCCCS’s
proposed methodologies before enhanced
payments can begin. AHCCCS anticipates
that enhanced payments for qualifying claims
by qualifying providers with dates of service
on or after January 1, 2013 will not begin
until after July 1, 2013, but will be made
retroactively to January 1, 2013 once CMS
approval is received.

Enhanced payments are limited to Evaluation
and Management (E/M) codes (99201-
99499) and vaccine administration codes
(90460, 90461, 90471-90474) provided during
calendar years 2013 and 2014. These services
must be provided by qualified primary care
providers who self-attest as required under
federal regulations.

CMS defines qualified providers as physicians
who practice internal, family practice or
pediatric medicine, or any sub-specialty of
those that is recognized by the American
Board of Medical Specialties, the American
Osteopathic Association or the American
Board of Physician Specialties who meet one
of the following criteria:

• Physicians board-certified in one of those
specialties or sub-specialties or

• Physicians who practice of one of the
specialties or sub-specialties described above
who are not board-certified and submitted
claims for services provided to Medicaid
during calendar year 2012 for
which 60 percent of the Current Procedural
Terminology (CPT) codes reported are E/M
or vaccine administration procedures. For
physicians who registered with the AHCCCS
program after December 31, 2012, the 60
percent requirement applies to Medicaid
claims for the prior month.

To receive the enhanced payment, CMS requires
physicians who meet the criteria to provide a
self-attestation to AHCCCS verifying that they
qualify for the enhanced payment through either
the requisite board certification or the 60 percent
CPT code requirement.

Physicians filing the required attestation on or
before April 30, 2013 will be paid the enhanced
fee retroactively for dates of service from
January 1, 2013 forward for all primary care
eligible services. Physicians filing the required
attestation on or after May 1, 2013 will be paid the
enhanced fee on a going forward basis from the
time the attestation is received.

For more information, please see:
azaheccs.gov/commercial/ProviderBilling/rates/
PCSrates.aspx

Primary Care Provider Enhanced Fee
Attestation Page

Primary Care Provider Enhanced Fee
Attestation Memo
AHCCCS Provider Re-enrollment

To comply with the Affordable Care Act and 42 CFR 455, Subpart E and as a part of the provider registration process, all providers registered with AHCCCS are required to re-enroll. You will receive notification by mail along with information about where to access re-enrollment forms. After the documents are processed, you will be sent information about payment and site visit requirements.

Frequently Asked Questions

Q1. What is re-enrollment?

A. Re-enrollment is completion of the provider registration process and payment of the enrollment fee. Enrollment fees and site visits only apply to certain provider types. (Required Fee and/or Site Visit by Provider Type)

Q2. When will re-enrollment begin?

A. Re-enrollment began in January 2013.

Q3. When do I have to make my fee payment to AHCCCS?

A. You will receive notification in the mail with due dates for fee payment to AHCCCS.

Q4. When should I start completing and submitting the forms?

A. If you were registered with AHCCCS before January 1, 2012, you will be notified by mail or e-mail when it is time to re-enroll. The notice will list the required forms and direct you to a website where you can access the forms. All forms must be submitted by the deadline noted on the letter or your AHCCCS identification number will be terminated. Terminated providers are not be eligible to receive payment for services rendered to fee-for-service recipients or provide services under contract with a prepaid health plan or program contractor. Federal regulations prohibit an unverified provider from participating in the AHCCCS program.

You may access forms at azahcccs.gov/commercial/ProviderRegistration/packet.aspx.

Q5. Who can complete the forms?

A. Individual providers who are authorized signers on file with AHCCCS can complete the forms. The forms for companies/facilitates and groups may be signed by the CEO, CFO Administrator, Owner, Executive Director, President or Vice President.

Q6. Can providers submit the forms before receiving a re-enrollment notice?

A. No. If documents are received prior to receiving the re-enrollment notice, the documents will be processed as regular updates rather than re-enrollments.

Q7. Where should I send the completed forms?

A. Mail or fax completed and signed registration forms to:

Mail: AHCCCS Provider Registration
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002 or

Fax: 602-256-1474
(Attn: AHCCCS Provider Registration)

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Q8. How long does it take to process the re-enrollment forms?

A. Re-enrollment forms are typically processed within 15 business days if submitted information is complete. Some updates may take longer depending on the volume of documents we receive. When forms are faxed in, it usually takes 24 hours to appear in the system.

Q9. How will I know I have completed the re-enrollment process?

A. You will receive a re-enrollment completion letter when your documents have been processed or when your enrollment fee is paid and the site visit, if required, has been conducted. You will be notified if your provider type requires an enrollment fee and site visit.

Q10. Who do I contact with questions?

A. Please call or write the AHCCCS Provider Registration Unit if you have any questions.

- **In Maricopa County:**
  602-417-7670, Option 5

- **Outside Maricopa County:**
  800-794-6862

- **Out-of-state:** 800-523-0231

Arizona Health Care Cost Containment System
Attn: Provider Registration Unit
P.O. Box 25520, MD-8100
Phoenix, AZ 85002

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**UnitedHealthcare Supports World Elder Abuse Awareness Day June 15**

Please join UnitedHealthcare on Monday, June 17, 2013 as we wear purple to observe World Elder Abuse Awareness Day.

UnitedHealthcare has made prevention of elder abuse a priority and formed a national advisory board to address this serious problem. Our efforts to help prevent abuse, neglect and exploitation include the following initiatives focused on member engagement, education and training, and community partnerships:

- Abuse and Neglect Clinical Training: educating our care coordination teams
- Mental Health First Aid: promoting holistic care and community awareness
- Caregiver Support: supporting those who support our members
- Community Pilot or Independent Study: developing best practices to support our members
- Peer Ambassador Program: empowering and engaging our members as leaders in the community
- World Elder Abuse Awareness Day Activities: supporting national visibility through awareness campaigns

For more information on elder abuse and neglect, please go to **ncea.aoa.gov**.
Coordination of Care Between Primary Care Physicians and Specialists

Primary Care Physicians (PCPs) and specialists share responsibility for communicating essential patient information that leads to a higher quality of care.

Relevant information from PCPs that should be provided to specialists includes member history, diagnostic tests and results, and reasons for the consultation or office visit. The specialist should likewise provide the PCP with results of the consultation or office visit, ongoing recommendations and treatment plans.

Information exchange between providers should be timely, relevant and accurate to facilitate ongoing patient progress as we work together to improve the patient’s overall health status.

Documenting Coordination of Care Activity in Treatment Records

Network providers should coordinate care with each member’s PCP and hospitals, when applicable, and document these communications in the patient’s record.

Consistent and comprehensive information-sharing can improve the overall quality of care by:

- Confirming that a member followed through with a referral to a specialist
- Minimizing potential adverse medication interactions
- Allowing effective treatment management for members with co-morbid behavioral and medical disorders
- Reducing the risk of relapse for patients with substance-use disorders

If a member refuses to allow the release of this information, please document the reason for refusal in their record.

Communication Between Behavioral Health Clinicians and PCPs

To help facilitate timely and effective communication between behavioral health clinicians and PCPs and/or other treating specialists, United Behavioral Health, operating as Optum, has developed a coordination of care checklist for your convenience. You may access the form on Optum’s Provider Express Quick Links under “Forms” or simply document your coordination of care activities in progress notes or your own record-keeping system.

Coordination of care should occur at these times:

- Initiation of treatment
- Throughout treatment as clinically indicated
- Time of transfer to another treating clinician, facility, or program
- Conclusion of treatment

Member records should include documentation of activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities and consultants. If our member refuses to allow coordination of care, please document the reason for refusal.
United HealthCare Community Plan

Practice Matters is a quarterly publication for physicians and other health care professionals and facilities in the UnitedHealthcare network.